

Cambridge University Hospitals NHS Foundation Trust

Addenbrooke's and the Rosie Hospitals

Quality Report

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

Ratings

Overall rating for this hospital

Inadequate



Urgent and emergency services

Requires improvement



Medical care

Requires improvement



Surgery

Requires improvement



Critical care

Requires improvement



Maternity and gynaecology

Inadequate



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Inadequate



Summary of findings

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Letter from the Chief Inspector of Hospitals

We carried out a comprehensive inspection between 21 and 24 April 2015 as part of our regular inspection programme. In December 2014 Cambridge University Hospitals NHS Foundation Trust had been identified as having only two elevated risks and one risk on our Intelligent Monitoring system. However, in May 2015 the system showed that there were five elevated risks and four risks.

Cambridge University Hospitals NHS Foundation Trust is one of the largest in the UK with around 1100 beds. The trust provides a major trauma centre for the east of England and specialist services in immunology, foetal medicine, IVF, neurosurgery, ophthalmology, genetics and metabolic diseases, specialised paediatric, cancer and transplant services. These services, as provided at Addenbrooke's Hospital and the Rosie Hospital were inspected as part of the core services within this report. The trust also provides district general hospital services to patients predominantly coming from Cambridgeshire, Essex, Suffolk and Hertfordshire. The demographics vary during the year due to the large student population of approximately 24,488.

The clinical departments are clustered together into five divisions:

Division A: Musculoskeletal; Digestive Diseases and ICU/Periops

Division B: Cancer; Laboratory services; Imaging and Clinical support

Division C: Acute Medicine; Inflammation/Infection; Transplant

Division D: Neuroscience; ENT/ Head and neck/ Plastics; Cardiovascular-Metabolic

Division E: Medical Paediatrics; Paediatric Critical Care and Paediatric Surgery; Obstetrics and Gynaecology

Whilst we inspect core services, these crossed divisions. We were able to disaggregate some of the performance information for the trust across our core services.

During this inspection we found that the trust had significant capacity issues and was having to reassess bed capacity at least three times a day. This pressure on beds meant that a number of routine surgery admissions were cancelled as there were no beds available. We found that staff shortages meant that wards were struggling to cope with the numbers of patients and that the adult critical care areas were not staffed in line with national guidance. We reported this to the hospital trust management immediately and undertook enforcement action to place a condition on the trust's registration in relation to Addenbrooke's Hospital to ensure that there were sufficient staff in place to care for critically ill patients. We have since been assured by the trust that there are systems now in place to ensure that staffing in this area is in line with national guidance and we have removed this condition from the trust's registration.

We have rated this location as inadequate overall due to significant concerns in safety, responsiveness and the disconnect between ward staff and the divisional leaders. We found that the staff were exceptionally caring and that they went the extra mile for their patients..

Our key findings were:

- There was a significant shortfall of staff in a number of areas, including critical care services and those caring for unwell patients. This often resulted in staff being moved from one area of a service to another to make up staff numbers. Although gaps left by staff moving were back-filled with bank or agency staff, this meant that services often had staff with an inappropriate skills mix and patients were being cared for by staff without training relating to their health needs. Despite this patients received excellent care.

Summary of findings

- Pressure on surgical services meant routine operations were frequently cancelled and patients were waiting longer than the 18-week referral to treatment target for operations. Pressure on the outpatients department meant long delays for some specialties and not all patients being followed up appropriately, particularly in ophthalmology and dermatology. There were some outstanding maternity services but significant pressures led to regular closures and a midwife to birth ratio worse than the recommended level.
- Disconnected governance arrangements meant that important messages from the clinical divisions were not highlighted at trust board level.
- Introducing the new EPIC IT system for clinical records had affected the trust's ability to report, highlight and take action on data collected on the system. Although it was beginning to be embedded into practice, it was still having an impact on patient care and relationships with external professionals.
- Medicines were not always prescribed correctly due to limitations of EPIC, although we were assured this was being remedied.

However, we also found:

- Caring staff who did everything they could for patients in their care.
- Effective and robust multidisciplinary working across the trust.
- The emergency department and major trauma centre were efficient and effective.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must ensure that:

- All patients awaiting an outpatient's appointment are assessed for clinical risk and prioritised as to clinical need.
- Effective governance and management arrangements are put in place in outpatients.
- Systems or processes must be established and operated effectively to enable the outpatients department to assess, monitor and improve the quality and safety of services.
- Services around end of life are reviewed to allow for fast track or rapid discharges to be undertaken in a timely way.
- Patient dependency in the intensive care unit is reviewed and staffing monitored against this on a day to day basis to ensure compliance with the Faculty of Intensive Care Medicine / Intensive Care Society core standards for ICU (Ed1) 2013.
- There is adequate staffing to provide safe care for patients requiring non-invasive ventilation.
- Data collection for the ICNARC case mix programme is monitored and that data collected is reliable, accurate and representative of the functioning of both critical care units.
- Patients are discharged from critical care units to the wards in a timely manner and minimises the number of patients being discharged after 10pm.
- It encourages collaborative working and sharing of clinical governance data between the general critical care unit and the Neuro Critical Care Unit.
- Medicines are managed in line with national guidance and the law.
- All patients who may lack capacity have a mental capacity assessment and, if appropriate, a deprivation of liberty safeguards (DoLS) assessment and that patients' consent is properly sought before treatment.
- All emergency equipment is checked in line with policy.
- Risk assessments are completed and correctly recorded.
- All environments are safe and that high levels of nitrous oxide in delivery suites are addressed.
- Consistent foetal heart rate monitoring is provided in maternity services.

In addition, the trust should:

- The impact of high bed occupancy on the admission of emergency patients and the provision of emergency surgical services at Addenbrooke's Hospital is reviewed.
- Review the provision of end of life care to consider providing cover over seven days a week.

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- Ensure that focus is given to drive improvement and delivery of the end of life care service, including community engagement and investment in the service.
- Ensure the estates department is staffed with enough appropriately trained people to facilitate a more timely response to maintenance requests to help improve the environment, infection control and health and safety for patients and staff.
- Improve the skill mix across critical care to ensure that 50% of staff complete their certificate in critical care in line with best practice standards.
- Staff on the wards should be clear who has a DNACPR in place at all times to minimise the likelihood of incidents where patients may be resuscitated against their expressed wishes.
- Ensure access to dedicated physiotherapy and clinical pharmacy services seven days a week.
- Ensure that there are arrangements in place with clear management plans for the merging of two mortuaries in Cambridgeshire.
- Review the arrangements for patients undergoing termination of pregnancy for foetal anomalies on the labour ward.
- Ensure that medical and surgical patients are cared for in an appropriate ward.
- Reduce the number of cancelled surgery admissions.
- Consider the use of pain assessment tools for patients who require additional assistance in communicating their needs.

We saw areas of outstanding practice including:

- The allergy clinic had a one-stop allergy service that provided diagnosis and management of a wide range of allergic disorders. This clinic was dynamic and comprehensive.
- Virtual clinics had been set up in a number of areas, each consisting of a multidisciplinary team of staff including nursing and consultant grade staff. The purpose of the clinic was to review patient diagnostic tests and notes to make treatment decisions without the need for the patient to attend an appointment. Patients were then called and treatment options explained over the phone.
- The chaplaincy and bereavement service offered a one-stop appointment where bereaved relatives could see all trust staff that they needed to see in one visit. Bereaved relatives were also invited back six weeks after the death to enable staff to provide emotional support and answer any questions. The six-week follow-up had been devised at Addenbrooke's and rolled out nationally.
- The specialist palliative care consultants at Addenbrooke's had won National and International recognition as an area of excellence in palliative care for their work in developing the "Breathlessness Intervention Service".
- The online educational resource – cambridgecriticalcare.net – developed by the neurological critical care team is a repository of educational resources aimed not only at local trainees, but trainees nationally and internationally.
- Patients previously treated within critical care were invited to a twice-yearly focus group to help drive service improvement. Through this focus group, real change had been implemented, including improving the transition of care from the critical care area to the ward, establishment of a quiet/interview room for doctors to speak to relatives on the critical care unit, and the re-design of the relatives' room.
- On the general critical care unit, a junior doctor jointly with the IT department developed an application for a mobile tablet called "My ICU Voice" to enable patients who had a tracheostomy to communicate with staff.
- Team working in the critical care unit was outstanding. Given the limited resources, all members of the multidisciplinary team worked collaboratively to ensure patients received kind and compassionate care. Nursing staff were observed doing everything they could to ensure patients' carers were well informed of their loved ones' condition.
- There was well-managed and coordinated medical handover and follow-up of patients following admission, with all specialties being represented for effective care management planning.
- The "supervisor of midwives" network at the trust was outstanding and was an important contact for patients and staff. The purpose of supervision of midwives is to protect women and babies by actively promoting safe standards of midwifery practice.

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- The Birthing Unit in The Rosie Hospital had facilities that were outstanding and state of the art. They included 10 birthing rooms, all with en-suite bathrooms, mood lighting and music systems, a fold-down double bed, birthing balls, slings, birthing stools, floor mats and comfortable seating and access to a sensory garden.
- The Neonatal Intensive Care Unit is at the forefront for provision of care for babies. The neonatal transfer team (ANTS) was the first such team to formally and consistently enable parents to travel with their sick babies.
- The ACTIVE Children and Young People's Board enabled current and former young patients, and any other children who were interested, to meet and share ideas. The ACTIVE Children and Young People's Board was involved in producing child-friendly information and in projects such as Teens in Hospital, which was looking at ways of improving the experience of young people, especially those on adult wards.

On the basis of this inspection, I have recommended that the trust be placed into special measures.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

There were clear arrangements in place to protect patients from abuse and avoidable harm. Medical and nurse staffing was at safe levels through effective recruitment and retention. Patients were efficiently assessed, monitored and cared for to prevent or respond to deterioration in their condition. Incidents were reported and fully investigated where needed. Lessons were learnt from incidents and complaints, in order to improve the service. Infection prevention and control was well established.

Treatment was based on best practice and national evidence-based standards and guidelines. However the outcomes for patients were not always in line with national expectations we were particularly concerned about patients with sepsis as audits showed that not all patients received the appropriate treatment in line with guidance. Staff were appropriately qualified and trained for their roles. There was an established education and training culture in support of improving care and treatment and developing staff. Multidisciplinary working contributed to efficient working and was promoted by a culture of support and teamwork. Patients were asked about their wishes and supported to make decisions about their care and treatment. We saw that staff consistently offered care that was kind, respectful and considerate. Staff supported patients promptly in managing pain and anxiety.

The trust was not meeting the four-hour waiting time target for treatment and discharge from the emergency department. The performance on this target was affected by the integrated system of admission to the hospital, which meant GP admissions were also managed through the emergency department. The integrated system had been chosen as a clinically effective and safe arrangement. Departmental leaders and staff had implemented systems to maintain flow and

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escalate problems as soon as there were indications of delays in patient flow. The trust had programmes of work to improve patient flow through the hospital.

Leadership of the Emergency Assessment Department was effective. There was an open and positive culture and supportive multidisciplinary working. Managers and staff were focussed on development and continuous improvement in patient care.

Medical care

Requires improvement



Overall, we found that medical care services at Addenbrooke's Hospital required improvement. This is because we found concerns in relation to safety, effectiveness, responsiveness and leadership of the service. However the staff remained caring despite the concerns in other areas. Staff worked hard to ensure that patients received the best possible care.

We had concerns in relation to nursing staffing and the movement of staff between wards. The respiratory ward was not staffed in line with national guidance and this increased the risk of potential avoidable harm for patients who required non-invasive ventilation (NIV). Staff did not always report incidents when they should have done and staff did not always receive feedback about incident investigations. We found gaps in the checking of emergency resuscitation equipment in some ward areas.

The neuropsychology service was providing effective care to inpatients and outpatients requiring the service. However, we found that none of the neuropsychology staff were on the British Psychological Society's Specialist Register of Clinical Neuropsychologists or receiving supervision from a professional on the register, though they were professionally registered with the Health and Care Professions Council as clinical psychologists which is a legal requirement.

Clinical staff were not always able to access the information they required – for example, diagnostic tests such as electrocardiographs (ECGs) to assess and provide care for patients. This was because ECGs had to be sent to a central scanning service to be scanned into the electronic recording system.

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once the patient had been discharged. This meant their ECGs would not be available for comparison purposes if a patient was re-admitted soon after discharge.

Where agency staff were used, they were not always able to access information about patients they were supporting. In addition, all staff, we spoke with, had limited knowledge of their responsibilities under the Mental Capacity Act (MCA). Nursing staff were unclear about the procedures to follow when reaching decisions in people's best interests.

However, staff had not received training in the MCA or Deprivation of Liberty Safeguards (DoLS)

Staff were unable to show us where care plans had been completed. Some staff told us the doctors' orders had replaced care plans on the new EPIC IT system. These orders were task-orientated and did not always reflect the holistic needs of the patients. Some staff told us there were no care plans on the new IT system.

We observed care and found this to be compassionate from all grades of support and clinical staff, including doctors. We also saw and patients told us that privacy and dignity was maintained at all times. Where possible, patients were involved in their care and treatment and were given information to support their decision-making. We found that patients could access emotional support if they needed to.

We found there was insufficient bed capacity to meet the needs of patients within the hospital. This resulted in a large number of patients being cared for in non-speciality beds and this had negative implications for their safety whilst receiving care and treatment. Implementation of the electronic recording system had impacted on the care people received. For example patients were unable to receive blood transfusions within the ambulatory care unit and had to be admitted to a ward.

We were told and records demonstrated that patients requiring elective treatment often experienced cancellation or had to wait for up to 12 hours for a bed to become available because of bed capacity issues. In addition, there were significant numbers of people who were experiencing delayed

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discharge because they were waiting for packages of care in their own homes and could not be discharged by the hospital until funding had been agreed for this care.

Medical care services were generally well led at a local level. However, leadership was not consistent across the medical services area. There was a recognition that staff were working under pressure but staffing levels and skill mix had not always been taken into account within the divisional risk registers, nor were there any action plans to ensure staff were supported. Although staff told us they felt supported by their line managers, divisional directors and divisional lead nurses. They also shared concerns that sufficient action had not been taken to address key risks such as staffing levels, the movement of staff between wards, flow throughout the hospital and issues associated with the electronic recording system.

Surgery

Requires improvement



We rated surgical services as requires improvement: Surgical wards were not always clean, nursing staff were moved between wards and staff were not always familiar with the wards or had experience in dealing with surgical patients. The trust frequently cancelled routine operations due to bed capacity issues. Issues were raised by staff but were not addressed by the senior management team within the divisions.

Storage temperatures of the rooms used to store medicines were not monitored or recorded.

Although, when we measured the temperature it was within acceptable limits, we were not fully assured that medicines storage adequately maintained their quality. The environment within two surgical wards was not clean. We found fungi growing in a shower room which had an impact on the patients of this ward.

Medical staffing was appropriate at consultant, middle grade and junior doctor level of skill mix.

However, there was a shortage of nursing staff within surgical wards, with a number of vacancies.

All surgical wards used agency staff, but we found that they did not always have appropriate induction or skill mix. Often an inappropriate skill mix on the

Summary of findings

wards mean staff did not have time to adequately meet patients' needs. However there was a culture of incident reporting which was consistent with feedback and learning from incidents.

Staff we spoke with were not aware of the recent changes to legislation in respect of Deprivation of Liberty Safeguards and awareness of the Mental Capacity Act was poor. This meant that patients were not always assessed or treated appropriately. Treatment and care was provided using evidence-based national guidelines. There was good practice, for example, in pain management, and in the monitoring of nutrition and hydration of patients. Multidisciplinary working was evident. Staff had access to training and received regular supervision and annual appraisal. We spoke with patients and they told us that staff treated them in a caring way; they were kept informed and involved in the treatment received. Patients were being treated with dignity and respect.

Surgical services were not responsive. Some specialties did not meet the national time of 18 weeks between referral and surgery. Operations were cancelled due to bed capacity within the hospital. Capacity pressures and a lack of available beds resulted in patients spending longer periods in the theatre recovery areas.

There was evidence to support people with complex needs, for example, people with a learning disability. We saw that reasonable adjustments were made to the surgical services to accommodate any patients with complex needs. Information, leaflets, and consent forms were available in a standard format. . Easy read versions are created on request by the patient and/or clinical team. Patients we spoke with said they were satisfied with how staff dealt with any concerns they raised.

Surgical services were not well-led and required improvement. Staff we spoke with told us they felt pressurised when patient admissions fluctuated. Surgical services had plans to address capacity issues but identified risks were managed in a reactive manner.

There was positive awareness amongst staff of the expectations for patient care across the trust. Staff

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Critical care

Requires improvement



we spoke to were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service within the area they worked.

Overall, we rated the Critical Care services provided at Addenbrooke's Hospital as requiring improvement. Concerns were raised before the inspection about staff shortages resulting in patients requiring high level care not receiving the level of care they should have had and during the inspection further concerns were raised about this. Our observations and findings during the inspection substantiated the concerns raised by staff and we took action immediately to protect patients from the risk of harm.

Staffing numbers and skill mix on the Intensive Care Unit and the Neuro-Critical Care Unit were not in line with the Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units (Edition 1). We observed that this was having an impact on the staff providing care and we saw evidence of poor practice as a result. This included patients being left unattended or being looked after by healthcare assistants. Poor hand hygiene was observed by staff between patients, resuscitation trolleys were not checked in line with trust policy and medications were left unattended. The concerns relating to staffing had been raised through various avenues to the senior management team but no action had been taken immediately to address those concerns. The senior management team had a clear understanding of the national guidelines but there was poor recognition of the impact this was having on staff and there was a lack of flexibility in reviewing staffing establishment when concerns were raised. The process for assessing patient acuity was well established, although there was minimal evidence of reviewing staffing establishments to meet changes in demand.

During the implementation of the trusts' health informatics software, a key member of the team responsible for data collection and upload to the Intensive Care National Audit and Research Centre (ICNARC) case mix program was seconded to assist design and implementation of the system. A

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subsequent move to merge systems for data collection combined with the inexperience of a member of staff identified to fill the vacancy for data collection resulted in questions around the reliability of data collected on both units. The trust had problems with the completeness of ICNARC data which had not been submitted for two years. Locally there was some mitigation in the collection of local data sets but the trust was unable to benchmark its data against other units over this period. The trust has since completed the training for staff and has re-started submitting data to the case mix program.

Bed occupancy for the critical care service was high. In March 2015, bed occupancy was 93% on the Intensive Care Unit and 95% on the Neuro-Critical Care Unit. In February, the average occupancy was 113% on the Intensive Care Unit and 109% on the Neuro-Critical Care Unit because patients were occasionally being provided with care by the rapid response team. Across the trust, the length of stay for patients and delayed discharges to ward areas were seen as a significant risk to flow. This was having an adverse impact on the Critical Care Unit, with more than 1 in 3 patients on both Intensive Care and Neuro-Critical Care having a delay in discharge during 2014. Furthermore, as a result, more than 40% of patients admitted to the two units were discharged to the wards after 8pm in March 2015.

Whilst we found strong leadership at ward level, there was a clear disconnect between the local leadership and leadership at divisional management level and between the division and the executive team. There was a drive at executive level to devolve leadership to divisional levels within the organisation. This resulted in a significant re-structure of the leadership to critical care services, and whilst progress had been made the critical care lead recognised that there was more work to be done with shared learning and consistency relating to the governance processes of both Intensive Care and Neuro-Critical Care. There were numerous examples of outstanding teamwork within the Critical Care Unit. Staff worked collaboratively to ensure patients received the best care possible within their limited resources. Junior

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members of the team spoke very highly of the senior nurses and consultants in the department. Patients on the unit were cared for by kind and compassionate staff, and the feedback from patients and carers during our inspection was very positive.

We saw a strong ethos of multidisciplinary working amongst all members of the team within critical care. The critical care Rapid Response Team provided outreach services into the ward, proactively identifying patients who would benefit from closer monitoring and supporting ward teams 24 hours a day.

Staff used patient diaries to document each patient's stay in Critical Care and they were reviewed in a dedicated follow-up clinic after patients were discharge from critical care. The follow-up clinics provided a strong focus for the review of a patient's physical and mental health after being in hospital. Patients and carers were invited to twice-yearly focus groups to share their experiences and help drive service improvement.

We saw a number of examples of innovation arising from the focus groups and these have been detailed in our report on responsive care.

There was a strong culture of service improvement and research. Both the Intensive Care and Neuro-Critical Care units had participated in a number of research ventures and the recruitment strategy and opportunities afforded to staff reflected the strong commitment towards research.

An online educational resource – cambridgecriticalcare.net – developed by the Neuro-Critical Care team is seen as an example of outstanding practice, with educational resources aimed not only at local trainees but trainees nationally and internationally.

Maternity and gynaecology

Inadequate



We found serious concerns regarding the safety arrangements in the maternity services which were not replicated in the gynaecology service. These related to the environment, equipment, lack of recording of risk assessments and substantial midwife shortages. There were continued thematic incidents reported, relating to fetal heart rate (FHR) monitoring, with limited evidence of changes in practice to improve safety. We found that the

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suitability, safety and maintenance of many types of equipment throughout maternity services were unsuitable. In the birthing unit, the environment was also found to be unsafe owing to poor ventilation whereby high Nitrous Oxide (gas and air) levels exceeded the safe “Work Exposure Level” (WEL) which the trust had known about since 2013. In maternity, numerous and essential patient risk assessments including venous thromboembolism (VTE) and early warning score (EWS) assessments were not being completed. Staff raised concerns to us that the maternity record system was potentially unsafe due to a combination of electronic and paper records being in use and being used inconsistently. However in gynaecology services risk assessments were undertaken in a timely and comprehensive manner. Across both services there were substantial and frequent staffing shortages, for all disciplines, which further increased the risk to people who used the service. This included medical and midwifery staffing numbers which were below national standards.

Whilst there were up-to-date evidence-based guidelines in place, we were concerned that these were not always being followed in maternity. This included FHR monitoring, VTE and early warning score guidelines. Staff were competent and understood the guidelines they were required to follow, however, lack of staffing and familiarity with the computer system (EPIC) made this difficult. Since the introduction of EPIC, outcomes of people’s care and treatment was not robustly collected or monitored. For example, there was no maternity dashboard available since December 2014. However, we did observe good practice in terms of audit, effective multidisciplinary team working and that staff consistently had the right skills, qualifications and knowledge for their role. Termination of Pregnancies (TOPs) for fetal anomalies took place on labour ward after 12 weeks of pregnancy. Therefore women experiencing this service were cared for throughout in rooms without sound-proofing. This meant they were often next door to laboring women and crying babies. However, we found that people were consistently treated with dignity, kindness, and respect throughout services.

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There was a lack of service planning across the directorate in relation to workforce planning, capacity to meet service demand and because there was no long-term plan to address the high levels of maternity closures. The maternity unit was closed 37 times between July 2013 and April 2015 mainly due to a lack of capacity or insufficient staffing. Referral to Treatment Times (RTT) for gynaecology patients were not being met in relation to national expectations, but we found that this was being addressed appropriately.

At unit level we observed examples of excellent leadership principles; however, leadership of the directorate overall required improvement. This was because senior managers had not responded appropriately or in a timely way to known and serious safety risks, there was a general lack of service planning, and because key performance data was not being collected robustly and therefore not being analysed. We recognised that EPIC was the root cause of the problems with data collection, and that prior to its introduction in October 2014 many of the data collection issues were not apparent, however, improving this issue was not seen as a priority.

Services for children and young people

Good



Children's services were protected from avoidable harm and effective, with a culture of reporting and learning from incidents. Staff understood their responsibilities for safeguarding children, and acted to protect them from the risk of avoidable harm or abuse. There were enough medical staff but there were nursing shortages in some areas, such as in the day unit and in the neonatal unit. The new 'EPIC' (a records management system) computer system added to pressures on staff but effective temporary solutions helped to protect patients. Multidisciplinary working was effective, and care was evidence based. Staff monitored patient outcomes and participated in national audit. They also gained appropriate consent before interventions. Staff morale was high, they had outstanding standards of patient-focused care, and they worked hard to meet children's and families' needs. Staff were caring, compassionate and empathetic.

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Children and parents felt well-informed and said staff were friendly and caring. Results of an external survey, and the many cards and letters expressing thanks, confirmed our findings.

Staff tailored services to meet individual needs and provided them in an attractive and child-friendly environment. Families could use translation facilities. Patients made few complaints but staff had a robust procedure and made appropriate changes to respond to concerns expressed. There was pressure on bed capacity with children as young as 14 occasionally having to be placed on adult wards by staff. Lack of adequate bed space across paediatrics was identified as a risk and was on the trusts risk register. The wait between being referred to the hospital and being seen was longer for most paediatric specialities than the 90% target. Senior managers provided clear direction and staff knew the trust's values. Staff keep up to date risk registers, incident records and audits and acted on areas for improvement. Staff, patients and families worked well together, to improve services.

End of life care

Requires improvement



Staff provided an end-of-life care service that was outstandingly caring. The palliative care team, mortuary and chaplaincy team locally were effective, responsive and well led. However, in the wider trust there were concerns with 'ceilings' of care around treatment at the end of a patient's life when they were not for resuscitation. This was not always well documented on the electronic medical record. Despite a clear flag on the electronic record staff were not always clear about who was or was not for resuscitation. Local teams were responsive to patient needs. However, the electronic records system (EPIC) created significant numbers of delayed discharges that impacted on patients receiving end-of-life care. We had concerns about how the service worked with community services to fast track discharges for patients at the end of their life.

The trust had introduced the "Last Days of Life" document to assist in caring for patients at the end of their life which had been uploaded within the electronic patient in January 2015. However we saw that staff continued to use the paper record. There were therefore two systems which directed nurses

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in how to care for patients. We found that where “Last Days of Life” was used this was poorly completed. The electronic record did not provide a holistic care record for patients as there was no care plan at the end of life. The trust had not participated in the National Care of the Dying audit as this was focused on the Liverpool Care pathway which was no longer used at the hospital. This meant that it could not benchmark its performance against other services.

The service provided person centred care to patients through support of people and their families for example with ‘The wedding box’. This was a box of donated items to assist with patients getting married whilst in hospital. The specialist palliative care service was providing effective care through innovation, national and international acclaimed work. However improvements were necessary to ensure that people received effective pain relief and that ceilings of care met their individual needs. The chaplaincy “Perry unit” support of bereaved friends and relatives has won national acclaim and had been adopted by other hospitals. The Breathlessness intervention service had won national and international acclaim as an area of excellence in palliative care.

Staff throughout the hospital knew how to make referrals and referred people appropriately. The palliative care team assessed patients in good time, to meet patient needs. The hospital's new integrated technology system (EPIC) had improved efficiency within the department giving staff better access to patient information. However there was much work to be done for the system to reach full potential. Many staff said they had struggled with EPIC and it was time consuming. The specialist palliative care team found patients dropped off the system, so kept two lists to avoid losing patients. Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end-of-life care.

The chaplaincy and bereavement service supported families’ emotional needs when people were at the end of life, and continued to provide support afterwards. This work had won national acclaim

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and is being used in other hospitals. However, the mortuary was dated, in need of repair and had potential capacity issues while awaiting the hospital's expansion.

Outpatients and diagnostic imaging

Inadequate



These two services were very different: the diagnostic imaging services were good across all our five key questions, but the outpatients' services required improvements to be made. Outpatient services were not working efficiently to protect patients from avoidable harm, with a weak incident and learning system. Staff could not describe incident reporting requirements and were confused about reporting requirements of serious incidents. They could not describe or provide evidence of incidents that had led to improvement.

Staff did not always properly assess patient risk, with excessive backlogs of patients waiting for follow up or routine appointments in some clinics. One serious incident had determined avoidable harm to a patient with 21 more patients feared to be at risk. We asked to review a copy of this risk assessment. However, the review was currently underway.

While introducing EPIC, processes to deal with remaining paper records were unclear. For example, staff documented follow-up appointment requests on notepads. Paper records which were not stored in EPIC were inconsistently stored within the outpatients department. Inaccurate discharge summaries led to a risk that patients would not receive appropriate follow up care.

The service was not responding to people's needs for appropriate and timely care and treatment.

There was a significant backlog of follow-up appointments in ophthalmology and dermatology and some patients reported waiting for an appointment for up to two years. The trust was not meeting a significant amount of its performance targets. The trust provided information that demonstrated that no new patients were waiting more than one year for an appointment.

However, diagnostic imaging services were providing appropriate and safe care. Staff within this department understood incident reporting processes and used effective infection control systems. They maintained equipment in line with

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appropriate legislation and guidance. The diagnostic and imaging department was part of the imaging service accreditation scheme (ISAS) which identified that the trust was performing well. There were excellent examples of multidisciplinary working, particularly in the infectious diseases clinic, and staff reported good internal relationships. There was excellent practice within the allergy clinic. The trust had implemented a one-stop allergy service to diagnose and manage many allergic disorders, this clinic was dynamic to the needs of patients and provided a comprehensive service.

Services generally met people's needs and staff understood how to support people with physical, mental health and cultural needs. Staff were friendly, approachable and caring. Patients said they were happy with their care and staff were kind and caring within outpatients and diagnostic imaging. Patients felt included in decision making and care planning for their conditions.

Overall, the service lacked robust management and governance system in the outpatients department. We could not be assured that staff were assessing and monitoring issues within the outpatients' department to ensure improvement.

Addenbrooke's and the Rosie Hospitals

Detailed findings

Services we looked at

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

Detailed findings

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Background to Addenbrooke's and the Rosie Hospitals

Sites and locations

Cambridge University Hospitals (CUH) comprises 12 locations registered with CQC.

Addenbrooke's Hospital and the Rosie Hospital (Women's Hospital) in Cambridge provide healthcare and specialist services such as transplantation, treatment of rare cancers and neurological intensive care. The trust became a NHS Foundation trust in December 2004. The trust has around 1096 beds covering a wide range of specialties.

Population served:

Patients predominantly come from Cambridgeshire, Essex, Suffolk and Hertfordshire.

The demographics varies due to the large student population of approximately 24,488. The 2011 census has the usual population of Cambridge at 123,900 people in the non-metropolitan area.

The town is the 167th most populated in the UK. Within the urban area, the estimated population is 130,000; the county area of Cambridgeshire has an estimated population of 752,900 people.

Deprivation:

The Indices of Multiple Deprivation indicates that Cambridge District is the 130th least deprived borough out of the 326 boroughs in the UK. (1st being the most deprived.)

Deprivation is lower than average, however about 15.7% (2,600) children live in poverty. Hip fractures in people aged over 65 years as well as hospital stays due to self-harm, drug misuse, and sexually transmitted infections are above the England average for Cambridge.

Our inspection team

Our inspection team was led by:

Chair: Louise Stead, Director of Nursing, Royal Surrey County Hospital NHS Foundation Trust

Head of Hospital Inspections: Fiona Allinson. Head of Hospital Inspections, Care Quality Commission

The team included nine CQC inspectors and a variety of specialists including, a clinical fellow, two safeguarding

specialists, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, a consultant surgeon, a consultant clinical neuropsychologist, an intensive care consultant, a consultant paediatrician, a junior doctor, 12 nurses at a variety of levels across the core service specialities and two experts by experience. (Experts by experience have personal experience of using or caring for someone who uses the type of service that we were inspecting.)

Detailed findings

How we carried out this inspection

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

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

The inspection took place between 21 and 24 April 2015 with an unannounced inspection on 7 May 2015.

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

We held a listening event on 21 April 2015, when people shared their views and experiences of

Addenbrooke's and the Rosie Hospitals. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

We carried out an announced inspection visit between 21 and 24 April 2015. We also conducted an unannounced inspection on 7 May 2015. We spoke with a range of staff in the hospital, including nurses, junior doctors, consultants, administrative and clerical staff, radiologists, radiographers, pharmacy assistants, pharmacy technicians and pharmacists. We also spoke with staff individually as requested and held 'drop in' sessions.

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

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Addenbrooke's and the Rosie Hospitals.

Facts and data about Addenbrooke's and the Rosie Hospitals

Urgent and Emergency Services

Information about service

- No. of attendances pa total 105,804
- No. of children 21,160 (20% of A&E attendance)
- Number of attendances admitted 19,599 (18.5 %)
- % left without being seen 1.2%
- % reattending within 7 days 5.63%
- FFT response rate 15.7%

Medical Care

Information about the service

- No. of medical wards 29
- No. of medical beds 440
- Emergency admissions to medical care in 2014/15 41,322
- Elective admissions to medical care in 2014/15 12,361

- Never events in medical areas in 2014/15 0
- SSNAP 'score' (A to E) D July to Sept 2014

Surgery

Information about the service.

- No. of surgical wards 20
- No. of surgical beds (inpatient) 282
- No. of day case beds 75
- No. of operating theatres 35

Critical Care

Information about the service

- Number of critical care beds: Total 137

Maternity and Gynaecology

Information about the service

Detailed findings

- Number of births pa (total) 5,482 (Jul13-Jun14)
- Number of antenatal beds 22
- Number of beds on labour suite 15
- Midwife/birth ratio 1:34 as of Dec 14
- No. of consultant hours on labour suite 60 hours pw
- Normal vaginal deliveries (%) 59.3
- Elective caesarean rate (%) 13.2
- Emergency caesarean rate (%) 16.0
- Number of occasions when unit has closed to admissions in past 12 months 24 (Dec 13-Dec 14)
- Midwife sickness rate 2.89% (Ave Dec13-Dec14)

Services for Children and Young People

Information about the service

- Number of beds for children + young people 100
- Number of wards 6
- Number of paediatric consultants 66
- Number of nurses on paediatric wards 252.81 WTE
- Number of neonatal cots:
 - Total 38
 - Level 1 14
 - Level 2 10
 - Level 3 14
- Number of admissions: Total 10,872

End of Life Care

Information about the service

- Total number of deaths in hospital pa 1362 (Apr13-Mar14)
- No. of referrals to specialist palliative care team pa 1244 (Apr13-Mar14)
- Cancer referrals 77% (Apr13-Mar14)
- Non-cancer referrals 23% (Apr13-Mar14)
- Specialist palliative care team consultants (FTE) 2.7
- Specialist palliative care nurses (FTE) 3.65
- Hours/days service is available on site Mon-Fri 9-5 and 8.30-4 Sat and Bank Hols
- Hours/days service is available by phone 24/7

Outpatients and diagnostic imaging

Information about the service

- Number of outpatient attendances (total) pa 592,288
- Number of outpatient attendances for:
 - Ophthalmology 44,812
 - Dermatology 30,495
 - Oncology 80,280
 - Trauma and Orthopaedics 34,645
 - Obstetrics and Gynaecology 32,308
 - Other 369,748
- % of patients attending for whom full records are missing 1.03%

Our ratings for this hospital







Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

The urgent and emergency services at Addenbrooke's Hospital is comprised of the Emergency Department, Clinical Decisions Unit and Ambulatory Care. The Emergency Assessment Unit provides a consultant-led emergency care and treatment service, which is the major trauma centre for East of England and provides the Trauma Network Co-ordination Service. It is divided into several areas, providing care for patients with minor injuries to major trauma. The emergency department has an integrated system of working, with GP admissions cared for through the department. This is unlike many hospitals where such admissions are managed through other admission wards. There is a paediatric area with separate waiting and treatment facilities. The clinical decisions unit is a ward area close to the main emergency department for short stays to allow for further assessment and observation. The minor injury area has eight cubicles and dedicated rooms with equipment to manage patients with eye or ear, nose and throat injuries.

All the clinical departments at Addenbrooke's hospital were grouped together under five divisions. The urgent and emergency services were in division C. Each division is led by a divisional director. They are supported by a divisional lead nurse, and Associate Director of Operations, divisional finance lead and a divisional workforce lead.

In the year to March 2015 the Urgent and Emergency Services at Addenbrooke's hospital saw 105,804 patients of which around 20% were children.

We used a variety of methods to help us gather evidence in order to assess and judge the urgent and emergency services at Addenbrooke's hospital. We spoke with 35 staff and 42 patients and relatives and examined 10 patient records during this inspection. We interviewed the clinical leads for Division C. We observed the environment and the care of patients, and we looked at records, including patient care records on the electronic recording system. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments and audit results.

Urgent and emergency services

Summary of findings

There were clear arrangements in place to protect patients from abuse and avoidable harm. Medical and nurse staffing was at safe levels through effective recruitment and retention. Patients were efficiently assessed, monitored and cared for to prevent or respond to deterioration in their condition. Incidents were reported and fully investigated where needed. Lessons were learnt from incidents and complaints, in order to improve the service. Infection prevention and control was well established.

Treatment was based on best practice and national evidence-based standards and guidelines. However the outcomes for patients were not always in line with national expectations we were particularly concerned about patients with sepsis as audits showed that not all patients received the appropriate treatment in line with guidance. Staff were appropriately qualified and trained for their roles. There was an established education and training culture in support of improving care and treatment and developing staff. Multidisciplinary working contributed to efficient working and was promoted by a culture of support and teamwork.

Patients were asked about their wishes and supported to make decisions about their care and treatment. We saw that staff consistently offered care that was kind, respectful and considerate. Staff supported patients promptly in managing pain and anxiety.

The trust was not meeting the four-hour waiting time target for treatment and discharge from the emergency department. The performance on this target was affected by the integrated system of admission to the hospital, which meant GP admissions were also managed through the emergency department. The integrated system had been chosen as a clinically effective and safe arrangement. Departmental leaders and staff had implemented systems to maintain flow and escalate problems as soon as there were indications of delays in patient flow. The trust had programmes of work to improve patient flow through the hospital.

Leadership of the Emergency Assessment Department was effective. There was an open and positive culture and supportive multidisciplinary working. Managers and staff were focussed on development and continuous improvement in patient care.

Urgent and emergency services

Are urgent and emergency services safe?

Good



There were clear arrangements in place to protect patients from abuse and avoidable harm. There was effective incident recording and reporting. There were established processes to improve clinical practice and the service to patients. There was good infection prevention and control. Cleanliness and maintenance of equipment was effective. Staff ensured safe management of medicines.

There were systems to respond to emergency situations and any deterioration in a patient's health. There were clear procedures to respond to signs or allegations of abuse. The department was divided into several areas and staff were deployed to meet patients' needs depending on activity at different times of the day. There were plans and training for staff to deal with major emergencies.

Incidents

- Incidents were reported, investigated and lessons learnt. We reviewed the incident reports for 146 incidents from September to December 2014 for the emergency department. Appropriate action had been taken in relation to all incidents.
- We looked at the serious investigation reports from incidents and saw that there had been full investigations. Learning from the incidents had been recorded, along with agreed actions.
- The department team used a structured framework (Lawton) to categorise and analyse incidents. This helped the team to identify themes in the causes of incidents and identify specific clinical improvements and actions aimed at preventing recurrence.
- There have been no Never Events (things that should never happen) and one serious incident requiring investigation relating to a confidential information leak. Staff had reported and investigated a problem with cardiac test leads that were able to connect incorrectly and so had provided a wrong diagnosis. This had been escalated to other departments in the trust and nationally through relevant medical equipment reporting channels.

- Staff told us about learning from a patient fall and the additional precautions put in place to prevent a similar incident. The incident had been discussed with ambulance service staff and managers, and protocols had been implemented across the services.
- Mortality and morbidity meetings were held, covering general, paediatric, mental health and trauma cases. Staff were advised of learning from such analysis through daily shift briefing, 'Feedback Friday', team meetings, away days, emails to all staff, and regular displays of latest information.
- All staff were aware of the Duty of Candour regulations. The trust had ensured wide awareness of this through staff leaflets and team briefings. We spoke with staff who could outline when this may be instigated.

Cleanliness, infection control and hygiene

- The department appeared clean in all areas. Staff we spoke with were aware of infection prevention and control procedures. There were sufficient hand-washing facilities and alcohol gel was available throughout the department.
- We saw staff following hand hygiene, 'bare below the elbow' guidance, and wearing personal protective equipment such as gloves and aprons whilst delivering care. Hand hygiene audits of the paediatric area, the emergency department and the clinical decisions unit had reported 100% compliance from May 2014 to December 2014. Band 7 nurses undertook the audits across the different areas monthly.
- There were protocols in place to use a side room opening directly into the ambulance bay for patients with possible infectious disease. Ambulance staff were advised to hold the patient in the vehicle until the appropriate bay was available.
- Domestic staff told us there was always staff available to maintain cleanliness as there was a team arrangement with other departments. There were clear cleaning schedules and responsibilities.
- Staff reviewed the MRSA/ C Diff status of patients using a new clinical record system called EPIC and took precautions as necessary. The infection control committee had noted that due to bed flow issues patients had been admitted to ward beds with risks present. Staff had been reminded to check the system and add information if available to the alert section for the patient.

Urgent and emergency services

- There were checks on cleaning effectiveness weekly in the areas of the emergency department. Scores were consistently over 98% in the records from October 2014 to January 2015.

Environment and equipment

- The emergency department was well organised, with equipment to hand where required.
- Equipment was safe and ready for use in emergencies. We examined resuscitation and monitoring equipment in areas of the department. There was a clear system for checking and securing equipment so that it was ready for use in an emergency. We examined the record of daily checks of resuscitation trolleys. We found some days where equipment had not been checked in line with trust policy which was for checks to be undertaken every day. There were ten omissions in March and five omissions since the 1st April to the time of our inspection for one of the trolleys. There were seven omissions in the records for resuscitation trolley checks throughout March in the children's area. We saw that trolleys were sealed and tagged as complete and there was a central record of checks being made.
- We saw that medical engineering staff were routinely checking equipment. Equipment found to be faulty was immediately swapped out to ensure all workspaces were fully equipped when required. We examined check labels on monitors and hoists and saw that equipment had been checked appropriately. Patient trolleys, equipment and curtains providing privacy appeared clean throughout the department.
- Staff in the emergency department were aware of the risk to patients with mental health problems who may require specific care. Interview rooms in the emergency department had been risk-assessed and adapted to remove specific dangers such as ligature points (places where someone could tie a ligature to strangle themselves) and collapsible bed rails.

Medicines

- All medications were securely stored. Medication cupboards were secured by key code door access, with all medications in area B/C and paediatric medicines also locked in cupboards. In area A medications were securely stored in a key coded cupboard.

- We checked the records and stock level of controlled drugs in the paediatric area, resuscitation and area B/C of the emergency department. All records were accurate, showing the correct amount of stock stored at the time.
- Fridge temperatures in the resuscitation area had omissions in the daily checks. During the inspection we also found this fridge to be unlocked. When this was raised with the trust we found that a risk assessment had been undertaken in 2013 and mitigating actions put in place.

Records

- We examined clinical records for patients in the emergency department. We spoke with patients and discussed their care with their nurse. Clinical notes were entered on the electronic patient records system. Staff advised that they had been supported to use the electronic patient record by initial training. Some staff in the emergency department team had been involved in development work before and after the launch of the new system to adapt the system for speed and relevance to their clinical practice. For some injuries or conditions, the notes were against checklists or prompts to ensure comprehensive assessment and adherence to policy and clinical guidance.
- Three patients we spoke with were at risk of pressure ulcer development. Each patient had been in the department lying on an emergency trolley for three or more hours. Staff had assessed the risk visually and through experience and decided that a pressure-relieving additional mattress should be used. We saw on the electronic record that the use of the mattress had been recorded and position changes were recorded on the intentional rounding section of the record. ('Intentional rounding' is a process of making rounds of an area of service to check at regular intervals that patient care needs are being met.) Staff told us that even patients who stay for longer periods do not have detailed pressure risk assessments made or recorded until they are admitted to ward areas. However, the clinical records, whilst limited in details such as no detail of the plan of care to prevent deterioration of skin integrity, showed that risk assessments were routinely being undertaken for patients on trolleys.
- The information system has prompts for key elements of patient assessment, such as checking for the risk of

Urgent and emergency services

venous thromboembolism. We saw that staff were reminded by the hospital newsletter to perform the assessment and were prompted for each patient by the system.

Safeguarding

- Policies and procedures on managing concerns or the risk of abuse were available to staff. Staff knew how to raise concerns about adults and children at risk of abuse.
- The clinical information system had a checklist to remind staff to assess and record any risk of abuse to children or adults. We saw that this checklist was completed on the clinical records we reviewed.
- There were clear processes and procedures in place for safeguarding children in the emergency department. There was a current policy in place for the trust and was available to staff to access through the trusts intranet webpage.
- The review of three children's records showed that all had been assessed for the risks of safeguarding or any additional support. Staff provided us with examples of incidents which they had raised relating to safeguarding children and showed us the incident form which corroborated what we were told.

Mandatory training

- Staff received training in key issues related to the emergency department. Staff interviewed said there was good support to attend training. Clinical staff in different areas were not undertaking roles, such as initial triage, unless they had been trained and passed competency checks for that role.
- The training schedule had been affected by staff in all departments needing significant training input related to the new clinical record system, EPIC. Despite this, 88% of staff had completed safeguarding training (target 90%); 89% had completed infection control training (target 90%), and 88% of Emergency department staff had completed information governance training (target 95%).

Assessing and responding to patient risk

- All patients, including children, who attend as emergencies or following a visit to their GP were

assessed and treated as needed in the emergency department. Departmental staff told us this meant patients' conditions were assessed appropriately and made safe before admission to a ward area.

- Clinical recording of patient observations, including the early warning scores for patients' conditions, are held on the computer system. The system has alerts built in to ensure a patient with deteriorating clinical signs is notified to the appropriate clinical practitioner. The system has advantages over paper records at the bedside as the patient's record can be viewed by a doctor from any workstation connected to the system – for example, from another unit or ward.
- There were clear procedures to promote safe working and guide staff through escalation procedures when the department was full or the hospital bed state was causing a backlog to the emergency department. The nurse in charge of the department ensured that senior clinicians and the rest of the team were working to manage high levels of activity and progress care of patients through to discharge or admission from the department.
- Rapid assessment of patients' conditions was undertaken on patients admitted by ambulance and other patients as required. Patient treatment bays close to the ambulance entrance were staffed by senior nurses and medical staff to undertake the assessment and ensure diagnostic tests are done quickly as required.
- We observed that patients on emergency trolleys always had the safety sides elevated when required. This meant that elderly, frail patients or those with lowered levels of consciousness were cared for safely and protected from falls.
- The department monitors the time from arrival to initial assessment. The national standard is 15 minutes. We saw that patients were seen on arrival by a nurse at the main entrance or ambulance bays. Time to initial assessment was within one minute in most cases.
- The staff described to us that one of their main challenges was dealing with acutely unwell patients, both adult and adolescent, in the emergency department due to the lack of placements available in the community or inpatient mental health facilities and the availability of support given the resources of the one team providing mental health liaison support to Peterborough and Cambridgeshire.

Urgent and emergency services

- The emergency department had three open serious incident investigations which they raised regarding the care for adolescent patients and timeliness, availability and response of CAMHS services. The team could evidence to us how they were working with the local community teams and mental health trusts to improve the delivery however progress in this area was slow.
- The department has two nurses and one health care assistant trained in mental health to provide guidance and support to staff treating mental health patients. The department has access to liaison psychiatry that provides both medical and nursing care and expertise. Medical staff within the service could request for an emergency medical consultant to support them if there was a need to consider the possible detention of a patient under the Mental Health Act.

Nursing staffing

- There were appropriate nursing staff levels across the department. There were 219 whole time equivalent staff to cover the main and children's emergency department, and the clinical decisions unit. This figure included specialist emergency nurse practitioners. Recruitment to additional posts had been effective, with only 15.5 whole time equivalent vacancies at the beginning of May 2015.
- As for other parts of the trust, the department had recruited registered nurses from overseas. The competence of these staff had been assessed and additional training given to enable staff to work in the emergency department. Seven of the ten nurses were ready to fulfil their role as registered nurses but could not yet practise in this way. This was due to delays at the Nursing and Midwifery Council in processing their United Kingdom registration.
- The layout of the department included several different areas where patients were cared for, including the ambulance bay or assessment area, resuscitation room, areas A and B with treatment bays, and Area C with chairs for patients to wait and receive treatment. In addition, there was a minor injury area, waiting room, and paediatric waiting and treatment rooms. The staffing levels reflected the requirement to protect patient safety in all these different areas and at different times of day.
- At all times during our visit we found a suitable skill mix, with experienced and senior nurse staff available for the different areas of the department. We found that staff

rotated through different areas and covered each other appropriately for breaks. There were several different clinical areas and we saw that patients were always appropriately monitored and supported.

- In order to maintain safe staffing levels, bank and agency staff were used. Over half of the bank and agency cost was to ensure safe paediatric nurse specialist cover. Agency staff told us they had received an induction and orientation prior to commencing work in the department.

Medical staffing

- We saw there was consultant cover in the emergency department throughout the day. Consultant medical staff were available to manage care throughout the department as needed. One person was allocated as the emergency physician in charge so that there was clear leadership at all times internally and in dealing with other departments or services.
- The rota allowed for consultant cover from 8am through to 2am. After this time there was registrar cover, with consultants on site to be called. Staff told us that in practice consultant staff were regularly in the emergency department beyond 2am due to high activity or calls to attend patients with major trauma.
- There was effective recruitment, meaning that there were 15 consultant staff and 11 registrar level staff in the emergency department. There were 18 junior doctors employed at the time of our visit. This meant that locum use was minimal. Consultants stated that they filled gaps in rotas themselves or the department used staff who had undergone training and knew the departmental processes and systems.

Major incident awareness and training

- The department had major incident plans as part of the hospital and community-wide arrangements. Staff told us they had received training annually and we observed a group of new staff having the arrangements being explained. All staff were included in training, including health care assistants.
- Each shift had dedicated staff allocated for chemical, biological, radiological or nuclear (CBRN) response so that the team would be ready immediately if a patient with contamination was to be admitted. All staff were trained in erecting the temporary outdoor shelters for decontamination.

Urgent and emergency services

- There were clear protocols for dealing with patients suspected of having Ebola virus infection. Staff told us they had code E training so they were aware of best practice. We observed that patients arriving by ambulance were asked specific questions to identify any possible risk of serious infection.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement



The service required improvement as whilst the treatment was provided in line with national guidance several of the College of Emergency Medicine audits showed poor results. Although many of these were dated 2013 we saw little evidence of improvement. We were particularly concerned in respect of the sepsis audit as a number of key indicators were below 50%.

Staff were appropriately qualified and were well supported through regular training, competency checks for approval to undertake specific roles and clear working protocols and procedures. There were effective levels of care 24 hours a day, seven days a week with senior medical staff providing care directly or reviewing care to ensure accurate diagnoses and treatment.

There was strong multidisciplinary working within and outside the emergency department. Staff worked collaboratively in order to maintain high standards of care and efficient working. Patients were included in their care and supported to make decisions about care and treatment.

Evidence-based care and treatment

- Initial assessment of patients with different conditions were undertaken against standard checklists adapted from CEM guidelines. This included the care for patients with head injury, suspected stroke, emergencies of the eye, chest and abdominal pain. For each condition there was clear guidance of the time by which assessment should be made and under which criteria a senior doctor should be informed.

- Patients with suspected bone fracture were assessed and treated according to agreed fracture management protocols. All patients were followed up within 72 hours by an orthopaedic consultant.
- Patients who may be living with dementia were screened using a standard tool.
- Junior medical staff used the hospital intranet to check clinical procedures and guidelines for practice.
- The emergency department was the trauma centre for the region. There was a network clinical lead on duty, or on call, at all times to provide advice and be available to care for patients admitted or transferred from trauma units. Clinical protocols for managing patients with severe trauma were available in a standard manual (TEMPO) that all other units used.
- Some staff had developed aspects of the new clinical information system to support their work. Staff showed us quick links to checklists and standard text they had saved on personal login sections. This meant they could undertake faster recording and prompting of appropriate tests according to the patient's condition.

Pain relief

- We observed many examples of staff asking patients if they were comfortable, checking pain levels and ensuring timely analgesia was administered. This was also demonstrated in the emergency department patient survey.
- The Pain in Children audit against the College of Emergency Medicine guidelines was being prepared at the time of our visit. Clinical staff were adhering to the guidance but audit checks had been delayed due to the difficulty of collating data from the new clinical information system.
- In the A&E survey for 2014 the Emergency department performed better than other departments in providing pain control to patients in good time and for providing food or drink as needed. However in other audits the hospital scored well in initiating pain relief but scored less well in the evaluation and reassessment of pain relief. These audits included patients with renal colic and fractured neck of femur.

Nutrition and hydration

- We observed staff offering patients drinks if clinically safe and they had been in the department for some time. Intentional rounding also ensured that patients' nutrition and hydration was considered.

Urgent and emergency services

Patient outcomes

- The department undertook national College of Emergency Medicine (CEM) audits to benchmark performance against best practice. Audits included consultant sign-off, vital signs in the majors area, renal colic, fractured neck of femur and severe sepsis and septic shock.
- We examined audit reports and saw that recommendations for improvement and re-audit had been identified. Staff told us that audit reports were communicated via meetings, displays, emails and routine staff briefings.
- In the audit of consultant sign-off in 2013 the trust performed worse than the national average in all but one of eight measures: discussion with the patient. In the seven other measures they performed worse than the national average. The standard states that three types of patients groups should be reviewed by a consultant prior to discharge. These are: Adults with non-traumatic chest pain, Febrile children less than one year old, Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. Consultant sign off for these conditions was significantly below the national average.
- The unplanned re-attendance rate within 7 days for the emergency department shows that the trust is performing better than the England standard but was below the England average at below 6% as opposed to an England average of 7% in September 2014. The England standard is the target to be achieved whereas the England average is the level achieved in the average English trust.
- We reviewed the audit of consultant sign off for 2013 of Adults with non-traumatic chest pain, febrile children less than one year old, and patients making an unscheduled return to the Emergency department with the same condition within 72 hours of discharge. The results were worse than the England average at that time for most indicators including for a consultant first seeing a patient and reviewing case records after discharge. Since this date learning points were identified and consultant staffing has been supplemented but we did not have more recent audit data to compare any improvement.
- Audits for adherence to clinical guidance and outcomes were not being conducted at the time of our visit. The new information system did not have codes applied to the entries required for some clinical audits and this meant staff were considering continuation of paper based audits.
- Audit data for fractured neck of femur care were only available for 2012/13 with results being better than UK average. The trust was in the top 25% in England for six of the indicators which related to being given pain relief and obtaining an x-ray in a timely manner. However, for the evaluation of pain relief the trust was in the bottom 25% for England.
- In the audit of renal colic in 2012/13 the trust scored above the England average for seven of the indicators. However the trust scored below the England average for re-evaluating pain relief.
- Audit results for care of patients with severe sepsis and shock were available for August 2013. These showed the care did not meet standards of CEM for most elements of the care. Staff told us they had been working to the guidelines to meet the standards but we did not see any evidence of the improvements made. The audit showed that the hospital was not recording vital signs (45%), test urine (25%) and undertaking blood culture monitoring (83%) as part of the initial assessment of the patient. Some treatments were not recorded as having been initiated in the department. These treatments included bolus doses of colloids (74%) and high flow oxygen (47%). The results show that in some instances less than half the patients admitted with sepsis received appropriate assessment and treatment in line with national guidance.
- Trauma Audit and Research Network (TARN) figures for the 2014 calendar year indicate that survival rates at the trust are slightly better than the average for England, with 1.3 additional survivors out of every 100 patients.
- In audits of patients taking a paracetamol overdose, in 2013-2014, the trust performed well on checking paracetamol levels and treating patients with raised levels promptly.
- In audits of patients with asthma, in 2013-2014, most patients had their observations checked (49 out of 50). 68% had salbutamol given appropriately and half had hydrocortisone prescribed. Therefore the trust performed well in this audit.

Competent staff

- There were specific roles designated across the department for which staff had to have training and

Urgent and emergency services

competence checks before undertaking that role. Nurses undertaking initial assessment for patients walking in or being brought in by ambulance were trained and assessed as competent to carry out that role. Emergency nurse practitioners were qualified and maintained their competence as independent practitioners to assess and treat patients attending the department. We saw that these staff followed clinical guidance and best practice and were involved in continual audit and development of their skills.

- Staff in the emergency department had access to a training matrix and were provided with opportunities on away days to develop relevant skills for the role.
- There were consultant training days. The most recent day in April 2015 included sessions updating staff on major incidents, emergency clinical procedures, and lessons learnt from the trauma network. Other professional development sessions included the use of the new information system and clinical skills such as chest trauma care.
- There were two staff members employed to provide clinical education in the department. These were experienced staff who provided training in practice areas.
- Training for junior medical staff was regular and consistent. Medical staff we spoke with told us that specific training for junior doctors and additional sessions about emergency medicine had always taken place on schedule and they considered it a useful programme. There were one to one sessions with consultants to supervise the experience and daily departmental rounds were also focussed on learning.
- Health care assistants had been trained to carry out additional tasks according to protocols and after having their competency checked.
- Staff who required additional support to maintain or improve competency were identified and a specific framework of support developed for the individual staff member.
- Medical staff commencing work in the emergency department were given information about current guidelines in use such as managing infectious diseases. They were also advised about learning from past incidents.

Multidisciplinary working

- There was good multidisciplinary team working and integration with the rest of the hospital. The model of

the service was that all admissions were assessed in the emergency department and seen by the emergency department or Medical staff interchangeably. This meant high flexibility in the team to manage different profiles of patients attending at any time, either general medical or emergency conditions.

- There was effective internal multidisciplinary team working. We saw that physicians' assistants worked effectively as part of the team integrating well to enable medical and nursing staff to continue with their roles.
- Junior medical staff told us that there was good support from medicine for the elderly services in the hospital for patients admitted to the clinical decision unit.
- There was good support to the work of the department by pathology staff undertaking point of care testing. Blood tests were available 24 hours a day to check for all general blood levels and also specific checks for cardiac injury, blood clot, liver, pancreas and kidney function. 3000 tests were completed per month and results were provided when possible within around 35 minutes.
- In the paediatric emergency care area there were play specialists as part of the team for some shifts. We observed that the specialist supported children through distraction and play which meant that nursing and medical procedures could be performed with less stress for the child and family.

Seven-day services

- The department is open at all times. Senior medical staff are available to provide patient care and advice to 2am each day. They also provide on-call cover for major trauma cases, providing advice to other trauma units and attending the emergency department as needed when patients are admitted. Nursing staff told us that consultants are often in the department through the night attending trauma cases or supporting the team at time of high activity. During our inspection a consultant had been in the department continually through the previous night.
- The consultant cover had been improved from April 2015 to ensure additional cover and safety at times of higher patient activity. From 4pm to midnight during the week and 11am to 8pm at weekends an additional shift meant three consultants were available to support the team and provide senior clinical and operational decision making.

Access to information

Urgent and emergency services

- There was a clinical information system in use which staff had been involved in developing before and since implementation in October 2014. Patient records were accessed from workstations at many available mobile points beside the bedside and clinical base areas.
- There was a standby arrangement in place for making clinical records and printing out details if the main system became unavailable. This was tested daily by staff.
- Clinical staff stated the system allowed them to check records from any available terminal connected to the network. This meant that during discussions over the telephone with specialists the clinicians could view latest test results, past history and current observations. The system also made it easier for senior staff to check results, scan reports, then identify and call back patients who had been discharged with a clinical problem unresolved.
- The new clinical information system was not easily adapted to the re-audit work of clinical standards which meant consultant staff were considering continuation of paper based reviews.
- Mental health trust staff who may be asked to attend the emergency department or clinical decisions unit patients have read only access to the clinical information system to review records of patients being referred. Hospital staff have read only access to the community information system to review case notes of patients with past medical history of mental health problems.
- Waste management in the department included bins to dispose of any used documents with personal information. This preserved patient confidentiality.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff discussing care and treatment with patients and their relatives. Detailed explanation was a feature of discussions to support patients in making informed choices.
- We saw during our observations that staff sought consent from patients before undertaking treatments. Mental capacity could be recorded on the clinical information system when appropriate.
- Of the ten patient records examined all had a social history and background undertake and in three cases the level of the patients understanding about their care and treatment was identified during the assessment as

requiring a mental capacity assessment. This was undertaken using the trust template by a member of the medical team to determine whether the patient had capacity or not. This process was in line with best practice guidelines.

Are urgent and emergency services caring?

Good



We observed that staff provided care that was consistently caring and respectful. Patients and their relatives gave us positive views about the care they had received.

There were good levels of privacy in the department. Where this was difficult, such as in waiting areas or curtained cubicles staff were careful to maintain privacy and dignity. When there were delays in admission or transfer to other services staff ensured good levels of care in the emergency department or the clinical decision unit until appropriate discharge from the emergency department could be arranged.

Staff included patients and their relatives in decisions about their care. Staff supported patients promptly in managing pain and anxiety.

Compassionate care

- Friends and family trust scores for patients recommending the service were better than national average for 11 of the 12 months to November 2014. This corresponded to the introduction of the new clinical information system and fall in performance on waiting times in the emergency department. The response rate was above the England average of 14% in May 2015 at 15.7%.
- The most recent survey results returned by patients to the emergency department for January 2014 to February 2015 show that over 90% (1619 out of 1764) would recommend the service to friends or family.
- In the A&E survey of 2014 the trust performed as good or better than other trusts for all questions. This emergency department performed well on providing information to patients about their condition and care and for providing pain killers in good time when patients asked for them. The trust was joint fourth nationally in the positive response to this survey.

Urgent and emergency services

- The emergency department had a policy of allowing close relatives to be present when a patient was receiving emergency care and staff provided emotional support at this time.

Understanding and involvement of patients and those close to them

- Children and families were well supported in the emergency department. We asked parents about the care. Three parents attending with children told us they were happy with the explanations given about their care and treatment and about any waiting times. They said appropriate pain relief had been provided.
- We observed staff being caring and respectful with patients and relatives. Staff informed patients of the plan of care and about any procedures or tests that were proposed.
- As patients arrived in the department on foot they were met by a registered nurse, trained to undertake assessment, this was an immediate reassurance to patients who were rapidly provided with any first aid then moved to the relevant part of the department.

Emotional support

- Patients told us they were well supported by staff. Patients we spoke with in the waiting area had been given good information about waiting time and their treatment.
- Bereavement counselling services were available including for parents of children that may die in the department. Support was also available for staff involved in caring for families where there was severe trauma or a sudden infant death.
- Staff had arranged for phone chargers to be available for patients or relatives to use in an emergency if they needed to contact other people using personal phones in time of crisis.
- The paediatric waiting area was well equipped and the spaces adapted to be appropriate for children and families.

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

Requires improvement



The department was not meeting the four hour waiting time target for emergency departments. The departmental leaders and staff had implemented systems to maintain flow and escalate problems as soon as there were indications of delays in care and patient flow. Current performance was around 75% for patients being seen within four hours of arriving at the department. This meant that some patients experienced extended waits to be seen and treated.

The department had been developed to deliver services to meet the needs of patients where possible. Patients with minor injuries, major trauma or GP referrals were managed in ways appropriate to their needs. Staff were also participating in projects at trust and health economy level to review the systems of care and resilience. These projects aimed to tackle the increasing levels of attendance to emergency services and the flow of patients through the hospital. Effective arrangements were in place to support patients and relatives following complaints, learn lessons, and rapidly improve the service where required.

Service planning and delivery to meet the needs of local people

- Patient flow is a key issue discussed at working groups to improve the flow and experience of patients whilst promoting safe care. Emergency department consultants were on a 'front door model of care' steering group with a remit to establish a medical decisions unit close to the emergency department. The aim of this would be to aid flow through the department although they wish to retain patient initial care in the emergency department as this was considered a safer and clinically effective arrangement.
- This was in addition to a hospital capacity review work to assess options of increasing capacity in hospital and community.

Meeting people's individual needs

Urgent and emergency services

- The electronic patient record had additional sections that staff used to record and plan care for patients with complex needs. A management plan was developed for such patients, for example elderly frail patients or those living with dementia or mental health problems. Staff accessed these sections using an additional information tab on their screen. This section could alert staff to ongoing problems seen in previous admissions and therefore remind staff of specific medical needs or ongoing plans of care.
- Frail elderly patients were referred to a team providing specialist advice for frail elderly (SAFE team). This meant that patients complex needs were assessed on admission and then appropriate plans of care and discharge were arranged.
- Staff cared for patients living with dementia in ways appropriate to the individual. There was a small store of resources that staff could use to divert or occupy people who may be living with dementia. We saw that one elderly patient was offered and made use of the equipment to very good effect which meant the person was given a focus to counteract the disorientation of being in the emergency rooms.
- Following an incident dealing with a family from the traveller community staff had arranged for information and training about this group. Consultants had attended training around cultural issues and we saw information sheets that had been provided to staff.
- There was access to translation services should these be required for patients in the department.
- Medical and nursing staff told us they would discuss with the learning disability specialist nurse if they needed advice for such patients.
- Patients transferred to the clinical decision unit had good management of their plan of care. We saw that patients with mental health problems or needing support at end of life had appropriate care or arrangements for transfer that suited their needs.
- New signs had been displayed throughout the department. These had been developed by the design council specifically for A&E departments to be visually clear and easily understood. Signs were to provide information about the flow of patients and explain the function of different areas. This meant there was clear information for patients and families to aid understanding of the busy clinical areas and reduce anxiety.
- Signs in each children's cubicle provided explanation to parents about the process of managing patients.
- We observed regular handovers between medical staff about the status of the department overall at shift changes and clear clinical handovers when transferring or referring patients. When patients were held up due to other teams being unavailable from other parts of the hospital decisions were made about diagnostic tests and admission to ward areas by the senior medical staff in the emergency department to prevent delays.
- The emergency department had two rooms allocated for relatives of seriously ill patients. The rooms were clean and tidy with appropriate furniture and décor.
- The relatives' rooms had been designed to be safe to be used for discussion with patients who had mental health problems and may require specific care and support.
- The paediatric waiting area was well equipped and the spaces adapted to be appropriate for children and families.
- The department had signs placed in prominent places around the corridors which were uncovered when needed to reveal a dragonfly symbol. This was to alert staff that there were bereaved relatives somewhere in the department and to be sensitive in terms of noise.

Access and flow

- The emergency department has an integrated system of managing emergency and GP admissions to the hospital. All these patients are managed through the emergency department rather than the typical arrangement in hospitals in England where GP referred patients enter the hospital through an admission department or ward.
- This integration has a negative effect on the performance figures if comparing with other emergency departments. The four hour waiting time performance for the emergency department had been around the national standard of 95% during 2013/2014 and was around 75% in the current year. There had been a noticeable deterioration since October 2014.
- The flow of patients and activity levels is monitored by the department senior nurse and the emergency physician in charge on each shift who troubleshoot delays or problems transferring to wards or other departments. There were two hourly checks by the senior clinician in each area of the department to ensure delays were dealt with.

Urgent and emergency services

- Operational managers attended the department and work with medical and nursing staff to monitor workload and facilitate the flow of patients through hospital departments and ward areas. Other options had been implemented to maintain patient flow. The hospital had a system to close and deep clean ward areas in rotation. The management team had decided to suspend this on a temporary basis in order to free up bed capacity. Wards teams have been urged to discharge patients who could be ready before midday to free up bed availability for patients being admitted through the emergency department.
- There were 131 cases where patients waited between 4 and 12 hours for admission after the decision to admit in the last 18 months at the hospital. 86% of those were within the last 6 months. Of the 131 breaches, 115 were due to the emergency department and hospital being at full capacity. 16 cases were in December 2014 when the hospital declared major incident status for capacity. In comparing with other hospitals this performance should be seen in the context that all GP admissions are cared for in the emergency department.
- We checked the waiting times for children in the paediatric area during our visit. There had been 46 children cared for on 23 April 2015, of these seven had waited more than four hours to be admitted to a ward. Five of these were due to bed availability in the hospital, and two were due to delay in acquiring blood test results.
- In the year to September 2014 around 2% of patients left the department without being seen. This was better than the England average performance for this indicator
- The average waiting time for ambulance staff to handover their patients and return to availability was just above the ambulance service target of 30 minutes for April 2015. This was around the average for all acute trusts in East of England.
- There was a traffic light system outside the department ambulance door which gave ambulance staff an immediate view of the likely waiting time and when to seek help from the department for particularly critically ill patients on arrival. There was a registered nurse of sufficient experience and training based at the ambulance entrance and rapid assessment bays just inside the entrance.
- These bays were manned by a senior doctor and a nurse to ensure patients were assessed quickly and efficiently with the relevant diagnostic tests ordered. The patient was then referred to the appropriate section of the department and specialist medical team.
- Each week the department leads attended a task force meeting with the clinical commissioning group to discuss the system wide options to improve the flow of patients through the emergency department and the hospital back to the community.
- Some patients were referred to a clinic set up within the hospital site. This urgent care centre with GP and nurses in attendance treated 960 patients in ten weeks from February to April 2015 also contributing to maintaining flow through the hospital and reducing waiting times.

Learning from complaints and concerns

- Between April and December 2014 the trust had received 56 complaints regarding the emergency department, two regarding the Emergency Assessment Unit and one regarding the clinical decision unit. The top two concerns reported being the quality of care and the attitude of staff.
- Staff had noted patient comments about confidentiality when discussing personal medical issues. This had led to chairs being moved in the initial assessment area to make discussions more discreet, and signs were displayed reminding staff of confidentiality.
- We examined the team meeting minutes, governance meeting minutes and shared learning board throughout the department. All of them detailed feedback and learning from complaints which had been received.
- We spoke with 35 members of staff during our inspection and we specifically asked four about what feedback or learning they were aware of regarding complaints. All were able to provide examples of where information had been shared through meetings, during handovers, on information boards and in during supervision with managers. We were assured that feedback and lessons learnt from complaints was being provided.

Urgent and emergency services

Are urgent and emergency services well-led?

Good



There was strong leadership and management of the emergency department. There was strategic planning and options were investigated to improve the service. Senior staff were approachable and encouraged a strong team ethos. There were several established systems to ensure good clinical governance and monitor performance. However audit outcomes were not always meeting national expectations. The division and department held a risk register which identified current risks and the mitigating actions. All staff were focussed on providing high-quality urgent care for patients and maintaining efficient flow through the service. There was a positive culture with a strong team ethos and good relationships across all professionals, managers and local partners.

Vision and strategy for this service

- The emergency department staff had been involved in planning future service configuration. There had been a strategic away day in September 2014. This had included discussion and planning about short, medium and long term plans for the future in the context of the NHS finances and local opportunities.
- There was also an Urgent Care and Emergency Department programme board working with hospital departments and partners in the community to improve pathways through the service and the acute hospital.
- Although plans for new build or refurbishment had not been fully agreed since the planning day departmental leads had worked closely with division managers and options were being prepared for approval as funding becomes available. Staffing, service configuration for the medium and long term were being developed. This included the possible opening of a medical decision unit to improve the flow of some GP referred patients.

Governance, risk management and quality measurement

- There were several established systems to ensure good clinical governance and monitor performance. The

clinical governance and infection control committees were specific for the emergency department. However audit outcomes were not always meeting national expectations.

- Each meeting produced action points as required and we saw that these were disseminated through the teams in flexible ways, by email and daily briefing meetings and displays to ensure continual improvement to quality of the service.
- These meetings reported to divisional programme and quality boards, and into the Trust Board to enable oversight and learning across departments.
- Learning from incidents led to changes in practice. All staff were aware of the incidents that had been reported recently. Junior medical staff were advised of recent incidents on induction and that, following learning from recent cases, patients with specific conditions must be reviewed by consultant staff.
- The division and department held a risk register which identified current risks and the mitigating actions. Key risks noted were the capacity and flow through the department. Long term and short term actions were detailed. Other risks included the provision of appropriate care for mentally ill adults and children.

Leadership of service

- There was effective leadership of the emergency department. Senior staff were visible as clinical and managerial leads, with clear levels of accountability and control over operations.
- There were identified roles allocated on each shift and displayed on a large board in the department. Nursing teams were established with experienced staff supporting and appraising junior members of staff.
- Staff we spoke with felt supported by the local management within the emergency department and that the team were a cohesive team.

Culture within the service

- Nursing staff told us they felt it was a very supportive department to work in, they said staff work well together across the professional disciplines. We saw that staff interacted in a supportive way to ensure safety and efficiency for patient care.

Urgent and emergency services

- Staff who had been working in the department for a few weeks said it was a good place to work, in particular the attitude of all staff with each other was seen as supportive and a good place to develop skills and experience.
- Cleaning staff reported that they knew the chief executive and had met him in the workplace. They told us the emergency department was a great place to work. Cleaning staff said they were seen as part of the department team and felt pride in maintaining clean areas for patient care.

Public and staff engagement

- Staff told us they are informed and included in developments of the service. There were daily briefing meetings and weekly notices with useful information and latest important changes and learning from incidents or complaints. Separate paediatric briefing sheets were displayed and emailed to staff that included staff or other changes to ensure good communication and involvement of all staff.
- Patients were invited to provide feedback and comments using either the electronic system in the department or through the use of comment cards.







Comment cards were analysed within the service and worked to provide feedback to staff weekly on what they needed to improve upon. The team were able to give an example of a change to the waiting room environment and information available to read as a result of patient engagement through comment cards.

- The trust has an electronic newsletter which is emailed out to the patients who subscribe to the mailing list and in this newsletter information regarding urgent and emergency services is provided.

Innovation, improvement and sustainability

- In addition to working groups reviewing the flow of patients through the emergency department and hospital the nursing team have an emergency department process review group to challenge ways of working and identify areas for improvement.
- There were improved systems to reduce violence in the city as a result of alcohol use. The service shared anonymised information about patients attending with injuries with local police services to identify areas in the city where violence was prevalent and related to alcohol purchase.

Medical care (including older people's care)

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

Information about the service

The medical care services at Addenbrooke's Hospital covered a wide range of specialities, including acute medicine, infectious diseases, respiratory medicine, cardiology, care of the elderly, medical oncology, renal medicine, endocrinology and diabetes, gastroenterology, haematology and hepatology. Medical care services also included the delayed transfer of care (DTOC) ward, the clinical decisions unit and two discharge lounges.

All the clinical departments at Addenbrooke's Hospital were grouped together under five divisions. The medical wards were split between the five divisions. Each division was supported by a divisional director and a divisional lead nurse.

There were 60,598 admissions to medical care services at Addenbrooke's between July 2013 and June 2014, of which 34% were emergency admissions, 6% were elective and 60% were day cases.

According to information provided by the trust, medical care services had a complement of 440 inpatient beds across 29 wards, including the medical short stay emergency unit (MSSEU). During our announced inspection we visited all of the medical care areas and wards managed throughout the divisions. We also visited the delayed transfer of care ward and the discharge lounge. We visited the wards during the day and we conducted an evening visit. Based on information received before the inspection, we specifically considered the neuropsychology service. This service provides neuropsychology services to

inpatients and outpatients, including patients who have had strokes, traumatic injuries and other neurological conditions. We carried out an unannounced inspection and visited wards D5 and N3.

We used a variety of methods to help us gather evidence in order to assess and judge the medical care services. We spoke with 20 patients and those important to them, 37 doctors, including junior doctors, middle grade doctors and consultants, 44 registered nurses, eleven health care assistants, two student nurses, ten allied healthcare professionals and a number of other support staff, such as nutritional support staff and housekeeping staff. We interviewed the clinical leads for Division C, as this was the division under which most of the medical care services came. We observed the care and the environment and we looked at records, including patient care records on the electronic recording system. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments and audit results.

Medical care (including older people's care)

Summary of findings

Overall, we found that medical care services at Addenbrooke's Hospital required improvement. This is because we found concerns in relation to safety, effectiveness, responsiveness and leadership of the service. However the staff remained caring despite the concerns in other areas. Staff worked hard to ensure that patients received the best possible care.

We had concerns in relation to nursing staffing and the movement of staff between wards. The respiratory ward was not staffed in line with national guidance and this increased the risk of potential avoidable harm for patients who required non-invasive ventilation (NIV). Staff did not always report incidents when they should have done and staff did not always receive feedback about incident investigations. We found gaps in the checking of emergency resuscitation equipment in some ward areas.

The neuropsychology service was providing effective care to inpatients and outpatients requiring the service. However, we found that none of the neuropsychology staff were on the British Psychological Society's Specialist Register of Clinical Neuropsychologists or receiving supervision from a professional on the register, though they were professionally registered with the Health and Care Professions Council as clinical psychologists which is a legal requirement.

Clinical staff were not always able to access the information they required – for example, diagnostic tests such as electrocardiographs (ECGs) to assess and provide care for patients. This was because ECGs had to be sent to a central scanning service to be scanned into the electronic recording system once the patient had been discharged. This meant their ECGs would not be available for comparison purposes if a patient was re-admitted soon after discharge.

Where agency staff were used, they were not always able to access information about patients they were supporting. In addition, all staff, we spoke with, had limited knowledge of their responsibilities under the Mental Capacity Act (MCA). Nursing staff were unclear

about the procedures to follow when reaching decisions in people's best interests. However, staff had not received training in the MCA or Deprivation of Liberty Safeguards (DoLS)

Staff were unable to show us where care plans had been completed. Some staff told us the doctors' orders had replaced care plans on the new EPIC IT system. These orders were task-orientated and did not always reflect the holistic needs of the patients. Some staff told us there were no care plans on the new IT system.

We observed care and found this to be compassionate from all grades of support and clinical staff, including doctors. We also saw and patients told us that privacy and dignity was maintained at all times. Where possible, patients were involved in their care and treatment and were given information to support their decision-making. We found that patients could access emotional support if they needed to.

We found there was insufficient bed capacity to meet the needs of patients within the hospital. This resulted in a large number of patients being cared for in non-speciality beds and this had negative implications for their safety whilst receiving care and treatment. Implementation of the electronic recording system had impacted on the care people received. For example patients were unable to receive blood transfusions within the ambulatory care unit and had to be admitted to a ward.

We were told and records demonstrated that patients requiring elective treatment often experienced cancellation or had to wait for up to 12 hours for a bed to become available because of bed capacity issues. In addition, there were significant numbers of people who were experiencing delayed discharge because they were waiting for packages of care in their own homes and could not be discharged by the hospital until funding had been agreed for this care.

Medical care services were generally well led at a local level. However, leadership was not consistent across the medical services area. There was a recognition that staff were working under pressure but staffing levels and skill mix had not always been taken into account within the divisional risk registers, nor were there any action plans to ensure staff were supported. Although staff told us

Medical care (including older people's care)

they felt supported by their line managers, divisional directors and divisional lead nurses. They also shared concerns that sufficient action had not been taken to address key risks such as staffing levels, the movement of staff between wards, flow throughout the hospital and issues associated with the electronic recording system.

Are medical care services safe?

Requires improvement



Medical care services at Addenbrooke's Hospital required improvement because patients were not protected from avoidable harm due to the movement of ward staff to unfamiliar wards, the lack of reporting of incidents, IT issues following the implementation of EPIC, and because the environment did not always protect patients from avoidable harm. The movement of staff between wards to provide cover for contingency wards meant that donor wards were at times left with reduced numbers of staff and recipient wards were staffed with staff who were not necessarily familiar with the ward or did not have the relevant skills and experience to care for patients in these areas. We found that whilst donor wards' nurse staffing levels were supplemented with bank or agency staff the regular ward team had additional duties placed upon them by the redistribution of staff, such as supervision of overseas student nurses as well as oversight of agency and bank staff. We found that the respiratory ward was not staffed in line with national guidance for patients requiring extra support such as non-invasive ventilation (NIV).

Staff told us that they did not always report incidents due to time pressures. We corroborated this through reviewing patient records and reports of incidents. Staff highlighted that they did not always receive feedback on incidents that had been reported. There was little evidence of the sharing of lessons learnt from incidents reported across the directorate. The new electronic patient record system had been introduced in October 2014 but we found that whilst patients received care through "order" there was no individualised care plans in place to reflect the patients' needs. Clinical staff were not always able to access the information they required – for example, diagnostic tests such as electrocardiographs (ECGs) to assess and provide care for patients.

There were suitable arrangements for the prevention and control of infection and the safe management of medicines. People's personal and confidential information was stored securely. We found gaps in the checking of emergency resuscitation equipment in some ward areas.

Medical care (including older people's care)

Staff were aware of their role in relation to safeguarding children and adults living in vulnerable circumstances and acted according to local policies when abuse was suspected.

Incidents

- Between February 2014 and January 2015 there had been 35 serious incidents reported throughout the divisions for medicine, including older people's care. Information provided by the trust showed slips, trips and falls as the most commonly occurring incident, followed by confidential information leaks. We were concerned that this number of serious incidents was low in comparison to the size of the service and the concerns that had been raised in relation to staffing.
- The trust's policy indicated that incidents were reported through the trust's electronic reporting system. We spoke with a range of staff across the service and all were aware of how to report incidents. Between October 2014 and April 2015 there had been 240 incident reports submitted relating to staffing levels.
- Most of the nursing staff told us they did not always report incidents when they should have done because they didn't always have time. This had also been reported within division C's March divisional combined performance meeting minutes, where it was acknowledged that incidents were not always being reported due to low staffing levels.
- Staff were able to provide us with examples of when they had reported incidents, and understood what constituted an incident. For example, nursing staff could describe how medication incidents were reported and gave us examples of incidents that had resulted in a change in practice. We were therefore assured that suitable arrangements were in place to learn from medicine-related incidents.
- Staff told us they did not always receive feedback from incidents they had reported. One of the divisional lead nurses told us that outcomes of incidents were shared with staff, and staff were told when changes were made as a result of an incident but rationale for the changes and lessons learned from incidents were not always shared with staff.
- Incident data was discussed within each speciality as part of their bi-monthly clinical governance meetings and as part of the wider divisional combined performance meetings.

- A root cause analysis tool was used to investigate serious incidents, and we saw that where required an action plan was put in place to reduce the risk of the incident happening again. Action plans included evidence of feedback and actions for learning. Where necessary, action plans indicated where further training for staff was required.
- Mortality and morbidity were discussed within each medical speciality as part of the trust's clinical governance meetings on a bi-monthly basis.
- The trust displayed information within ward areas explaining their responsibilities relating to Duty of Candour. (Duty of Candour is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong and harm has been caused.) Information provided by the trust showed that where incidents had resulted in harm they were discussed with patients and those who were important to them.
- Senior staff were aware of their responsibilities relating to Duty of Candour and were able to give us examples of when Duty of Candour would apply.

Safety thermometer

- The NHS safety thermometer is a national initiative, local improvement tool for measuring, monitoring and analysing patient harm and harm free care. Performance against four possible harms – falls, pressure ulcers, urinary tract infections (UTI) and venous thromboembolisms (VTE) – was monitored on a monthly basis and the results were prominently displayed on all of the medical wards and units we visited.
- From December 2013 to December 2014 there was an increasing trend in the number of hospital-acquired pressure ulcers reported to the safety thermometer survey for medical wards. There was also a slight increase in catheter-related UTIs. The majority of falls on medical wards took place after June 2014.
- The trust was monitoring the incidence of pressure ulcers and falls through its Nursing Quality Metrics. Staff were unable to tell us about any changes that had been implemented to reduce the number of pressure ulcers. However we noted that pressure relieving equipment was available for these patients.

Cleanliness, infection control and hygiene

Medical care (including older people's care)

- The Department of Health's Code of Practice on the prevention and control of infections and related guidance was adhered to within the wards providing medical care.
- Monthly hand hygiene audits were undertaken. Results were mostly around 100% across medical and care of the elderly wards, with the exception of ward K3 (cardiology and coronary care), where figures had dropped to 89% for three out of the previous nine months. The clinical decision unit scores were approximately 97% in January.
- Staff were compliant with the trust's infection control policies and protocols such as hand hygiene and bare below elbows policies. However, on the Medical Short Stay Emergency Assessment Unit we saw several nurses who had rolls of tape attached to their lanyards. We saw these rolls of tape had collected dust and had been in close contact with nurse's uniforms. There is the possibility that these rolls of tape could be used to secure patient's dressings and were not being stored in line with best practice for the prevention and control of infection.
- Staff demonstrated they had a good understanding of infection prevention and control. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms.
- All wards had antibacterial gel dispensers at the entrances and by people's bedside areas. Appropriate signage regarding hand washing for staff and visitors was on display. Side rooms were used where possible as isolation rooms for patients at increased infection control risk (for example, those with diarrhoea). There was clear signage outside the rooms so that staff were aware of the increased precautions they must take when entering and leaving the room. We saw that these rooms were also used to protect patients who had low immunity. We did, however, see one incident on the medical short stay emergency unit where a patient had been placed in a side room because they were suspected of having tuberculosis. The patient's wife had been allowed to enter the room without any personal protective equipment (PPE) and staff had failed to communicate the infection control risks with the patient or their visitor.
- Where side rooms were not available patients who were experiencing the same symptoms were nursed together in bays.
- We observed the space in the haematology day case unit to be very compact, with patients sitting very close together due to lack of space. This increased the risk of infection for patients who were immunocompromised.
- Within the discharge lounge we observed a patient who required barrier nursing being escorted to the toilet. However, the toilet had not been identified as an isolation toilet. This meant there was an increased risk of spread of infection.
- We observed that cleaning of the environment was not always as thorough as it should have been. On one ward we saw that there were faeces on the floor of the shower room. We pointed this out to a senior member of staff. The next day we visited the ward and found the faeces had not been cleaned away but it was evident that the shower room had been used by patients. Again, we alerted this to a senior member of staff. When we returned to this ward during our unannounced inspection we noted the shower room had undergone a deep clean.
- We observed that the management of sharps complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. However, on wards G4 and N2 we saw that sharps containers were not always dated and signed on assembling and that temporary closure was not always used when sharps containers were not being used.
- In the last 12 months there had been no reported MRSA Bacteraemia incidents, but there had been 22 reported cases of Clostridium difficile infection across the medical wards. Six of these were classed as unavoidable by the trust.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside most wards to identify themselves on arrival before they were able to access the ward. Staff had swipe cards to open doors. However, we noticed that some wards did not operate this system and we were able to enter these wards and walk around unchallenged. For example, we walked onto the liver unit and were not challenged as to

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who we were. This meant that patients were not protected from avoidable harm as some patients were confused and could exit the ward as well as people entering it unchallenged.

- Most areas we visited were bright and well organised but when we visited ward D5 we noticed the ward to be poorly lit due to some of the lights in the ward not working. This meant that patients who were frail and elderly or with visual impairment may have difficulty navigating the ward in a poor light. Staff could not tell us how long the lights had not been working. We brought this to the attention of the nurse in charge and throughout our inspection we saw that action had been taken to ensure the lights were working.
- We found that each clinical area had resuscitation equipment readily available. There were systems in place to ensure it was checked daily to ensure it was complete and ready for use. On some wards, however, this equipment had not been checked every day. We found examples where days were being missed in the last few months. For example, on the medical short stay emergency unit (MSSEU) we found that resuscitation equipment had not been checked for 13 days in March and for nine days in April. On the respiratory ward, we found no gaps in recording throughout March but there were gaps on five days in April.
- The trust implemented the new electronic record system to record all aspects of patient care. Staff told us there were not enough computers to undertake this task and we saw an example where one doctor was using their own personal laptop to update information whilst undertaking a ward round. The doctor told us they did this because there were not enough portable computers on the ward.
- Throughout our inspection we did not identify any major environmental risks or hazards. However, we did notice that some ward areas were not as spacious as others – for example, on the delayed transfer of care (DTC) ward and G4 which was a care of the elderly ward. This meant that staff had difficulties when moving and handling patients and elderly patients may have problems when moving throughout the ward.
- The ward areas we visited were generally well maintained but some ward areas had insufficient storage, which led to equipment such as clean linen being stored inappropriately on open trolleys in bathrooms. This meant that in some cases bathrooms were difficult to access and were rarely used.

- There were systems to maintain and service equipment as required. Firefighting equipment had been checked regularly. Hoists had been serviced regularly. Where electrical testing had been completed, we saw labelling on equipment to demonstrate that testing had been undertaken and on which date.
- Patient Led Assessments of the Environment (PLACE) in 2014 showed 93% in medical wards for condition, maintenance and appearance. This was a slight improvement from the previous year's score of 92%.

Medicines

- Medicines were prescribed electronically throughout the medical specialities and the care of the elderly wards.
- We looked at the prescription and medicine records for six of 52 patients on two medical wards. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed. However, the trust's electronic recording system did not support the prescribing of medical oxygen. If medical oxygen was required it was written as an order on the IT system with a range of parameters and not on the medicines administration record. The system prompts nursing staff to document the administration of oxygen.
- Medicines requiring cool storage were stored appropriately. Records showed that medicines were stored at the correct temperature and so would be fit for use. However, the temperature of rooms used to store medicines that were required to be stored at room temperature were not being monitored or recorded. When we measured the temperature in these rooms we were not fully assured that medicines were always stored in a way that maintained their quality.
- Controlled drugs (medicines that are required to be stored and recorded separately) were stored and recorded appropriately.
- Emergency medicines were available for use and there was evidence that these were regularly checked and were in tamper-evident containers.
- Each patient had a bar code on their wrist band that was scanned prior to the administration of medication. In addition, we heard nurses ask the person their name and date of birth. This helped staff to ensure they were giving prescribed medicines to the correct person.
- On the medical short stay emergency unit (MSSEU) we observed nurses administering medication. We saw one

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nurse leave a medicine trolley unlocked and unattended whilst they went to the other side of the bay to check the identity of a patient in one area of the ward. We also observed two nurses administering medication in another part of the unit. Each nurse had been allocated a bay in which to administer medication but there was only one medicine trolley. This meant the nurse from one bay had to remember what medication their patient had been prescribed and go into the other bay to collect medication from the medicine trolley to administer to each patient. This could increase the risk of patients receiving the wrong medication.

- Where patients were able to, they administered their own medication. We spoke with one patient who had been provided with a lockable drawer in which to store their medication. The patient was able to continue to take their medication at the times they were used to taking the medication at home.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that medication was available for patients when it was needed.
- A pharmacist visited all wards each weekday. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date.
- Pharmacy staff were readily available on the wards to provide medicines to patients on discharge. This meant that patients were not kept waiting unduly for their medicines.

Records

- An electronic records management system had been introduced trust wide in October 2014. Staff told us of their concerns relating to the electronic reporting system but many staff told us this system had overcome problems relating to illegible writing. We saw that records were legible, signed and dated. They were easy to follow and medical staff had detailed 'orders' for patients' care and treatment. However, we saw no evidence of individualised care plans. We were told by nursing staff that care plans were not yet available on the system. Some staff told us the doctors' orders had replaced care plans on the IT system. These orders were task-orientated and did not always reflect the holistic needs of the patients.
- Staff told us they had received initial training to use the electronic recording system but most staff told us this

training had been insufficient and had not really prepared them for the problems they would encounter when using the system. Some staff told us the support for the rollout of the electronic recording system had been withdrawn too soon. However there was a 24-hour support line for staff who experienced problems when using the electronic recording system and staff told us this was helpful.

- Consultants expressed frustration that they were often unable to access previously performed electrocardiographs (ECGs). [An ECG is a diagnostic test that records the electrical activity of the heart]. This was because the ECG had to be sent away to be scanned into the electronic recording system. One consultant gave us an example of when the ECG had been performed the day before but was not available when they needed it to review a patient. We saw this had been identified as a red risk on division D's risk register with a comment that it should be resolved in one month. It was difficult for us to ascertain how long ago this had been written as there was no date attached to the action or date for review.
- We received information from stakeholders prior to our inspection that indicated there had been ineffective discharge letters sent out by the trust. There were concerns that included a lack of information about treatments or diagnoses people had received or missing information in relation to medications. This meant that there was a risk of people receiving inappropriate follow-up or after care due to inaccurate records produced by the trust. The trust had taken action to address this and were undertaking audits to ensure that information had been provided.

Safeguarding

- The adult safeguarding policy was being updated to reflect current national policy at the time of our inspection.
- Adult safeguarding training was mandatory throughout the trust. The uptake of this training throughout the medical and care of the elderly wards was generally above the trust's target of 90%. We looked at the training figures for 18 medical wards and found that four of the wards were below the trust's target of 90% for nursing staff having completed this training. These included N3 (82%), C6 (87%), K3 (89%) and EAU 3 (87%) for adult safeguarding. However we found in eight areas of the medicine service doctors training in adult safeguarding

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was poor with those working in the endocrine service showing only half the doctors had attended this training. We noted that within medical service the level of attendance at children's safeguarding level 2 training was generally poor with attendance rates from 33% to around 50%.

- There was a safeguarding lead for the trust and all of the staff we spoke with could tell us who the safeguarding lead was and how they would escalate safeguarding concerns to this person.
- Nursing staff were clear about their safeguarding responsibilities and knew where to seek advice and report concerns.

Mandatory training

- Staff we spoke with were aware of the mandatory training they were required to undertake and they told us they received mandatory training. Staff confirmed that most of the mandatory training was undertaken by e-learning, with the exception of moving and handling in which a practical session took place.
- Mandatory training included topics such as conflict resolution, equality and diversity, health and safety, infection control, information governance, safeguarding adults and level 1 safeguarding children, fire safety, moving and handling and resuscitation.
- Mandatory training was monitored throughout the divisions and information received from the trust indicated that for staff the overall target rate for mandatory training was 90%. Whilst training rates were better in some topics, the training rates for fire safety, moving and handling, and resuscitation consistently fell below the trust's target of 90%.
- The rates for the completion of mandatory training were variable across the wards providing medical care. For example, with the exception of four wards, between 47% and 89% of nursing staff were up to date with fire training. Only three wards were achieving the trust's target of 90% for moving and handling training. On other wards between 40% and 85% of nursing staff were up to date with their moving and handling training. With the exception of five wards, training rates for resuscitation were between 57% and 89%. The rates for training in safeguarding adults was more encouraging, with between 87% and 100% of staff having completed this training. We found it difficult to obtain an accurate picture due to medical services being provided across a number of divisions.

Assessing and responding to patient risk

- The trust had an up to date operational policy on prevention and management of the deteriorating patient for staff to follow.
- The trust used a Modified Early Warning score (MEWS) system to identify deteriorating patients. A score was calculated following each physiological observation and this determined the level of risk of deterioration for each patient.
- If a patient's MEWS was greater than three, health care assistants had a responsibility to report this to the nurse who was assigned to looking after the patient or to the nurse in charge. The nurse assigned to the patient was responsible for monitoring the patient's condition and for escalating any concerns to a senior level.
- The trust provided a rapid response team (RRT) who would review patients who had been identified by ward staff as deteriorating and would assist with initial stabilisation and management along with the patient's own medical team.
- The trust had very clear guidelines about who to contact if a patient was deteriorating.
- As part of the Nursing Quality Metrics, frequency and completeness of physiological observations and MEWS scores were monitored in a sample of patients on all of the medical wards. We looked at the Nursing Quality Metrics for March 2015 and saw that physiological observations had been completed and were found to be above the trust's target of 95%.
- Nursing handovers occurred at every shift change, during which staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients.
- Risk assessments for patients for venous thromboembolism (VTE), pressure ulcers and falls were undertaken appropriately and were reviewed at the required frequency. Risk assessments identified required actions to minimise any potential risk to patients.
- Patients who were at risk of falling were identified by a symbol of a leaf on the wall at the back of their bed space.
- Between the hours of 2am and 7am there was one matron on duty for the entire hospital. The matron was supported by two band six nurses from Divisions C and D and one band six nurse from each of the other divisions (A, B, and E) as well as three nurses from the

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specialties of critical care, emergency department and the outreach team. The band six nurses would be responsible for checking staffing on the ward areas and assessing any risk, whilst the matron was responsible for ensuring patients who were being admitted to the hospital were appropriately allocated to a ward. Nursing staff across the trust expressed their concerns about this arrangement and gave examples of where patients had been inappropriately placed. For example, one patient who had bowel surgery had been placed on the respiratory ward. Staff on the respiratory ward were concerned because they were not surgical nurses.

Nursing staffing

- Most wards providing medical care had nursing vacancies. K3 and N3 had vacancy rates of around 19%. Six areas had between six and seven whole time equivalent staff not in post. K3 the coronary care unit used 14% agency or bank staff and N3 the respiratory ward used 13% bank and agency staff in December 2014. Sickness rates were between 1.5 and 2% for K3 and between 3.3 and 6.7% for N3. With turnover for these wards being around 13%.
- The trust used the safer nursing care tool (SNCT) to assess the nursing skill mix and the number of staff required for each ward. The trust measured staffing on the basis of one nurse to eight patients. The trust stated that they reviewed areas where staffing was greater than one nurse to eight patients. The tool did not take account of the acuity of the patient. Acuity means the level of seriousness of the condition of a patient. This meant there were areas where staffing was sometimes inadequate in relation to the acuity or dependency of patients. The last safer nursing care tool review was undertaken in July 2014. The trust's safe staffing policy stated that a review of staffing establishments was undertaken a 'minimum of twice a year, and when there was a service change'. This was due to be undertaken in January 2015 but had been delayed because of the introduction of the trust's IT system. The review on the ward undertaking non-invasive ventilation (NIV) began week commencing 4 May 2015 following the raising of our concerns.
- The Chief Nurse produced a nurse safe staffing exception report that was presented to the Board of Directors on a monthly basis. The report highlighted that matrons and senior nurses were working increased levels of clinical time to support the clinical areas and that office time and mandatory training had been reduced to optimise rosters.
- Nursing and medical staff raised concerns about staffing levels across the directorates. Staff told us that they were moved around on a regular basis to fill staff shortages on other wards, even though this meant their ward would also be left short.
- Not all staff felt confident about working on unfamiliar wards but most understood the need to maintain safe staffing levels across the entire hospital.
- The trust was reliant on bank nurses to fill shifts that were not covered. Nursing and medical staff told us they couldn't rely on agency nurses because they were not familiar with the trust's electronic recording system. Shifts were therefore being filled by the trust's own staff who had been offered an incentive of double pay if they worked over their contracted hours. Senior staff told us the number of hours worked and the performance of these staff was being monitored to ensure staff did not work too many hours and therefore compromise their health or the safety of patients. Bank staff told us they had received an induction to the wards on which they were working.
- All of the wards we visited displayed a staff information board which detailed the daily planned and actual number of staff (registered nurses and healthcare assistants) on each shift. We observed the information on some of the boards to be incorrect because staff had been moved to other areas of the hospital to help out on other wards that were short staffed. We heard from staff that this happened frequently and witnessed staff being sent to other wards during our inspection. The hospital provided acute treatment for patients on the acute stroke ward. This ward had 14 beds. Ward staff told us of their concerns relating to staff arrangements, particularly when staff were moved at night, as this would leave just two registered nurses plus one healthcare assistant on the unit. Staff were continually being moved to other ward areas to relieve staff shortages and staff told us of their concerns that insufficient staffing compromised the safety of highly dependent patients, especially when patients had recently been thrombolised.
- The respiratory service had a national reputation for the breadth of its respiratory services for the local and regional population. However, the respiratory ward

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could only accommodate a proportion of patients with respiratory conditions but an attempt was made to centralise services for those requiring non-invasive ventilation (NIV). The respiratory ward could accommodate five patients requiring NIV plus two patients with a tracheostomy. (A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help a person to breathe.)

- However, the trust was not adhering to national guidelines in respect of the number of staff required to care for people requiring NIV. British Thoracic Society 2008 Guidelines state that there should be a minimum staffing ratio of one nurse to two patients for at least the first 24 hours of NIV. At the time of our inspection staff told us there were three patients on the unit who potentially required NIV and that they were expecting a patient from the emergency department who also required NIV. There should have been four trained staff plus two health care assistants on duty for the whole ward overnight but for the night shift there were only two registered nurses and two health care assistants. We escalated our concerns to senior staff within the trust. The trust took action to ensure that an appropriate number of staff were on duty. When we re-visited the ward as part of our unannounced inspection there were four patients who were receiving NIV. There should have been four trained staff plus two health care assistants on duty for the whole ward overnight but again we found there were only two registered nurses and two health care assistants. We raised our concerns with the deputy chief nurse, who was aware of the situation and escalated again at that point. We were informed the shifts had been filled. We were not assured that there was a system in place to ensure that patients requiring NIV were always receiving nursing care in accordance with the British Thoracic Society Guidelines nor from staff who were experienced in this type of care.
- The trust had recruited registered nurses from overseas. At the time of our inspection many of them had undertaken their induction and were ready to fulfil their role. However, they were unable to practice due to delays in the Nursing and Midwifery Council (NMC) in processing their registration.
- We observed an evening nursing handover between staff on two medical wards. We saw that printed handover sheets were used, which listed patients' conditions and treatment. The quality of handover was

variable but relevant information was handed over to the incoming staff. The handover sheet was updated manually and printed off as the patient recording system did not pull through updated information to facilitate the handover process. This meant there was a risk that some information might be missed and not handed over to incoming staff due to IT limitations.

- The trust had a nursing and midwifery safe staffing levels escalation policy but we found that this was not always followed. For example, on the respiratory ward where staffing levels fell below a safe level this was not always escalated as it should have been. Of the incidents reported from this ward 11% related to staffing level concerns. However a further 16% of incidents related to patient falls most of which were not witnessed by nursing staff.

Medical staffing

- The trust had a higher number of consultants and middle grade doctors than the national average.
- The junior doctors provided daytime cover across all of the medical speciality wards. In the evening there were four junior doctors covering groups of medical wards and there were three junior doctors covering the wards overnight.
- There was a middle grade rota providing 24-hour cover seven days a week for the wards that didn't have overnight middle grade cover. In addition to the middle grade cover for medical inpatients, there were on-call specialty cover rotas in cardiology, infectious diseases, respiratory medicine, nephrology, hepatology and stroke. There were also weekend-only full shift rotas for acute medicine, medicine for the elderly / stroke, gastroenterology and diabetes & endocrinology.
- The Rapid Response Team was staffed by middle grade intensive care doctors and specialist nurses, and provided 24-hour cover seven days a week to support the wards with deteriorating patients.
- The trust told us that all of their medical rotas were compliant with the New Deal and Working Time Directive.
- Junior doctors we spoke with told us that consultants were contactable and supportive.
- Consultants told us that 10% of "second on" registrar (a further doctor available at registrar level) night shifts remained unfilled whilst there were gaps of 20% in the specialist registrar rotas. Consultants told us the trust attempted to fill these gaps with internal staff as

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external staff were not familiar with the trust's electronic recording system. Gaps were often filled at the last minute as the trust offered an incentive for staff to work at this late stage. We did not receive any evidence to indicate how many of these shifts remain unfilled.

- We observed that medical handovers were efficient, and there was effective verbal and written communication regarding the location of patients and their conditions. The handover was attended by 12 consultants and multiple specialist nurses and all of the medical specialities were represented. Daily medical handovers took place. At this meeting every admitted patient was discussed and patients who had not already been assigned to a Consultant for on going care, were assigned to the most appropriate specialist. Patients were confidently handed over and accepted. In addition, each patient who had been discharged was also discussed to ensure that appropriate plans and follow-up had been arranged for that patient. Because all of the specialisms were represented at this handover, the most appropriate actions could be agreed. Administrative staff were also present to ensure all decisions were entered onto the electronic recording system.
- The national clinical guidelines for stroke (2012), highlight that access to psychological intervention in the acute phases is important and the Sentinel Stroke National Audit Programme (SSNAP) acute organisational audit report (2014) stipulates that Clinical Psychology is an essential part of the multidisciplinary team. The current national average provision of clinical psychology is 0.04 WTE per 10 stroke beds. We note that the department has 0.5 WTE for approximately 100 beds, which equates to 0.05 per 10 beds.

Major incident awareness and training

- The trust had a major incident and escalation policy. Most of the staff we spoke with were aware of the trust's major incident plan.
- The chief executive officer told us the last time the major incident plan was used was throughout the introduction of the electronic recording system.

Are medical care services effective?

Requires improvement



We judged that medical care services at Addenbrooke's hospital were not always effective and required improvement. This was because patient outcomes were not in line with the national averages, patients experienced a long length of stay and there was a lack of supervision of staff. In addition, staff we spoke with had limited knowledge of their responsibilities under the Mental Capacity Act (MCA). Nursing staff were unclear about the procedures to follow when reaching decisions in persons' best interests. We witnessed an incident where a patient was restrained without a valid deprivation of liberty safeguard being in place. However, this was not surprising as staff had not received training in the MCA or Deprivation of Liberty Safeguards (DoLS)

We saw that assessments, which covered most health needs such as clinical needs, mental health, physical health, and nutrition and hydration needs, had been undertaken. However, staff were unable to show us where care plans had been completed. Some staff told us the doctors' orders had replaced care plans on the electronic patient record system. These orders were task-orientated and did not always reflect the holistic needs of the patients. Some staff told us there were no care plans on the IT system. .

We did however see that patients' care, treatment and support were based on national guidance and legislation. We saw good examples of multidisciplinary team working, especially on the acute stroke and stroke rehabilitation wards.

Evidence-based care and treatment

- The medical specialities used provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines.
- There were specific care pathways for certain conditions, in order to standardise the care given. Examples included stroke pathways, sepsis, pulmonary embolus and chronic obstructive pulmonary disease (COPD) pathways.

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- Staff carried out assessments, which covered most health needs such as clinical needs, mental health, physical health, and nutrition and hydration needs. However, staff were unable to show us where care plans had been completed..
- The endoscopy department had been awarded Joint Advisory Group (JAG) accreditation. The accreditation process assesses the unit infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance. We observed the endoscopy unit operating at full capacity and noted the pride and enthusiasm of staff for the service they provided.
- In the opinion of our specialist, the quality of the outpatient neuropsychology assessment service is outstanding, as demonstrated by review of records and record keeping, review of clinic rooms and resources available to and used by the service and the views of multiple consultant neurologists and a rehabilitation consultant who regularly refer patients to the service. Collectively the general theme was that the service delivery had improved positively since the new heads of department had been appointed; more patients are seen and seen more quickly.
- The trust used a traffic light system to identify the level of support required by patients.
- Protected meal times were in place on all wards we visited. We observed a lunch time meal on one of the medical wards. We saw that available staff went to assisted patients to eat and drink and they helped them to move into a suitable position to eat.
- On the Lewin ward we saw that patients were encouraged to eat their meals in the dining area. There were nutritional support assistants who were available to assist patients to eat their food if they required support.
- We saw that meal times were generally calm and well managed.
- Staff on the acute stroke ward assured us that patients who had had a stroke were assessed in a timely manner to ensure they were able to safely swallow and were not denied food and fluids unnecessarily. We observed that fluid thickeners were issued as prescribed and that patients requiring diets of differing textures received their diet as planned. This demonstrated the trust had systems in place to ensure people with varying levels of compromised swallow were supported to receive appropriate nutrition and hydration.

Pain relief

- Most patients told us their pain was well managed. We observed staff asking patients about pain and taking appropriate action to control people's pain.
- Pain was assessed as part of the intentional rounding process (intentional rounding is where staff tend to patients at given time intervals to check a range of comfort requirements). However, we saw little evidence that the effects of pain control were being monitored, for example site, intensity and type of pain.
- The trust did not have any specialised tools in place to assess pain in those who had a cognitive impairment such as those living with dementia or a learning disability. This meant that pain in people who had a cognitive impairment may go unrecognised.

Nutrition and hydration

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

Patient outcomes

- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP), which aimed to improve the quality of care by auditing stroke services against evidence based standards and national and local benchmarks. During July to September 2014 SSNAP scored the trust at 'D' Grade (the lowest possible score is E). The audit identified poor results in the provision of speech and language therapy. An audit action plan was in place to address the shortfalls.
- The trust participated in the Myocardial Ischaemia National Audit Project (MINAP). This is a national clinical audit of the management of patients experiencing a heart attack. MINAP provides hospitals with information about their management of patients experiencing a heart attack and compares the information with nationally and internationally agreed standards. Addenbrooke's hospital performed worse than the England average in the MINAP audit in relation to the care of patients who presented with non ST elevation infarction (nSTEMI), which is a type of heart attack. The 2013/2014 MINAP audit showed that 86% of patients who presented with a nSTEMI were seen by a

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cardiologist against the England average of 94%, 59% of patients, including those after discharge were referred for or had angiography against the England average of 80%. The trust was in line with the England average for the number of patients who were admitted to a cardiac unit or ward at 55%.

- National Diabetes Inpatient Audit (NaDIA) 2013 participation showed that the trust performed worse than expected on 13 out of 21 questions. The trust performing worse than expected in questions covering medication and prescription errors, suitable and timely meals and emotional support. The audit showed that the trust scored better than expected in questions covering foot care and staff knowledge. We asked staff about the findings of the audit on ward F6, the diabetes/endocrinology ward. Staff we spoke with were not aware of the audit or its findings, or of any actions that were to be taken at ward level to address the shortfalls
- The average length of stay for elective and non-elective patients at Addenbrooke's hospital was slightly worse than the national average. This meant that patients were staying in hospital longer than in other hospitals around the country.
- Between January and March 2015, the trust as a whole conducted risk assessments of venous thrombotic embolism on 79% of patients, which is considerably below both the NHS-England goal of 95%, and the England average for that quarter of 96%. The percentage assessed during the preceding three quarters ranged between 74% and 86%.
- Emergency readmissions were mostly within the expected range and the standardised re-admission rates compared favourably with national rates except for clinical haematology, gastroenterology, and geriatric medicine services where they were above national rates.

Competent staff

- We were told that all new staff attended an induction. Staff we spoke with confirmed they had received adequate induction. Newly appointed staff said that their inductions had been planned and delivered well.
- Most staff told us that there were no formal systems in place for regular supervision sessions with their line managers, but that any issues were addressed via informal support from managers.

- Staff told us they received annual appraisals. Information provided by the trust indicated that appraisal figures for the medicine specialities were at 96% in December 2014.
- Nursing staff working on the medical wards told us there were little opportunities to undertake additional study and professional development.
- We saw there was a wide range of specialist nurses, for example the frail elderly team, palliative care team and safeguarding leads and noted their presence on the wards. Staff told us they knew how to contact these specialists and felt supported by them.
- Nursing staff on the ambulatory care unit had received training to enable them to cannulate and take arterial blood gases.
- National standards require that 50% of nursing staff working in coronary care have an additional qualification in coronary care nursing. 24 out of 35 qualified nurses working on ward K3 (cardiology and coronary care) had a coronary care nursing qualification. This meant that national guidelines were being met.
- Nursing staff on ward D5 told us the function of the ward had recently changed from being a short stay elective medical ward to a 16 bedded elderly care ward with eight elective beds. None of the staff on this ward had received any training in providing care for people with dementia and who very often had complex discharge requirements.
- The only person to have undertaken the hepatology course on the liver unit was the ward manager. Nursing staff had not been offered the opportunity to undertake this course within their speciality.
- Medical staff told us they were concerned about the start of new junior doctors in August because of the ongoing issues with the electronic recording system.
- Doctors told us that there was an effective system for training, professional development, assessment and revalidation of General Medical Council (GMC) registration.
- None of the clinical psychologists working in the department are registered on the British Psychological Society's (BPS) Specialist Register of Clinical Neuropsychologists (SRCN), though they were professionally registered with the Health and Care Professions Council as clinical psychologists which is a legal requirement. They were not supervised by a person on the specialist register. This is a requirement to

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be a clinical neuropsychology service though it was clear the service did not call themselves that. However, senior medical and nursing staff we spoke with referred to it as a clinical neuropsychology service. Our specialist considered that the senior staff carrying on the service were sufficiently skilled and experienced but lacked the specialist qualification. This also means that the service is unable to supervise any member of staff who wishes to gain this qualification.

Multidisciplinary working

- Wards teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date. This was particularly evident on the Lewin ward and R2, the acute stroke ward. However, staff on the Lewin ward told us they were short of two WTE physiotherapists and this impacted on the 45 minutes per day rehab guidelines for patients who were receiving treatment for a stroke.
- Throughout the trust patients' records were integrated with doctors, nurses and therapists using the trust's electronic recording system. This meant that all members of the team were aware of the input of others, and that care was well co-ordinated for patients and their relatives.
- Consultants we spoke with told us they found the input of other clinical teams and specialist nurses to be very good.
- Meetings on bed availability were held three times a day, to determine priorities, capacity and demand for all specialities.
- Senior medical staff we spoke with told us they had an excellent relationship with the neuropsychology service. We saw evidence of clear multi professional reviews of patients using the service with clinical responsibilities clearly marked.

Seven-day services

- Physiotherapy services were available 24 hours a day and seven days a week. At the weekends there were two whole time equivalent physiotherapists with three band

three to four staff to cover the medical and elderly care wards. There was one whole time equivalent physiotherapist who covered the whole of the hospital between 16.30 and 08.30 seven days a week.

- The trust had an internal imaging professional standard that all inpatient requiring imaging services would be seen within 24 hours of referral. Urgent and emergency imaging was available 24 hours a day and seven days a week.
- There was consultant cover 24 hours a day, seven days a week. Two consultants supported the acute take directly in the evening until 22.00 with one consultant on call overnight during the week. At the weekend consultant cover for the acute take was provided by two consultants from 1200 to 2200. Consultant on call rotas covered cardiology, infectious diseases, diabetes & endocrinology, nephrology, hepatology, gastroenterology, respiratory and stroke medicine. Consultants from each specialty were routinely scheduled ward work and to receive new patients at the weekend with middle grade and junior doctor support. The endoscopy on-call rota was staffed by consultants from gastroenterology and hepatology who also provided an on-call service to another hospital.

Access to information

- Within endoscopy, staff told us there were issues with accessing consent forms. Once completed, consent forms were sent to the unit office to be scanned into the electronic recording system. We asked to see a consent form for a patient who had attended the unit 12 days ago. The consent form had not been scanned into the electronic recording system. This meant that medical records within the electronic recording system were not always up to date. In addition, the electronic recording system permitted the uploading of endoscopy reports; however the system was not intuitive and relied on the operator to manually press a print function. Staff told us that some operators forget and this had led to some reports not being uploaded.
- Staff throughout the medical wards were unable to locate information relating to mental capacity assessments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Medical care (including older people's care)

- Patients were consented appropriately and correctly, where people were able to give their consent to care and treatment. We reviewed eight consent forms of patients requiring consent and we found these to be appropriately completed.
- We examined the training matrix provided by the trust, which showed that the training requirement in consent, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not a mandatory training requirement. We spoke with staff who confirmed they had not received or completed training in MCA and DoLS.
- Staff we spoke with had limited knowledge of their responsibilities under the MCA. We heard staff refer to patients as lacking capacity to make certain decisions when a mental capacity assessment had not been undertaken. Staff were unclear about the procedures to follow when reaching decisions in persons' best interests. All of the nursing staff we spoke to told us they would not be involved in completing a mental capacity assessment but would refer patients to the safeguarding lead.
- The requirements for lawfully depriving a person of their liberty was not always understood or appropriately recorded by staff. We looked at the records of two patients who were being deprived of their liberty, but were unable to establish whether appropriate steps had been followed to ensure these people were being lawfully deprived of their liberty.
- Staff were unable to locate information relating to MCA forms on the trust's electronic recording system. In addition, there were no care plans in place to support people who did not have capacity to make decisions.
- On the second day of our visit we saw a patient attempting to leave their ward as they wanted to go home. Staff told us this patient was confused and didn't have the capacity to make decisions about leaving the ward. We saw a health care assistant prevent the patient from leaving the ward by sitting the patient in a wheelchair and taking the patient back to their bed space. We looked at the medical and nursing records for this patient and were unable to establish whether a mental capacity assessment or a best interest's assessment had taken place. A member of staff told us that an urgent DoLS had been made in February for this

patient but there was no evidence of a further assessment having been made. A member of staff told us they would refer the patient to their safeguarding lead.

- Patients from the clinical decision unit were managed to ensure appropriate transfer for example to hospice or mental health service as needed. We saw that the clinical decision unit ward team and emergency department consultants had in specific cases cared for patients in the clinical decision unit for several days until suitable placement was secured. Staff including health care assistants in the clinical decision unit had additional training related to mental health problems because they were regularly asked to care for such patients for several days as local mental health services were not able to respond appropriately to referral requests.

Are medical care services caring?

Good



We judged that the caring aspects of medical care services were good. This was because patients and those important to them were positive about their experience of care and the kindness that staff showed towards them. We observed care and found this to be compassionate from all grades of support and clinical staff, including doctors. We also saw and patients expressed that privacy and dignity was maintained at all times. Where possible, patients were involved in their care and treatment and were given information to support their decision making. We found that patients could access emotional support if they needed to.

Compassionate care

- We spoke with 20 patients throughout our inspection. Feedback was mostly positive about the way staff treated patients receiving care throughout the medical wards. One patient told us "The care is excellent in this hospital." Another patient said "The nurses come quickly when I call the call bell." A patient on the coronary care unit told us "staff are very caring; they stayed with me when I was frightened."
- Patients we spoke with told us they felt safe in the hospital.

Medical care (including older people's care)

- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Medical and nursing staff we spoke with demonstrated an understanding of the importance of treating patients and those who were important to them in a caring and sensitive manner.
- We saw that interactions between staff and patients were positive, respectful and caring.
- Throughout our inspection we observed that patients' privacy and dignity were maintained; for instance we saw that care interventions were carried out behind closed doors or curtains and staff asked before they entered.
- We observed a speech and language therapist undertaking an assessment on a patient on the Lewin ward. The patient had their eyes closed and looked as though they were sleeping. The therapist spoke with the patient in a kind manner and gently woke the person, allowing enough time before undertaking the assessment.
- Most people we observed were well presented and looked comfortable in their surroundings.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. The trust's FFT response rate from its medical wards has been consistently below the England average for medical wards, but shows a strong increasing trend. The average response rates (from December 2013 to November 2014) varied across medical wards from 13% to 44%. In May 2015, 86% of patients would recommend medical wards D10 and G6. These were the lowest scores for the medical wards. Other wards that provided medical care scored above 90%.
- Patient led assessments of the care environment (PLACE) carried out in 2014, acute wards (which would have included some medical wards) achieved scores for privacy, dignity and well-being as 90%, this was slightly above the England average of 87%.

Understanding and involvement of patients and those close to them

- We observed that staff involved patients and those who were important to them in their treatment and care.

Staff talked through what was happening with patients whilst undertaking care and treatment ensuring wherever possible that patients were aware of what was happening to them.

- As nursing staff told us they were unclear about the procedures to follow when reaching decisions in a persons' best interests. This meant that there was a risk that patients would not always be empowered or supported to understand or be engaged in their care and treatment.

Emotional support

- Patients and those close to them told us that clinical staff were approachable and they were able to talk to them if they needed to. Staff told us they would initially provide emotional support for patients and those who were close to them.
- Patients could access a range of specialist nurses, for example in stroke and cardiac services. We saw that staff offered appropriate support to patients and those who were close to them in relation to their psychological needs.
- There was a hospital chaplain who could be contacted to provide emotional support. There was also a multi faith area available in the hospital that patients or those close to them could access.
- Staff told us the chaplain was available to support staff as well as patients.
- On the acute stroke ward there was some but limited psychological support available.

Are medical care services responsive?

Requires improvement



We judged that the responsiveness of medical services required improvement. This was because there was insufficient bed capacity to meet the needs of patients. This resulted in a large number of patients being cared for in non-speciality beds and this meant the trust was not always responsive to the specialised and individual needs of patients whilst they were receiving care and treatment. We found that the implementation of the electronic recording system had impacted on the responsiveness of

Medical care (including older people's care)

the service people received, for example patients were unable to receive blood transfusions within the ambulatory care unit and had to be admitted to a ward in order to receive this treatment.

Patients requiring elective treatment often experienced cancellation or had to wait for up to periods of 12 hours for a bed to become available because of bed capacity issues. In addition, there were significant numbers of people who were experiencing delayed discharge because they were waiting for packages of care in their own homes and could not be discharged by the hospital until funding had been agreed for this care.

Service planning and delivery to meet the needs of local people

- The trust had a designated ambulatory care unit which enabled staff to deliver care closer to home and avoid unnecessary admission to hospital.
- Some patients on the ambulatory care unit were taught how to administer their own intravenous antibiotics and where appropriate, patients on the haematology unit were taught how to administer their own chemotherapy. This enabled patients to continue to administer their treatment in their own homes.
- There was limited commissioning of services to provide early supported discharge. This meant that patients were not enabled to return to their own homes whilst receiving support and treatment.
- We observed the space in the haematology day case unit to be very compact with patients sitting very close together due to lack of space. This could compromise privacy and dignity for some patients.
- Nursing staff on ward D5 told us the function of the ward had recently changed from being a short stay elective medical ward to a 16 bedded elderly care ward with eight elective beds. This meant that patients coming into the ward for elective medical procedures were being treated in a ward with patients who often required intensive support. Staff told us that elective beds would be filled with outliers and this meant that patients coming in for planned procedures would be cancelled if the elective care beds were full. Some of the patients on this ward would come in to have further tests for liver transplantation. One patient who regularly attended this

ward for an elective procedure told us that recently they waited ten hours for a bed and but was then cancelled and had to go home. The procedure was rebooked for the following Monday.

- Signage around the hospital was very poor. There were no signs to indicate wards in the lift areas off the main concourse. We heard many people throughout the hospital expressing despair with trying to find wards. As inspectors we found it difficult to navigate our way to the ward areas.

Access and flow

- Length of stay and delayed transfers of care and discharges had a significant impact on the flow of patients throughout the hospital. At the time of our inspection we were told that bed occupancy across the trust was at almost 100%. This was worse than the England average. It is generally accepted that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital. We looked at information provided by the trust and saw that bed occupancy rates on the medical wards were consistently high. Throughout our inspection the trust declared an internal critical alert.
- The average length of stay for medical care was above the national average. This was attributed to issues relating to accessing care packages, care facilities in the community and the large geographical area covered by the trust.
- Patients requiring medical care usually entered via the emergency department, however, some patients may pass straight through to the ambulatory care unit and some patients passed straight through to a specialist service. Once assessed by staff in the emergency department patients were then admitted to a ward area.
- The MSSEU was a medical area, ideally used to provide care for patients up to 72 hours. Patients should then be moved to the most appropriate ward to have their medical needs met. Staff told us the average length of stay on the unit was four days. At the time of our inspection we spoke with one patient who had been on the unit for six weeks, whilst another patient told us they had been on the ward for two weeks. In addition, there were ten outliers on the unit who did not have acute medical needs. Staff on the MSSEU told us that bed flow

Medical care (including older people's care)

issues throughout the hospital impacted on their ability to appropriately transfer patients to other wards. This had a knock on effect on the unit being able to accept patients from the emergency department.

- The ambulatory care unit was a day unit with the aim of avoiding hospital admission. Patients attended the unit either from the emergency department, via their GP or from the imaging department within the trust. The unit was open from 8am to 7pm Monday to Friday and was open for a shorter amount of hours at the weekend. Patients would undergo investigations and go home if this was appropriate.
- Staff on the ambulatory care unit told us about problems associated with the introduction of the electronic recording system. The system identified the unit as an outpatient facility and this meant there was no facility for staff on the unit to administer blood transfusions. This led to approximately ten patients per week having to be unnecessarily admitted to a ward to have their blood transfusion.
- Staff on the ambulatory care unit told us the criteria for admission had not been made very clear and they often received patients from the emergency department in order to ensure breach avoidance.
- Staff on the ambulatory unit also told us that patients on the unit were often overlooked as they were not seen as a priority. They were often reviewed last and this led to delays in patients being admitted to a ward.
- The trust provided a stroke telemedicine system which could be available out of hours. It operated using internet video-conferencing arrangements. This meant there could be access to a stroke consultant at all times. However, since the introduction of the trust's electronic recording system, staff reported the IT system could not support the stroke telemedicine software. If it was required the service manager had to go home to set up the system on their personal laptop. This meant the system would not be used effectively to provide remote assistance for those patients who would benefit from it and in reducing unnecessary hospital admissions.
- The trust had a Short Term Assessment Rehabilitation Team (START) who was dedicated to providing a pathway to community health and social services for patients who came through the emergency department. The START team also supported the wards to discharge patients into the community. At the time of our inspection there were 83 patients within the medical wards who were deemed to be fit for discharge. 38 of these were waiting for Continuing Health Care (CHC) forms to be completed. Staff told us they had to complete CHC forms in the electronic recording system but write them out by hand as the system did not support the submission of these forms.
- The START team was a small team and were struggling to meet the demand of the service. The team consisted of 4.6 whole time equivalent (WTE) discharge nurses in post to undertake continuing health care assessments for patients waiting to be discharged. The lead for discharge planning told us there was an establishment for 8.6 WTE discharge nurses and at the time of our inspection, the lead for discharge planning told us they had put a business case forward to increase the size of the team.
- The trust had a Delayed Transfers of Care (DTOC) ward where patients were placed if there was a delay in their transfer of care. We spoke with one patient on this ward who told us they had been there for two weeks whilst waiting for a package of care. This patient told us that staff had not explained why they had moved to this ward. Another patient told us they were desperate to go home but was unclear why they couldn't go home as no one had explained this to them.
- The trust had a discharge lounge which operated between the hours of 8am and 8pm. We observed this facility to be underused throughout our inspection. We saw that only two patients had passed through the discharge lounge on the Monday prior to our inspection. Staff told us that numbers varied between 2 and 20 patients per day.
- At the time of our inspection, there were on average, 47 medical outliers across the hospital. [Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space].
- During the period April – December 2014, 27% of patients experienced one ward move, 12% were moved twice, 5% three times and 6% were moved four or more times. These results show that half of patients admitted to Addenbrooke's Hospital were not treated in the correct speciality ward for the entirety of their stay. The trust did not monitor the reason for moving patients between wards and could therefore not clarify whether the moves were made for clinical reasons. Throughout the month of April 2015 there had been 296 bed moves from one medical ward to another.

Medical care (including older people's care)

- Referral to treatment times (RTT) for all medical specialities including cardiology, gastroenterology and neurology were mostly in line with the England average and geriatric medicine was 100% compliant with RTT.
- The neuropsychology service was treating more patients than in previous years. In 2010 the service saw 46 inpatients (161 appointments) and 266 outpatients. In 2014 the service saw 288 inpatients (761 appointments) and 448 outpatients. Our specialist concluded that the volume of patients seen per week and waiting times are in line with other regional neuropsychology services. However the ward sister from the stroke unit reported that the stroke patients received a "poor" service from clinical psychology. It can take 3 days before a patient referred is seen. There was a clear recognition that the quality of the service delivered was good but access to it is limited due to a lack of resource and patients with high needs (i.e. either behaviourally or emotionally) often have to go without a service due to the lack of resources.
- Most people we spoke with knew who their consultant was; however, some did not, and said that they did not know what their treatment plans were, and when they may be able to go home. For example, one patient told us they did not know which consultant they were under. They had received a scan the previous day but had not been told the results. The patient told us they had no idea of when they would be going home.
- Staff were able to access interpreting services 24 hours a day for people who did not speak English as their first language.
- We saw that pictorial menus were used throughout the medical and elderly care wards. This enabled patient's living with cognitive impairment such as dementia to interpret the different choices that were available.
- The trust had a designated learning disabilities specialist nurse who could provide support for staff should a person with a learning disability be admitted to any of the medical wards. Staff told us that patients who had a learning disability would come into the hospital with a hospital passport.
- We noted that patient assessments identified when patients had sensory deficits and staff were aware of these. We observed specialist equipment in use to aid communication for patients with a hearing impaired patient.
- The environment on the elderly care wards was variable. Some wards did not have windows and there was very little natural light due to the design of the building. This ward environment was not suitable for people with cognitive impairment due to the poor natural lighting and limited space for the storage of equipment. We saw that generally, bathrooms and lavatories were suitable for those with limited mobility. There were adequate supplies of mobility aids and lifting equipment such as hoist to enable staff to care for patients who were unable to mobilise without the use of such equipment.
- All patients who were over the age of 75 were seen by the trust's Specialist Advice for the Frail Elderly (SAFE) team. This was a multidisciplinary team who provided a seven day service and assessed patients within four hours as they came into the emergency department. When patients were allocated to their wards, they also provided advice to staff at ward level that were supporting patients over the age of 75 years.
- On ward G6 we saw there was an activities board which detailed activities available for patients each day of the week. Reminiscence therapy was available Monday to

Meeting people's individual needs

- We saw a range of displays with information for patients on the wards we inspected. These were usually relevant to the type of speciality and included information such as dementia care, care after having a stroke and emergency management of patients with Parkinson's disease.
- The leaflets displayed were all written in English, but staff told us they could order leaflets in different languages if they were required.
- Patients had their needs assessed by both medical and nursing staff and where required we saw input from other members of the multidisciplinary team. We did not see any care plans but we saw that needs had been assessed by doctors and instructions had been given for nurses to follow. In addition, we saw that nurses undertook risk assessments.
- We saw that a system of 'intentional rounding' was taking place to ensure patients' fundamental needs were being met. We saw that records were made of these intentional care rounds and that generally they were being carried out at the specified frequencies. Intentional rounding was monitored through the divisional Nursing Quality Metrics. Information provided by the trust indicated that for March 2015, documentation relating to intentional rounding had been completed in line with the trust target of 95%.

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Friday and varied meaningful activities were available for patients to join in. Throughout our inspection we saw an exceptional singing and dancing activity which was attended by many patients on the ward. We were particularly interested to see a patient who had difficulty with breathing was taking part with singing. We could see a marked improvement in the patient's well-being for having taken part in this activity. We saw that all of the patients and staff taking part in the activity were smiling and we felt that all who participated really benefited from the activity. Staff told us these activities took place on wards G4, C6, G6 and J2. The person who organises this group had encouraged others to join the group through placing posters across the trust.

- Staff told us they were able to access bariatric equipment if this was required.
- Overall, we found that there were arrangements to ensure patients were cared for in single sex facilities and had access to single sex washing and toilet facilities. However, we noticed on ward D5 that the signage to indicate gender on the door to the toilets was incorrect following the movement of patients between bays. We therefore witnessed a male patient going into a toilet that had a male sign on the door, but was intended for female patients. This could compromise the dignity of some patients within that area of the ward.
- Clinical areas displayed printed health-education literature produced by national bodies. Some of this information was general in nature whilst some was specific to the speciality of the ward. For example, literature about strokes was available throughout the stroke wards.
- The neuropsychology department offers an excellent range of tier 3 and 4 specialist neuropsychological services for people with neurological disorders. Ranging from outpatient diagnostic assessment to inpatient acute rehabilitation.

Learning from complaints and concerns

- The chief nurse was responsible for complaints within the trust. The trust board received data about complaints as part of their integrated quality, performance, finance and work report. In addition, complaints were discussed at the local divisional boards and the monthly divisional and executive meetings. Information received by the trust indicated that all complaints are seen and signed off by the Chief Executive Officer (CEO). There were 48 complaints

relating to medical services. Of these 18 related to the care provided by medical staff and 14 to the care given by nursing staff. The action taken by the hospital was appropriate and where learning across the service was required this was highlighted.

- The total number of complaints received by each medical ward was monitored through the divisional Nursing Quality metrics.
- We saw posters explaining how to make a complaint within the ward areas throughout the trust. We also observed comment boxes where patients and those close to them could give feedback.
- We observed whiteboards displaying comments in relation to 'you said, we did' which demonstrated that services encouraged patients to give feedback and make complaints and that services responded to comments that were made.
- Staff told us they tried to deal with people's complaints at ward level, before they escalated into more serious complaints.
- Although staff told us that learning from complaints took place at a ward level, we were not assured that learning from complaints was shared across the divisions in relation to the medical wards.
- One relative of a patient told us they had complained to the trust about the fact that staff were constantly being moved from the stroke rehabilitation ward to other wards within the hospital. The relative felt this was impacting on patient care. This relative met with a senior representative of the trust and was told this was because the ward was not an acute ward and the impact on care was not so great. Throughout our inspection we saw that nurses and HCAs were frequently being moved from acute medical wards.

Are medical care services well-led?

Requires improvement



Leadership was not consistent across the medical services area. Addenbrooke's hospital consisted of five divisions and medicine was spread across the divisions. Each division was led by a divisional director and a divisional lead nurse. There was little evidence to demonstrate that the divisions worked well together to share learning and issues to improve services for patients with a medical health problem. Although staff told us they felt supported by their

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middle managers we identified concerns that sufficient action had not been taken at a more senior level to address key risks such as staffing levels, the movement of staff between wards, flow throughout the hospital and issues associated with the electronic recording system. There was a recognition that staff were working under pressure but staffing levels and skill mix had not always been taken into account within the divisional risk registers, nor were there any action plans to ensure staff were supported.

Vision and strategy for this service

- There was no separate strategy for medical services within the trust. However, the trust had a vision and strategy that included being the best at everything they chose to do, being a health care system, not just a hospital, to take a leadership role across the wider health economy, focus on compassion and care alongside clinical excellence and to embrace innovation in all that they did.
- The trust's values were to work together to be safe, kind and excellent. These values demonstrated that the trust wanted staff to provide the highest standard of care and compassion through how they cared for patients and how they worked with each other. Most of the staff we spoke with were aware of these values and we saw that staff provided a kind and compassionate service to people. The values of the trust were displayed in predominant areas around the hospital such as the ward areas and corridors.

Governance, risk management and quality measurement

- Staff told us they knew how to escalate concerns relating to clinical governance. Ultimately concerns would be raised with the clinical leads for each division. We saw that clinical governance meetings took place across the divisions and within specialities.
- Senior staff told us about the difficulties staff were experiencing since the implementation of the electronic recording system. This had been introduced in October 2014 and had led to difficulties in capturing specific data used to measure quality.
- There was a risk register for each of the divisions, which included risks relating to medical care and care for the elderly. We saw that lack of capacity and patient flow had been on Division C's risk register since June 2012 and had been reviewed every three months. The latest review was in April 2015.

- Some risks had been on the risk register since 2006 and still presented. There was a lack of action plans and a lack of ownership for the risks identified.
- One matron from one of the divisions told us the division had overlooked the fact that skill mix and staffing levels were a risk and had only recently added them to the division's risk register.
- There were regular governance meetings throughout the directorates relating to acute medicine, specialist medicine and care of the elderly. We reviewed the minutes of the meetings and saw that discussions about complaints, audit outcome, risk and incident analysis was occurring.
- In the neuropsychology service there was a lack of clarification about the service specification. Heads of service were unaware how many beds they provide a service to, or the funding arrangements for the services offered. New services have been supported such as outpatient TBI service without clear commissioning arrangements. On discussion with the Consultant in Neurorehabilitation he was able to clarify that the Lewin Unit is currently has 8 level 2b beds but takes 30-40% Level 1a. It is noteworthy that NHSE specify that a level 1a unit must have a minimum of 2-3 WTE Clinical Psychologists for 20 beds, and a level 2 unit should have 1.5-2 WTE. This suggests that the current provision of Clinical Psychology is resourced. However, it is unclear how the Assistant Psychologists time is allocated across the services. We asked for the service specification during the inspection but the documents provided were not a full service specification.

Leadership of service

- Addenbrooke's hospital consisted of five divisions and medicine was spread across the divisions. Each division was led by a divisional director and a divisional lead nurse.
- The NHS Staff Survey 2014 saw the trust performing worse than average for 62% (18/29) of the key findings. 52% of key findings fared worse in the 2014 survey than it did in 2013. Measures of staff engagement were worse than in 2013. Staff reported above average (worse) rates of harassment, bullying, or abuse from staff. However the trust performed in the top 20% of trusts in respect to staff appraised in last 12 months, of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months and staff feeling pressure to attend work when feeling unwell.

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- All of the staff we spoke with said they felt supported by their line-managers and staff told us they felt supported by their divisional directors and divisional lead nurses. However, staff shared concerns that sufficient action had not been taken by senior management to address key risks such as staffing levels, the movement of staff between wards, flow throughout the hospital and issues associated with the electronic recording system.
- Staff spoke highly of the chief nurse, but staff consistently told us they did not see other members of the executive team in ward areas.
- The chief executive officer (CEO) and the medical director were said to be approachable and were highly regarded by all of the consultants we spoke with.
- There was a lack of effective engagement with staff throughout the hospital in relation to changes that affected their work. For example staff on one ward we visited told us the nature of their ward had changed. The ward previously provided a service for patients who required elective medical procedures. Staff told us they were informed on the Friday that the ward would be changing to reduce the number of elective beds to create beds for the elderly. This change was taking place on the Monday. Neither staff or patients had been involved in consultations relating to this change.

Innovation, improvement and sustainability







Culture within the service

- Staff spoke positively about working at Addenbrooke's hospital. However staff told us that morale was low because of problems associated with staffing levels and workloads.
- Patients acknowledged a caring and positive culture and were mostly happy with their experience of care.
- The workforce was diverse and there was a growing number of overseas nurses in post.

Public and staff engagement

- There was no credible plan for managing the issues associated with medical outliers; a situation which we felt was not sustainable.
- The pressure upon beds throughout the trust was causing consultants genuine concern that junior staff training was being compromised and that the recruitment of patients into clinical research trials was being severely compromised contrary to the NHS 'stated aims
- The trust had the facility to use telemedicine within their stroke services; however since the introduction of the electronic recording system this service had been severely compromised.

Surgery

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

Information about the service

Adult surgery services at Addenbrooke's hospital are provided across 13 surgical wards, including day surgery units. Provision includes general surgery, trauma and orthopaedics, ear, nose and throat (ENT), urology, ophthalmology, oral surgery, plastic surgery, and neurosurgery. The service is split across four divisions.

There are 35 operating theatres, including the main theatres and ophthalmology, with plans to increase with two further theatres. There are also pre-assessment and day case surgery areas. The hospital saw 39,751 patients within surgery during 2014/15. The 'hospital provider spells', which identify the continuous stay of a patient using a hospital bed, identified that within surgery, 42% were day cases, 30% were elective and 28% were emergency surgical cases.

During our inspection we:

- visited all surgical areas and services
- spoke with 28 medical staff, 10 ward managers, five senior managers, 24 registered nurses and other health care professionals who were on the hospital wards at the time of our inspection, for example, pharmacists and radiographers spoke with 13 patients examined nine patient records, including medical notes

Summary of findings

We rated surgical services as requires improvement: Surgical wards were not always clean, nursing staff were moved between wards and staff were not always familiar with the wards or had experience in dealing with surgical patients. The trust frequently cancelled routine operations due to bed capacity issues. Issues were raised by staff but were not addressed by the senior management team within the divisions.

Storage temperatures of the rooms used to store medicines were not monitored or recorded. Although, when we measured the temperature it was within acceptable limits, we were not fully assured that medicines storage adequately maintained their quality. The environment within two surgical wards was not clean. We found fungi growing in a shower room which had an impact on the patients of this ward.

Medical staffing was appropriate at consultant, middle grade and junior doctor level of skill mix. However, there was a shortage of nursing staff within surgical wards, with a number of vacancies. All surgical wards used agency staff, but we found that they did not always have appropriate induction or skill mix. Often an inappropriate skill mix on the wards mean staff did not have time to adequately meet patients' needs. However there was a culture of incident reporting which was consistent with feedback and learning from incidents.

Staff we spoke with were not aware of the recent changes to legislation in respect of Deprivation of

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Liberty Safeguards and awareness of the Mental Capacity Act was poor. This meant that patients were not always assessed or treated appropriately. Treatment and care was provided using evidence-based national guidelines. There was good practice, for example, in pain management, and in the monitoring of nutrition and hydration of patients. Multidisciplinary working was evident. Staff had access to training and received regular supervision and annual appraisal. We spoke with patients and they told us that staff treated them in a caring way; they were kept informed and involved in the treatment received. Patients were being treated with dignity and respect.

Surgical services were not responsive. Some specialties did not meet the national time of 18 weeks between referral and surgery. Operations were cancelled due to bed capacity within the hospital. Capacity pressures and a lack of available beds resulted in patients spending longer periods in the theatre recovery areas.

There was evidence to support people with complex needs, for example, people with a learning disability. We saw that reasonable adjustments were made to the surgical services to accommodate any patients with complex needs. Information, leaflets, and consent forms were available in a standard format. Easy read versions are created on request by the patient and/or clinical team. Patients we spoke with said they were satisfied with how staff dealt with any concerns they raised.

Surgical services were not well-led and required improvement. Staff we spoke with told us they felt pressurised when patient admissions fluctuated. Surgical services had plans to address capacity issues but identified risks were managed in a reactive manner.

There was positive awareness amongst staff of the expectations for patient care across the trust. Staff we spoke to were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service within the area they worked.

Are surgery services safe?

Requires improvement



We rated safe as requires improvement: The environment did not always protect patients from avoidable harm and current shortages of staff meant that patients were not always cared for by appropriately skilled and experienced nursing staff. Within the surgical wards there was a number of nursing staff vacancies. To achieve safe staffing levels, ward managers were using agency staff. Agency staff did not always receive an appropriate induction. We found patients on the wards were treated and cared for by both permanent and temporary nurses whose specialism and background was not surgery.

The environment within one surgical ward was not visibly clean. One ward had 2 showers for 28 patients. However, the discovery of fungal growth in one meant it was condemned, leaving only one useable shower. While staff had reported this 10 days prior to our inspection this had not been dealt with in a timely manner.

The surgical services had procedures for the reporting of pressure ulcers, and slips, trips and falls. Safety thermometer information of incidences of pressure ulcers and falls was low with 14 pressure ulcers and 13 falls reported. There was access to appropriate equipment to provide safe care and treatment. Surgical staff told us they were encouraged to report any incidents that occurred, and these were discussed at ward and trust management meetings. We saw that feedback was provided and learning from incidents was evident. The hospital's surgical safety checklist was not always fully completed for all patients. Patients were appropriately escalated if their condition deteriorated. Medical staffing was appropriate and there was adequate emergency cover.

Incidents

- There were three 'never events' within the surgical services at the trust between April 2014 and March 2015. These occurred within the operating theatres. A never event is defined as a serious, largely preventable patient safety incident that should not occur if the available

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preventative measures are implemented. The never event for trauma and orthopaedic surgery was reviewed by the division, which included a root cause analysis (RCA) of the incident.

- Between February 2014 and January 2015, surgical services reported 16 serious incidents through the Strategic Executive Information System (STEIS). The most frequently reported incident types related to grade 3 pressure ulcers and confidential information leaks. Other incidents reported also included an allegation of assault against a health care professional.
- All staff we spoke with said they were encouraged to report incidents. Incidents were discussed at ward manager and trust meetings. Information provided showed that all incidents in surgery had been addressed in a timely manner.
- Managers analysed all reported incidents to ensure that lessons were learnt and shared with staff. Twenty-four members of staff across all of surgery visited told us they were informed about incidents, and discussed any changes to practise at ward team meetings.
- We attended a meeting with senior managers within surgery. The meeting discussed incidents, their findings, and actions taken. When we returned to the wards we spoke with ward managers about the timely fashion that incidents were reported and action had been taken. We observed a ward manager discussing an incident with a member of their staff, which demonstrated staff were informed of lessons learnt regarding incidents.
- Each speciality within surgery had an identified outcome that was specific to clinical need. The morbidity and mortality meetings held within the directorates occurred on a monthly basis. This information was reported through the governance structure by the separate directorates to ensure early intervention. The data was monitored and reported to the trust board.

Safety thermometer

- The entrance to each ward had NHS safety thermometer information clearly displayed. This included information about infections, new pressure ulcers, new catheter urinary infections (C.U.TIs) and venous thromboembolism (VTE). This meant performance of the ward, or department was clearly visible to all patients, visitors, and staff.

- For surgery overall, prevalence rates of catheter related infections remained low throughout July 2013 and June 2014 and this included rates of pressure ulcers and falls with no improving or deteriorating trend.
- We spoke with six members of staff who were able to talk to us about safety thermometer data and the importance of ensuring the data that was displayed was up to date.
- We looked at the safety information data for A5 ward and the information displayed informed us that since June 2008 there were no MRSA cases on A5 ward. Also 87% of patients said that nutrition exceeded expectations. Inpatient falls data for ward A5 demonstrated that up to January 2015 there were 5 in-patient falls.

Cleanliness, infection control and hygiene

- Hand hygiene gels were available outside the wards and within the ward areas, including bays and side rooms. We saw that hand wash basins were available in bays and side rooms.
- Instructions and advice on infection control were displayed in the ward entrances for patients and visitors, including performance on preventing and reducing infection. Personal and protective equipment, such as gloves and aprons, were available in sufficient quantities.
- Most surgical wards we visited were visibly clean. However on the neurosurgical ward we found that a bathroom was condemned due to fungi growing in it. This action happened approximately 10 days prior to our inspection. The impact on patients meant that there was only one bathroom on the ward for all 28 patients to use. This posed a risk of infection. During our inspection the fungi was removed but the bathroom remained out of use because it required cleaning. The ward had no system for signing off repairs once completed by estates. There was a high awareness among staff about infection control. We saw that staff followed the trust policy on infection control. During our inspection visit we observed staff washing their hands and using hand gel between treating patients. We also saw staff observe to 'bare below the elbow' policy in clinical areas.
- Infection rates in surgery for C. difficile and MRSA were below national levels

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- We looked at completed audit data which demonstrated staff checked that bacteriological screening of patients was completed on admission, or before if it was a planned admission.
- There were dedicated cleaning staff within the operating theatres with clear responsibilities and their work was checked and audited.

Environment and equipment

- Resuscitation equipment, for use in an emergency in operating theatres and the majority of surgical ward areas, was regularly checked, and documented as complete and ready for use. However, we found one ward; ward A3, where there resuscitation equipment was not checked for three days in March 2015 and one day in April 2015. We brought this to the attention of a manager.
- There was sufficient equipment to maintain safe and effective care. Staff told us that when they requested equipment, the response was quick and efficient.
- There are toilets suitable for people with disability, with alarm pulls, immediately outside Trauma and Orthopaedics theatre recovery and Main Recovery. Staff supported patients to walk to the toilet facilities at this location. We noted that the ophthalmic day surgery unit was very well maintained. However, the environment was not suitable for the patients who attended with no separate areas for children and adults within the care and treatment bays or within the recovery area outside the theatres. The management team were aware of this within the ophthalmic day surgery unit, but had no business plan available to demonstrate that the trust was addressing this.

Medicines

- Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. However, we found that the storage temperatures of the rooms used to store medicines were not being monitored or recorded. When we measured the temperature it was within acceptable limits, we were not fully assured that the medicines were always stored in a way which maintained their quality. We saw controlled drugs were stored and recorded appropriately. Controlled drugs are medicines which are required to be

stored and recorded separately. Emergency medicines were available for use and there was evidence that these were regularly checked and were in tamper-evident containers.

- A comprehensive computerised prescription and medication administration record chart for patients was in place. This facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the computerised charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for ten out of 57 patients on two wards. Appropriate arrangements were in place for recording the administration of medicines. People were getting their medicines when they needed them and any reasons for not giving people their medicines were recorded. Allergies were recorded on the computer record chart.
- There was a pharmacy top-up service for surgical ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them. A pharmacist visited all wards each week day. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date.
- We spoke with a ward sister who told us that they carried out regular checks on the quality and accuracy of computerised prescription charts and we saw evidence to support this. We were therefore assured that any medication errors would be identified and resolved promptly.
- Nursing staff could describe to us the process of reporting medication incidents and gave us examples which resulted in a change in practice. We felt confident that suitable arrangements were in place to learn from incidents.

Records

- In surgical wards and theatres we examined 9 patients' records, which included assessments for patients treated in operating theatres. There were detailed and comprehensive pre-assessments made on patients prior to admission. Important information was raised as an alert within the electronic patient system known as

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EPIC. We looked at 36 five steps to safer surgery checklist records which were completed appropriately apart from in three theatres where areas of the checklist were not completed. .

- In ward areas, nursing staff and medical staff shared records to ensure risk assessments were completed; examples included checks for skin integrity, falls risk and nutritional risks.
- Completion of documentation was consistent within the wards that we visited. For example, we found assessment records within the neurosurgical ward to be complete and consistent with the trauma and orthopaedic wards.
- Separate notes within the electronic patient EPIC system were available for patients presenting with a risk of pressure ulcers or falls.
- Patient information and records were stored securely on all wards and departments we visited within surgery.

Safeguarding

- Staff in all surgical areas could explain safeguarding arrangements, and when they might be required to report issues to protect the safety of vulnerable patients.
- The training records within the wards visited identified that both medical and nursing staff had attended safeguarding training. This was confirmed by the staff we spoke with.
- We saw that there was a safeguarding lead within surgery for staff to gain advice and support from.

Assessing and responding to patient risk

- The surgical wards used the modified early warning score (MEWS) to identify if a patient was deteriorating. There were clear directions for actions to take when patients' scores increased, and members of staff were aware of these and the actions required to alert doctors.
- Risk assessments were undertaken in areas such as venous thromboembolism (VTE), falls, malnutrition and pressure sores. These were documented in the patient's electronic records and included actions to mitigate any risks identified by the assessment.
- Staff could assess and respond to a deteriorating patient in line with policy and guidelines. We observed the management of an acutely unwell patient who needed resuscitation. We observed good management skills by the multi-disciplinary team involved in the resuscitation.

- We spoke with staff in the anaesthetic and recovery area within theatres, and found that they were competent in recognising deteriorating patients. In addition to the early warning score, they used a range of observation charts and procedures, pathways and protocols for different conditions or operations. All theatre teams used the five steps to safer surgery checklist, which is designed to prevent avoidable mistakes; this was an established process within the teams. We looked at the completed checklists, which included the patient's identity and whether they had any known allergies.
- Two of the surgical wards we visited had outliers or patients with non-surgical conditions; this included the neurosurgical ward which had beds occupied by medical outliers. Nursing staff expressed concerns that they felt they lacked the necessary skills or training to support people diagnosed with medical conditions. Staff felt they may not be able to respond to the risk of patients transferred to the ward.
- Nursing handovers occurred at the change of shift. Staffing for the shift was discussed, as well as any high-risk patients or potential issues.

Nursing staffing

- Patients on wards were treated by nurses, sometimes not from the appropriate specialty. For example patients who had neurosurgery surgery being cared for by nurses who usually cared for medical patients. As such nurses were not familiar with the care support required. This affected the quality of care for patients, because their care was not treated by an expert member of staff. We found that patients' medications and care was delayed as replacement staff did not understand the complexity of procedures or were not authorised to administer medicines. On one ward we found that the lunchtime medication round had extended into the afternoon due to regular staff being available to undertake these as they were being called away by replacement nurses to assist in other caring duties with which the replacement nurses were unfamiliar. The managers we spoke with acknowledged that issues with skill mix were of concern.
- Staff on the wards told us staffing was a 'safety' concern. Some agency staff said they had not received any induction to the wards they were working within. Increased capacity within the hospital meant permanent members of staff were transferred to newly opened wards. This meant that the nursing staff on the donor wards had to supervise replacement nurses and

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those on the receiving wards were not always familiar with the medical conditions patients were experiencing. The impact on patients was mitigated through the professionalism of the nursing staff but patients were not always protected from avoidable harm.

- When we spoke with five agency nurses they were not confident in their surgical experience and one nurse told us that she had never worked on a surgical ward but was expected to have an in depth knowledge of surgical nursing procedures. We spoke with managers about these concerns and they recognised the pressure was placed on the permanent qualified ward nurses to lead these nurses.
- During our inspection of the ophthalmic day surgery unit we were told that there was not always a specific paediatric trained nurse available when the day surgery unit operating on children. The trust stated that when this occurred that the list was moved to main theatre to ensure the safety of children. However, staff told us that this did not always happen.
- The staff on C7 told us that nurse staffing levels were a concern. C7 is the ward for liver and gut conditions. We were told that there was a high use of agency nurses who were unable to complete the full tasks required of nurses working on ward C7. We noted that one substantiated registered nurse on the ward had to complete the administration of 17 intra-venous antibiotic's for patients. The trust reviewed the staffing on this ward and stated that there was only one agency nurse on each shift. One of these staff had regularly worked on this ward.
- Agency nurses, we spoke with, could not access the electronic EPIC patient record system and the regular nurses had to complete this task for them, which caused issues on the wards we inspected. The trust stated that training in EPIC had been provided to agency staff on launch and through a regular programme of training.

Surgical staffing

- Surgical consultants from all specialties were on-call for a 24 hour period.
- Surgical consultants told us they were well staffed and did not have any concerns. The medical staffing skill mix within surgery demonstrated that the surgical consultant whole time equivalent (WTE) was at 42% and this was above the England average of 40%.
- Junior doctors told us there were adequate numbers of junior doctors on the wards out of hours, and that

consultants were contactable by phone if they needed any support. There was a low vacancy rate for junior doctors. The junior staffing skill mix within surgery demonstrated that junior doctor WTE was at 15% and this was above the England average of 13%.

- Handovers were consistently formal and structured. During our announced visit we attended a surgical handover. The handover reviewed patient care based on the severity of their condition and any anticipated problems.

Major incident awareness and training

- Emergency plans and evacuation procedures were in place.
- We spoke with ten members of staff who were aware of the procedures for managing major incidents, winter pressures, and fire safety incidents. The surgical speciality wards we visited had medical patients being cared for within these wards.
- The ward managers were concerned that the needs of both surgical and medical outlier patients were not being met effectively. The bed occupancy rate within urology was consistently at 100% and there was between 22 to 24 outliers per day within the surgical wards and this impacted on pressures.

Are surgery services effective?

Good



We rated effective as good.

The service demonstrated that care was provided in accordance with evidence-based national guidelines and best practice. Policies and procedures were accessible, and staff were able to guide us to the relevant information. Outcome audit data was mixed with the trust scoring well in some areas such as admission to an orthopaedic ward but less well in ensuring patients had their surgery on the day of admission.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), but some were unaware of the recent changes to DoLS. Ward managers confirmed they were continuing to ensure that staff attended the training in relation to MCA and DoLS.

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There was a pain relief service available 7 days a week and we observed that nutrition and hydration was monitored and recorded.

Evidence-based care and treatment

- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations and national guidelines. We found the Royal College of Surgeons' standards for emergency surgery/surgery out of hours were consultant-led and delivered.
- Local policies, such as the pressure ulcer prevention and management policies were written in line with national guidelines, and staff we spoke with were aware of these policies.
- The trauma and orthopaedic care group participated in national clinical audits, such as the National Joint Registry. This registry collects information on all hip, knee, ankle, elbow and shoulder replacement operations, and monitors the performance of joint replacement implants. We looked at the Hip fracture audit and in 2013 / 2014 there were 429 cases submitted for which the bone health medication assessment of patients was above the England average of 97.3% and the trust was audited at 99.3%. This audit showed the trust was better than the England average (48.3%) for admitting patients to orthopaedic care within four hours (62.4%). However, the audit also showed they were below average (73.8%) for ensuring patients had surgery on the day, or the day after, their admission(67.2%).
- Surgery had a clinical audit programme which assessed compliance with national (such as National Institute for Health and Care Excellence (NICE)) and local guidance. The surgical team reviewed and implemented action plans after assessing areas where they did not comply.

Pain relief

- We looked at nine records which showed that patients' pain relief was risk assessed using the pain scale found within the medical early warning score (MEWS) system.
- Staff could access support from the pain management team when required. The pain service was available seven days a week.
- We spoke with 13 patients who told us staff assessed them pre-operatively for their preferred pain relief.

Nutrition and hydration

- We observed the use of fluid balance to monitor patients' hydration status.
- During our inspection we saw on all wards and units that patients had access to drinks by their bed. staff checked patients took regular drinks.

Patient outcomes

- The bowel cancer audit data (2014) showed that 99.2% of patients were seen by a clinical nurse specialist compared to the England average of 87.8%. The length of stay for patients above five days below the national average at 60% compared to an England average of 69.1%. Records showed that the discussion by the multidisciplinary team (MDT) was just below the national average at 98.9% compared to the England average of 99.1%.
- The hip fracture audit showed the trust was above the England average for pre-operative assessment by geriatrician achieving 85.7% compared to an England average of 51.6%. The records showed the hospital performed better than England in this audit.
- The records showed the hospital was better than the England average for protecting patients at risk of developing pressure ulcers.
- The standardised relative risk re-admission for elective surgery was above the England average within urology and neurosurgery and below within general surgery. Within non-elective surgery the re-admission rate was below the England average which included transplantation surgery.
- The Patient Reported Outcome measures (PROM) scores between April 2013 and March 2014 for both hip and knee replacements were in line with the England national average. The scores for varicose vein and groin hernia were slightly worse than the England average. The PROM score is the percentage of patients that have improved for each procedure.
- The average length of stay for patients having elective surgery was 3.3 days and for non-elective surgery the average stay was seven days.

Competent staff

- We spoke with three new members of staff who told us they had been supported when joining the hospital. They completed a trust-wide induction programme. When on the ward, they were given the opportunity to understand processes and procedures.

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- Managers told us they conducted one-to-one personal development supervision meetings with staff. Staff that we spoke with on the surgical wards confirmed this.
- Healthcare assistants told us that they were encouraged to gain further skills to support the qualified staff on the wards and units and we saw that courses were available. However we found that they could not be released due to low staffing levels and when they ask to go on courses it is often declined due to funding.

Multidisciplinary working

- All wards had daily ward rounds, which involved medical and nursing staff. They also other health care professionals within the multi-disciplinary team.
- Doctors and nursing staff told us they worked well together within the surgical specialities. We saw evidence of this on the surgical wards, operating theatres, and the day care unit.
- All wards we visited had dedicated pharmacy support, which helped to speed up patient discharges.
- Staff described the multidisciplinary team as being supportive of each other. Health professionals told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure safe and effective patient care.
- We looked at patients' records which showed patients were referred, assessed and reviewed by dieticians and the pain management team, when required.

Seven-day services

- Consultants worked throughout the week within the surgical services, supported by specialist registrars during the weekends.
- Staff told us that senior doctors completed consent forms in the pre-assessment clinic. They also told us they challenged a consent form completed by a junior doctor over the weekend. However, we observed a nurse with an incomplete consent form for a patient admitted to the ward. We brought this to the attention of the ward manager to address and investigate in order that consent was appropriately taken. .

Access to information

- Nursing staff told us they had problems with quick access to the EPIC, electronic patient-related information and records, whenever they required. The system was time consuming to use and it limited the

engagement with patients. We found that agency and locum staff also had access problems to the information in care records to enable them to care for patients. When agency and locum staff move around they often do not have access rights and rely on substantiated staff to enter details into the EPIC system which was frustrating. The trust stated that training in EPIC had been provided to agency staff on launch and through a regular programme of training.

- Nursing staff told us that when patients were transferred between wards or teams, staff received a handover of the patient's medical condition, and ongoing care information was shared appropriately in a timely way. We pathway tracked two patients and observed that this was the case.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff on A5 ward and C7 ward who had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS), but the majority of staff we spoke with were unaware of the recent Supreme Court changes to DoLS. This means that the trust must ensure that decisions about the living arrangements of a person without capacity do not amount to a deprivation of their liberty. The manager we spoke with confirmed they were still rolling out training
- The records, where applicable, showed clear evidence of informed consent, which identified the possible risks and benefits of surgery.
- All of the patients we spoke with confirmed they received clear explanations and guidance about the surgery, and said they understood what they consented to.
- Where patients did not have capacity to consent, staff demonstrated to us that formal best interest decisions were taken in deciding the treatment and care patients required.
- We spoke with 24 members of surgical staff. The majority were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). However, we found that five doctors and six nurses had limited knowledge about their responsibilities. This was highlighted to their managers during our inspection.

Are surgery services caring?

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Good



We rated caring as **good**.

Staff were caring and compassionate to patient's needs, and treated patients with dignity and respect. Patients told us that staff were caring, and were flexible in their support, to enable patients to access services.

We observed many episodes of caring interaction during our visit, with feedback from individual patients and relatives was universally positive. Observations of staff showed that they treated people with compassion and kindness in the department. Patients confirmed this when we spoke to them. One patient told us "the nursing staff are a great team."

Compassionate care

- Wards displayed the NHS Friends and Family Test results. We saw posters encouraging patients to feedback their views, so they could improve the care provided. Between December 2013 and November 2014 the results showed that an average of 84% of patients were 'extremely likely' to recommend the trust to friends and family, above the national England average.
- Throughout our inspection we witnessed patients being treated with compassion, dignity, and respect. One patient told us that "nurses always understood their needs and nothing was too much trouble."

We observed a ward round and saw that the nurses and doctors introduced themselves appropriately, and drew curtains to maintain patient dignity.

Understanding and involvement of patients and those close to them

- During our inspection we observed nurses, doctors and other health care professionals, introduce themselves to patients at all times, and explain to patients and their relatives about the care and treatment options. Staff responded to patients' questions clearly and in an understandable manner.
- The staff working within neurosurgery used opportunities to educate patients and their relatives on the health and care they received, which patients valued. We spoke with two patients who told us that it reassured them.

- Patients said they felt involved in their care. They had been given the opportunity to speak with the consultant looking after them.

Emotional support

- We spoke with doctors on the surgical wards who informed us that they recorded any detailed discussions with patients and relatives within the patient's electronic notes in the EPIC system.
- Clinical nurse specialists provided additional support to patients and ward staff where required, to enhance patient care and needs.
- Patients could access the multi-faith chaplaincy services for support. Information on how to access chaplaincy services was displayed on notice boards in the majority of areas we inspected. Staff told us they regularly interacted with the trust's palliative (end of life care) team, who provided support and advice during bereavement.

Are surgery services responsive?

Inadequate



We rated responsive as **inadequate**:

The service was not responsive to the needs of patients requiring admission. The hospital performed worse than the expected national average for cancelled operations. The trust overall performed worse than the expected average. The trust did not have a recovery plan in place to address this. The referral to treatment times within 18 weeks were broadly in line with the national average until October 2014, and then there was a steep decline in performance which has continued till April 2015. Since January 2015 fewer than 70% of patients requiring admitted treatment received treatment within 18 weeks. The trust stated that they were experiencing increased demand for beds and the implementation of the IT system EPIC had led to a declining referral to treatment time performance. However the trust has a recovery mobilisation plan in place to improve the speed at which patients can access care.

The bed occupancy rates for the hospital were higher than target ranges and we saw that bed occupancy within urology was at 100%.

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We saw that adult patients would be cared for in the same area as children in recovery. Neither group of patients had their privacy or dignity protected. There was no controlled access within the ophthalmic day surgery unit within recovery whereby we found children and adults shared the same recovery area and bays next to each other.

Within surgery we found that between October 2014 and April 2015, 129 patients who had their procedure cancelled on the day of surgery had not had the 28 days required to receive a new offer. During our inspection we observed that surgery had all non-urgent surgery cancelled for the 24 April 2015 due to no ability to deliver this service.

Cancelled surgery was endemic within surgery with 8 – 20 cancellations per day. Cancelled orthopaedic surgery resulted in two surgeons not operating since October 2014. We saw that the ophthalmic eye surgery theatre was not carrying out any waiting list cases.

Service planning and delivery to meet the needs of local people

- The service had a day surgery unit, which enabled people to have minor procedures without having overnight stays in hospital.
- On the day of their surgery, patients with elective (planned) surgery were admitted to the surgical admissions lounge. There nurses processed patients for surgery and the post-operative ward. However, we spoke with one nurse who informed us that within the ophthalmic day surgery unit, two days a week, patients are asked to be at the unit for 07:30am in the morning and have to wait for a 1:30pm start due to the consultant wishing to work this way. It is unnecessary for patients to arrive this early because they have already had their pre-assessment completed.
- It is expected that 90% of elective surgery patients should wait under 18 weeks from referral to treatment. The trust was not meeting this national waiting time target. However the trust has a recovery mobilisation plan in place to improve the speed at which patients can access care.
- Length of stay was longer than the national average for non-elective surgical admissions, which was 26% higher than the England average. However the hospital is a specialist centre and a major trauma unit and this could impact upon the demand for surgery.
- We looked at nine records and identified that discharge planning was not addressed in a timely manner with

patients. For many patients their delayed discharge revolved around their package of care from the local authority. The trust was working with partners to improve this.

Access and flow

- We observed that the trust followed the National Institute for Care and Excellence (NICE) guidance for fractured neck of femur. However, the hip fracture audit showed this clinical pathway was performing less well and not working as efficiently as should be expected, 67.2% of patients received surgery on the day of or after day of admission compared to the England average of 73.8%.
- The service was under considerable and sustained pressure to meet the competing demands of emergency and elective surgery in a hospital with limited capacity. They had made no progress in clearing the backlog of delayed operations. The trust stated that it has a recovery mobilisation plan in place to improve the speed at which patients can access care. The trust intended to further improve the time of patients waiting by the addition of a further two new theatres to the current 35 theatres.
- From October 2014 to April 2015 129 patients had their operation cancelled and their treatment was not rescheduled within 28 days. This was above the England average of 5% of patients, and showed no improvement over time.
- Cancelled surgery was endemic within surgery with 8 – 20 cancellations per day. Cancelled orthopaedic surgery resulted in two surgeons not operating since October 2014. We saw that the ophthalmic eye surgery theatre was not carrying out any operations on patients on the waiting list.
- Following surgery patients were often held in recovery because there were no beds available within the speciality service required due to a lack of realisation of discharge plans on the wards. Theatre staff told us it was not unusual for them to stay and look after patients' recovery in theatre, which had a 'knock-on' effect on surgery time.
- We did see within colorectal surgery that there was an enhanced recovery plan which reduced the length of patient stay from eight to six days which supported the achievement of the divisions Commissioning for Quality and Innovation (CQUIN) programme.

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Meeting people's individual needs

- There were dementia care and learning disability champions within surgery. We spoke with staff who understood who to contact for support.
- Staff were familiar with the hospital's procedures for translation services. Staff could print leaflets in different languages when the need arose and they could request a translator for more complex cases.
- There was information available, in all of the main areas, for many different surgical procedures and conditions. The reception area of the day surgery unit had posters and information available, which sign posted people to other appropriate care pathways and contact information for other services.
- The patients said they were given choices for food and snacks. However, they provided mixed views regarding the quality of the food available. We noted at one meal time that food on a tray was placed in front of a patient on the neuro surgery ward, who required assistance, and it was 15 minutes before anyone came. We brought this to the attention of the ward manager who addressed it immediately and ensured that fresh hot food was obtained for the patient.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Staff directed patients to the patient advice liaison services (PALS) if they could not deal with concerns directly.
- Wards displayed literature and posters, advising patients and their relatives how they could raise a concern or complaint, both formally and informally.
- Staff we spoke with told us that ward managers investigated complaints, and there was feedback on complaints in which they were involved.
- Patients we spoke with felt they would know how to complain or compliment about care and or treatment they received to the hospital if they needed to.

Are surgery services well-led?

Requires improvement



We rated well led as **requires improvement**:

There were a high number of cancelled operations which the trust did not deal with in a timely manner. Different divisions undertaking surgery lacked cohesion, and there was a perceived lack of support from senior managers within the divisions. Strategic plans did not address capacity issues all of the time within the service and there was no clear vision for the service. Cancelled operations were frequently brought to the attention of managers but not resolved at a senior manager level. Some staff told us they felt pressurised when patient admissions fluctuated. Senior managers were not always aware of the issues at ward and unit level and were too engaged in monitoring the additional pressures that had little impact at ward level.

We spoke with middle managers in surgery who told us that they felt that the senior managers did not challenge areas that required improvement and senior managers at director level were not prepared to have difficult conversations. A senior grade manager informed us that they raised a case of suspected bullying with their line manager and that they had received no feedback or the issue dealt with. However, staff felt supported by matrons within the divisions.

We spoke with staff within the ophthalmic day surgery unit who spoke to us about innovative ideas they had to improve service provision but this was not supported by consultants within the unit.

There was positive awareness amongst ward and unit staff of the values and expectations for patient care across the trust. Most staff from all disciplines within surgery told us they could speak openly about issues and incidents, and felt this was positive for making improvements to the service. Staff told us they felt there was an effective and supportive team working across professional groups in the surgical service.

Staff could raise any concerns, or share an experience, within surgery. Patients were engaged through feedback from the NHS Friends and Family Test.

Vision and strategy for this service

- The vision for the service was not clear to all staff groups. We asked a number of staff and they could not give a clear answer.
- Information relating to core objectives and performance targets were visibly displayed in the majority of areas we visited.

Surgery

- Strategic plans did not address capacity issues all of the time within the service and there was no clear vision for the service. Cancelled operations were frequently brought to the attention of managers but not resolved at a senior manager level.
- Ward and unit managers told us that they feel there is a weak strategy plan for consistency within the surgical service. Also they felt contingency wards were continually opened and shut in a hap-hazard manner, with no vision around any pro-active forward planning.
- Ward managers said they had access to good leadership development courses. We were told that the chief nurse had developed a supervisory ward manager's programme.
- Most staff reported to us that they respected and felt supported by their managers. However, staff commented that they did not always see a member of the executive team in the area, but they felt supported by the service leads and in particular visibly engaged leadership within theatres.

Governance, risk management and quality measurement

- Surgery services held monthly clinical governance meetings, with discussions on quality issues such as complaints, incidents, and audits. Staff could identify incidents and how they were shared with others during team meetings. We observed root cause analysis (RCA) reports disseminated to staff on duty.
- The wards, units, and theatres had quality dashboards for each service and ward area which showed their performance against quality and performance targets. Members of staff told us that these were discussed at team meetings but it was difficult for staff to attend because of rotas and they could not leave the ward as it was always busy.
- There were risk registers for all aspects of surgery, which included all known areas of risk identified in surgical areas. These risks were documented by the divisional teams, and a record of the action being taken to reduce the level of risk was maintained. The higher risks were also escalated on the trust's risk register. We examined the risk registers for the wards we visited and saw that some risks had no actions against them, while others still had outstanding actions, for example, the shower concern on ward A5 and the high numbers of patients who were cancelled for surgery.

Leadership of service

- Each ward had a manager who provided day-to-day leadership to members of staff on the ward. Members of staff told us that the manager was visible and approachable.
- Some staff said the executive leadership from the trust could be improved and felt their ideas did not always filter down to staff.

Culture within the service

- Staff were passionate and driven to provide good care to patients, but felt that this could not always be given, due to the pressure of work.
- Staff we spoke with worked well together as a team, and said they were proud to work for the trust.
- Throughout our inspection, we observed that staff were very open with the inspection team and where things were not right this was acknowledged by the ward managers. This meant that we were assured that the culture within the ward areas was an open culture. However, we were not assured of this in all areas. For example, ophthalmic surgery.
- Staff were aware of the importance of reporting incidents when things went wrong and understood how this could influence service change and improvement.

Public and Staff engagement

- Patients were engaged through feedback from the NHS Friends and Family Test. Governance meetings showed how patient experience data was reviewed and monitored.
- Staff took part in regular staff surveys. The trust collated and the results so that actions for improvement were identified.
- Notices were displayed at the entrance to wards and day units, inviting staff and patients to give feedback to the leadership team about the services they deliver as staff and received as patients.







Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines.

Surgery

- In order to make improvements to the service, the middle management team were aware of advances that it needed to make to deliver a sustainable surgical service and that this needed engagement from the executive team.

Critical care

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

Information about the service

The Critical Care service at Addenbrooke's Hospital comprises the John Farman Intensive Care Unit (the general intensive care unit), the Neuro-Critical Care Unit and the Intermediate Dependency Area.

The John Farman Intensive Care Unit has 20 critical care beds (12 side rooms and 8 open beds) over two floors and provides care for general medical, surgical and specialist liver services. From January to December 2014 care was provided for 1,066 patients.

The Neuro-Critical Care Unit has 23 critical care beds over two floors and provides specialist neuro-critical care and trauma critical care. In 2014 care was provided for 1,032 patients in the unit.

The Intermediate Dependency Area has 12 beds and is an open unit for the escalation of ward patients requiring closer monitoring and those stepping down from critical care areas. It is supported by the trust rapid response team. The Intermediate Dependency Area also provides care for patients who require non-invasive ventilation (supported breathing) and low level inotropic support (medication to help maintain blood pressure) with arterial line monitoring (continuous blood pressure monitoring).

Over four days, the inspection team visited all the areas providing critical care and spoke to the clinical and nursing leads for both units, the clinical director for critical care services, the divisional matron, the senior clinical nurse for adult critical care and the operations manager. We spoke with four consultants, four junior doctors, 10 staff nurses, two allied health professionals and two health care

assistants. We also spoke to 12 patients receiving care or their relatives, examined 14 sets of electronic patient notes, observed care being provided to over 20 patients and reviewed a range of data including staff rotas and the critical care minimum data sets provided to us by the unit.

Critical care

Summary of findings

Overall, we rated the Critical Care services provided at Addenbrooke's Hospital as requiring improvement. Concerns were raised before the inspection about staff shortages resulting in patients requiring high level care not receiving the level of care they should have had and during the inspection further concerns were raised about this. Our observations and findings during the inspection substantiated the concerns raised by staff and we took action immediately to protect patients from the risk of harm.

Staffing numbers and skill mix on the Intensive Care Unit and the Neuro-Critical Care Unit were not in line with the Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units (Edition 1). We observed that this was having an impact on the staff providing care and we saw evidence of poor practice as a result. This included one patient being looked after by healthcare assistant. Poor hand hygiene was observed by staff between patients, resuscitation trolleys were not checked in line with trust policy and medications were left unattended. The concerns relating to staffing had been raised through various avenues to the senior management team but no action had been taken immediately to address those concerns. The senior management team had a clear understanding of the national guidelines but there was poor recognition of the impact this was having on staff and there was a lack of flexibility in reviewing staffing establishment when concerns were raised. The process for assessing patient acuity was well established, although there was minimal evidence of reviewing staffing establishments to meet changes in demand.

During the implementation of the trusts' health informatics software, a key member of the team responsible for data collection and upload to the Intensive Care National Audit and Research Centre (ICNARC) case mix program was seconded to assist design and implementation of the system. A subsequent move to merge systems for data collection combined with the inexperience of a member of staff identified to fill the vacancy for data collection resulted in questions around the reliability of data collected on both units. The trust had problems with the completeness of

ICNARC data which had not been submitted for two years. Locally there was some mitigation in the collection of local data sets but the trust was unable to benchmark its data against other units over this period. The trust has since completed the training for staff and has re-started submitting data to the case mix program.

Bed occupancy for the critical care service was high. In March 2015, bed occupancy was 93% on the Intensive Care Unit and 95% on the Neuro-Critical Care Unit. In February, the average occupancy was 113% on the Intensive Care Unit and 109% on the Neuro-Critical Care Unit because patients were occasionally being provided with care by the rapid response team. Across the trust, the length of stay for patients and delayed discharges to ward areas were seen as a significant risk to flow. This was having an adverse impact on the Critical Care Unit, with more than 1 in 3 patients on both Intensive Care and Neuro-Critical Care having a delay in discharge during 2014. Furthermore, as a result, more than 40% of patients admitted to the two units were discharged to the wards after 8pm in March 2015.

Whilst we found strong leadership at ward level, there was a clear disconnect between the local leadership and leadership at divisional management level and between the division and the executive team. There was a drive at executive level to devolve leadership to divisional levels within the organisation. This resulted in a significant re-structure of the leadership to critical care services, and whilst progress had been made the critical care lead recognised that there was more work to be done with shared learning and consistency relating to the governance processes of both Intensive Care and Neuro-Critical Care.

There were numerous examples of outstanding teamwork within the Critical Care Unit. Staff worked collaboratively to ensure patients received the best care possible within their limited resources. Junior members of the team spoke very highly of the senior nurses and consultants in the department. Patients on the unit were cared for by kind and compassionate staff, and the feedback from patients and carers during our inspection was very positive.

We saw a strong ethos of multidisciplinary working amongst all members of the team within critical care.

Critical care

The critical care Rapid Response Team provided outreach services into the ward, proactively identifying patients who would benefit from closer monitoring and supporting ward teams 24 hours a day.

Staff used patient diaries to document each patient's stay in Critical Care and they were reviewed in a dedicated follow-up clinic after patients were discharged from critical care. The follow-up clinics provided a strong focus for the review of a patient's physical and mental health after being in hospital. Patients and carers were invited to twice-yearly focus groups to share their experiences and help drive service improvement. We saw a number of examples of innovation arising from the focus groups and these have been detailed in our report on responsive care.

There was a strong culture of service improvement and research. Both the Intensive Care and Neuro-Critical Care units had participated in a number of research ventures and the recruitment strategy and opportunities afforded to staff reflected the strong commitment towards research. An online educational resource – cambridgecriticalcare.net – developed by the Neuro-Critical Care team is seen as an example of outstanding practice, with educational resources aimed not only at local trainees but trainees nationally and internationally.

Are critical care services safe?

Requires improvement



Overall, we rated safety within Critical Care as requiring improvement because staffing levels were not sufficient to provide safe care to patients with such high levels of dependency. Staffing numbers and skill mix on the Intensive Care Unit and on the Neuro-Critical Care Unit were not in line with the Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units (Edition 1). This had an impact on the staff providing care and we saw evidence of poor practice as a result, including patients being left unattended or being looked after by a healthcare assistant, poor hand hygiene by staff between patients, resuscitation trolleys not being checked in line with trust policy and medications being left unattended. We reviewed the staffing issues on our unannounced inspection and saw that actions immediately taken remained in place.

There was an open culture around incident reporting and well established avenues for learning from incidents. We saw evidence of learning from incidents and changes that had been implemented as a result. One member of staff did, however, tell us that owing to staff shortages they did not always have time to report incidents. This concern was recognised and corroborated by the senior nurse for adult critical care. Staff were clear about their roles under the Duty of Candour legislation and identifying and escalating safeguarding concerns.

Safety thermometer data, reviewing the provision of harm-free care showed strong and consistent performance in preventing hospital acquired infections, clots and pressure ulcers. There was a lack of space for storing equipment on the Neuro-Critical Care Unit. Equipment was found stored in the high dependency area, in bed spaces with curtains drawn around it, in an unused shower area, and in the corridors this is a potential infection control and safety issue. We also found equipment blocking the fire exit in the corridor leading to theatres.

Incidents

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- Staff reported incidents on the unit through an online incident reporting system. Data reported through the system was analysed thematically and presented during monthly clinical governance meetings.
- From October to December 2014, 47 incidents were reported on the Neuro-Critical Care Unit. There were no 'never events' (things that should never happen) or events causing significant harm to patients. There had been an increase in the reporting of low and moderate harm incidents.
- During the clinical governance meeting on the Neuro-Critical Care Unit in March 2015, note was made of an incident regarding a syringe pump that had not been locked. Learning was disseminated through to the teams as a result. Staff we spoke to were able to tell us about this incident and the learning from it. Another incident reviewed related to documentation of the length of insertion of feeding tubes from the endoscopy department. This resulted in a change to the documentation structure on the trust health informatics system and led to safer practice. We also reviewed a detailed action plan for a patient the clinical team were unable to intubate, with attached learning from the case.
- On the Intensive Care Unit, from October to December 2014, 78 incidents were reported in total (66 minor, 11 moderate and one serious). This was an increase in the number of moderate incidents reported compared to the previous quarter. The one serious incident was a grade 4 pressure ulcer acquired within the community. Details of the finding had been shared with colleagues in the community, where an investigation was carried out.
- Further evidence of learning from incidents related to insulin being prescribed incorrectly following an incorrectly taken blood glucose sample. Staff made changes to glucose monitoring and established a regular audit of glucose monitoring to prevent a recurrence. We reviewed these audits and found good compliance with blood glucose monitoring and minimal occurrences of hypoglycaemia.
- Staff across all units learned from incidents through issues being highlighted on daily ward rounds and through clinical governance meetings. Senior staff held weekly business meetings and would also discuss clinical incidents.
- Eleven nursing staff and four medical staff told us when asked that there was an open culture relating to incident reporting and learning from incidents, and that they were strongly encouraged to report incidents.
- Three staff raised concerns to us formally of these one member of staff told us, however, that whilst they were encouraged to report incidents, they did not always have time to complete the forms as they were regularly short staffed on the unit. We were told that they did not always report "near-misses" and drug errors provided the patient did not come to harm. We discussed this with the matron and they acknowledged that staff could be too busy to fill in incident forms.
- Thematic analysis of incidents showed low grade pressure ulcers, procedure/protocol failures and medication errors as the most commonly occurring incidents. Key learning from this was presented at the staff governance meeting and learning disseminated to all staff.
- Practices within the service were in line with the recent Duty of Candour legislation. Training sessions were organised across the service to give staff an understanding of the new legislation. Consultants described a clinical incident in which a central line was placed in the carotid artery. This was identified promptly and rectified without any harm coming to the patient. The consultant provided full disclosure to the family and provided a written apology acknowledging the incident.
- Morbidity and Mortality meetings took place separately, quarterly within the Intensive Care Unit and the Neuro-Critical Care Unit. All deaths within the unit were reviewed during this meeting and lessons shared. There was no formal process, however, for sharing learning between the two critical care units.

Safety thermometer

- The safety thermometer was displayed at the entrance to the critical care units. There were two cases of C.Diff on the Neuro-Critical Care Unit in 2014 and one case of MRSA bacteraemia on this unit in February 2014. This represents good practices on the units, with no significant spikes in the acquisition of either infection. Compliance with the C.Diff care bundle was 90% in January and February 2015 and compliance with the MRSA care bundle 90%.

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- Provision of harm-free care as per the NHS safety thermometer was at 100% for the Intensive Care Unit for January and February.
- The Neuro-Critical Care Unit was consistently performing at more than 95% on the thermometer from May 2014 to February 2015.
- The Intermediate Dependency Area scored 100% for all months over the same period since May 2014, except for August 2014.
- Staff on all three units told us that results from the safety thermometer were compiled on a monthly basis and presented to them to set priorities for the ward.
- The Critical Care service had audited the completion of risk assessments for venous thromboembolism in July 2014 in line with NICE Quality Standard 3 (statements 1 & 2). This showed that 91% of patients had a VTE risk assessment done on admission, with 82% having a re-assessment completed in 24 hours. The VTE risk assessments had since been incorporated into the trust electronic records system EPIC with an aim to increase compliance with the quality standards to 100%.
- Since incorporation into the electronic system there had been 100% compliance with the VTE risk assessment on the Neuro-Critical Care and Intensive Care units over the last three months.
- There had been no reported incidents of Grade Three or higher pressure ulcers in the Critical Care service this year. Patients were turned three-hourly to prevent them acquiring pressure ulcers and this was clearly documented in the notes. All Grade Two sores and above were subject to a full root cause analysis and none investigated had been identified as preventable.
- There was one Grade Three pressure ulcer acquired in the hospital over the last year (2014). We reviewed the root cause analysis, which identified an over-reliance on pressure relieving boots. Learning from this incident was disseminated to staff.

Cleanliness, infection control and hygiene

- The Intensive Care Unit, Neuro-Critical Care Unit and the Intermediate Dependency Area were visibly clean. The cleaning scores on all units were consistently higher than 98%. Audits of cleaning practices and infection control were undertaken by the microbiology team, infection control nurse and a staff nurse from critical care. The last audit was carried out in February 2015.

Actions from these audits included dating of central venous catheter (CVC) lines post insertion and of water bags used in irrigation and management of catheter bags.

- During our inspection we observed staff not consistently adhering to the infection control and hand hygiene policy. In two hours of observations on the Intensive Care Unit we saw incidents of staff not wearing Personal Protective Equipment (such as aprons and gloves) when caring for patients, and not using hand gel or washing their hands when going into patients' rooms or between providing care for patients.
- All nursing staff and 92% of medical staff on the Intensive Care Unit had completed their mandatory infection control training but on the Neuro-Critical Care Unit only 82% of nursing staff and 87% of medical staff had done so (against a trust standard of 90%).

Environment and equipment

- All Critical Care areas were equipped with dedicated resuscitation trolleys, airway trolleys and difficult airway trolleys. Records showed that the airway and difficult airway trolleys were checked in line with trust policy and appropriately stocked.
- On the Neuro-Critical Unit in the trauma High Dependency Unit, we identified through examination of the records held on the resuscitation trolley that the resuscitation trolley had not been checked on seven days in February, 10 days in March and seven days in April when it is meant to be checked every day. The resuscitation trolley on the Neuro-Critical Care Unit had not been checked in line with trust policy on four days in March and six days in April 2015.
- Patient monitors in the Intensive Care Unit and the Intermediate Dependency Area had been identified on the risk register as out of date and requiring replacement. The monitors had been sourced and were to be installed. Temporary monitors were in use in the Intermediate Dependency Area in the interim. The monitors were still capturing essential information.
- A dedicated portable CT scanner was available on the Neuro-Critical Care Unit to perform urgent scans on patients who were too unwell for transfer to the main department. This service was provided by the radiology team.
- There was a lack of space for storing equipment on the Neuro-Critical Care Unit. Equipment was found stored in the high dependency area in bed spaces with curtains

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drawn around it, in an unused shower area, and in the corridors. We also found equipment blocking the fire exit in the corridor leading to theatres. This had been recorded on the risk register.

- Pressure-relieving equipment was available for staff to order for patients when they were admitted to the critical care service and identified as at risk of pressure ulcer development.

Medicines

- Medications were prescribed electronically on both the Intensive Care Unit and Neuro-Critical Care Unit. Allergies were also documented electronically. The system had inbuilt safeguards alerting prescribers to prevent administration of medications to which patients were recorded as being allergic. It also automatically alerted prescribers to potential drug interactions.
- Drug cupboards on the Intensive Care Unit were not observed to be secure at all times. During the inspection, we saw bags of intravenous fluids left unattended and medications left on the nurse's desk.
- The storage room for medicines was locked and keypad controlled, ensuring safety of the medicines.
- Drug cupboards on the Neuro-Critical Care Unit were found unlocked, with medications left unsecured. This is against guidelines for the management and storage of medications outlined by the Royal Pharmaceutical Society. This has been placed on the risk register (classified a green risk), with an explanation attached that urgent medications needed to be easily accessible to nurses, that use of key cupboards could potentially delay access to time-critical medications and that the area was constantly visually overseen by staff. A plan has been put in place to allow swipe card access to a locked room with medications stored in it. This had not been actioned at the time of inspection.
- Controlled drugs were not being regularly checked on the Intensive Care Unit. The trust standard was for records to be updated weekly until a month before our inspection, when the guidance was updated to daily checks. We reviewed the controlled drug register book for January to April 2015 and found regular gaps in updating the book. Between January and March 2015 the book was only being updated fortnightly. From 22 March, the book was updated once a week. One senior nurse we spoke to said that when they were busy the checks on controlled drugs would often get missed.

Records

- All clinical and nursing notes were documented electronically on the EPIC system. All members of the multidisciplinary team put their notes on the platform, allowing for ease of access and review of notes.
- All notes were time-stamped and carried the electronic signature of the person making them, allowing easy identification of prescribers and team members.
- We reviewed 14 sets of records and saw consistent documentation of nursing notes, including risk assessments and daily progress of a patient's clinical state. Admission assessments of a patient's nutritional state and pressure areas were consistently completed.
- Clinical notes included daily documentation of ward rounds, assessment of fluid status, review of sedation and evidence of input from the multidisciplinary team.
- Doctors told us that there was no standardised admission documentation or a form for use on daily ward rounds. Various clinicians had developed their own forms for assessment of patients. However the trust informed us that there was a standardised medical admission form on the IT system.

Safeguarding

- All staff were required to complete adult safeguarding training. All nursing staff and 88% of medical staff on the Intensive Care Unit had done so (compared with a trust standard of 90%). On the Neuro-Critical Care Unit 82% of nursing staff and 89% of medical staff had completed safeguarding training. Junior doctors had safeguarding training included within their trust-wide induction.
- The nurse educator accepted that completion rate for safeguarding training was below the trust standard, and said plans have been put in place to ensure that the standard was met by June 2015.
- Nursing staff were able to explain clearly processes for identification and escalation of patients likely to be at risk of safeguarding concerns. The Critical Care Unit had clear links with the safeguarding team to escalate such issues. However, on the Neuro-Critical Care Unit we identified a safeguarding concern relating to a patient, which the team had not considered. This patient's case was notified to the trust's safeguarding team, who took appropriate action.

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- We reviewed the documentation of a patient who had been identified by staff as being the subject of safeguarding concerns and confirmed the appropriate escalation and review of this patient.

Mandatory training

- All staff Intensive Care and Neuro-Critical Care Units (including doctors, nurses, allied health professionals and administrative staff) were required to complete mandatory training including equality and diversity, conflict resolution, health and safety, information governance, infection control, moving and handling, and resuscitation.
- Completion rates of a majority of training met the trust standard of 90% or were close to this target. However, training in the resuscitation modules was below the trust target for medical staff (82% of staff trained on the Intensive Care and Neuro-Critical Care Units).
- Practice development nurses monitored the uptake of mandatory training and dates had been allocated to staff not meeting the requirements. Nursing staff told us that mandatory training was given priority, and they were given time off the ward to complete it.

Assessing and responding to patient risk

- Observations were documented electronically for all patients on both the Intensive Care and Neuro-Critical Care Units. The software automatically calculated an early warning score and would flag up patients at risk to the staff providing care. The electronic system could be reviewed remotely by the Rapid Response Team, who could provide support when needed.
- Doctors in the consultant and junior doctor focus groups spoke highly of the service offered by the Critical Care Rapid Response Team. The team comprised a nurse and a doctor who provided outreach on to all adult wards 24 hours a day.
- There was good dialogue between clinical areas and the Intensive Care Unit regarding escalation of patient care relating to deteriorating conditions. We were provided with examples of cases from various services, including maternity, where appropriate actions were taken.
- We examined the notes of a patient on the liver unit and another with sepsis who had escalated early warning scores. The management of both patients was appropriate, with increased frequency of observations and timely moves to the Intermediate Dependency Area.

- The resuscitation officers would review the notes of all patients who had a cardiac arrest and would de-brief with the team if they felt that there was a deterioration in their clinical state that could have been picked up earlier. They encouraged staff to report these as incidents. This data is also collated and presented regularly at governance meetings in Critical Care and across the hospital, where relevant.
- Proactive decisions were made on the critical care units of ceilings of care for patients and this was discussed with relatives. We saw evidence of this whilst on site, with appropriate ceilings of care and a discussion around a patients' resuscitation status during the inspection.

Nursing staffing

- Significant concerns were raised by the nursing and medical staff about the staffing and skill mix, predominantly on the Intensive Care Unit and also on the Neuro-Critical Care Unit.
- The Intensive Care Unit nursing establishment was planned for 15 level three patients (requiring advanced airway support or support of two or more organs) and five level two patients (requiring single organ support). The Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units (Edition 1) recommends that each level three patient should have one-to-one nursing, and level two patients should have one-to-two nursing. In addition, for a 20-bedded unit, two supernumerary nurses should take on a leadership role within the department. The planned establishment for the Intensive Care Unit was 19 nurses (including the two supernumerary nurses).
- The acuity (level of need for care) of patients was assessed three times a day by the matron and staffing reviewed accordingly. When shortages were identified nursing staff from other units in Critical Care were moved to minimise the risk. We saw evidence of this during the inspection, with a nurse from the Neuro-Critical Care Unit being sent to the Intensive Care Unit. Staff worked collaboratively across all the Critical Care units to ensure adequate staffing when possible but resources were limited.
- Due to long term sickness and maternity leave, the department had not been staffed at establishment for a

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number of months before our inspection. This had been raised with management consistently by senior nurses, resulting in the recent appointment of five band 5 nurses to bring the establishment back to 19.

- The increased demand on the Intensive Care Unit meant staff were regularly nursing more than 15 level three patients, requiring the team to do what they describe as 'care group' patients between nursing staff. 'Care grouping' was a process where three trained nurses and one support staff member would care for four patients between them.
- We were informed that where possible this was mitigated by care grouping patients in the open bays but this could leave one nurse looking after more than one level three patient. There was no risk assessment, policy, procedure or agreement from the executive team for this practice to be undertaken.
- One member of staff told us that they consistently felt under staffed and were care grouping patients at least two to three times a week. They felt that if the numbers were not increased, care would "tip over" to being unsafe. Staff had completed six incident forms on this in 2014, up from three in 2013.
- The Intensive Care Unit was unable to meet the standard of two supernumerary nurses on a shift, meaning a lack of senior oversight and support for the staff. There was always one supernumerary nurse on shift but this was often at the expense of identifying patients to be care grouped in order to free a senior nurse to provide supervision. Senior nurses on the second floor were always allocated a patient to look after. They raised concerns that this did not allow them to have sufficient oversight of other patients in the area.
- There was minimal agency staff use in Intensive Care or Neuro-Critical Care. Staff on the unit enrolled on to the trust bank and filled in shifts that were vacant. However, the number of hours being worked on the bank by staff was not being monitored by the trust.
- Departmental orientation checklists were used to enable new staff to familiarise themselves with emergency equipment and medicines.
- On the Neuro-Critical Care Unit establishment was set at 22 nurses and three health care assistants for the 23 patients. Allocation was set at four nurses to look after six level 2 patients on the Trauma high dependency unit (including one nurse functioning in a supernumerary role) and dedicated nurses for the side rooms on Neuro-Critical Care Unit with care grouping of three nurses to four patients on the open bays.
- During our inspection we saw a ventilated patient being looked after by a health care assistant in the annexe area of the department while a nurse was taking a break. The health care assistant told us that this was not common, and that they were only looking after this patient as they were stable. This was escalated to the charge nurse, who informed us that leaving such a patient with a health care assistant was unacceptable.
- We were informed by the senior management team that it was not common practice for health care assistants on the Intensive Care Unit. However we were informed by four staff that on the John Farnham Unit that health care assistants routinely cared for patients' while nurses were on other tasks or on breaks and that they were instructed to call if they needed help.
- We were told of a clinical incident on the Neuro-Critical Care Unit in 2013 where a patient did not have neurological specific observations performed overnight on the unit. During the night the patient's neurological function deteriorated markedly, without this being identified. The incident was reviewed thoroughly and on root cause analysis it was felt to be partially attributable to care grouping of patients as well as other concerns.
- During the inspection we found that the senior management team had no effective systems and processes to match patient dependency and with safe numbers of staff despite concerns being raised by staff. Systems did not allow any flexibility to respond to increased demand from patient conditions and therefore placed patients at risk of harm.
- The Rapid Response Team was well staffed, with ten whole-time-equivalent staff (a combination of band 6 and 7 nurses). On a daily basis, two nurses and one doctor provided support to the entire hospital.
- We raised our concerns about the nursing staff to patient dependency ratio to the chief nurse and chief executive during our inspection. They said they would be reviewing their staffing establishment in May 2015.
- Following our inspection the Chief Nurse and nursing team reviewed the staffing levels versus patient dependency on both the Neuro-Critical Care Unit and the Intensive Care Unit for the three months before our inspection. The trust acknowledged through this review that the number of occasions where reduced numbers

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of registered nurses to provide care to level three patients that resulted in 'care grouping' was higher than they would consider acceptable. The inspection team found that the concerns were more prevalent on the Intensive Care Unit as the Neuro-Critical Care Unit was better staffed.

- On the Intensive Care Unit in February 2015 there was an insufficient number of staff on 22 of the 28 days, with 55 of 84 shifts (early, late or night) not staffed in line with Intensive Care Society guidelines to provide one-to-one care to level three patients. The same circumstances applied in March 2015 on 36 shifts over 17 days and up to 19 April 2015 on 46 shifts over 19 days. This resulted in 'care grouping' of patients.
- On the Neuro-Critical Care Unit in February 2015 there was an insufficient number of staff on eight days with 16 shifts (early, late or night) not staffed in line with Intensive Care Society guidelines to provide one-to-one care to level three patients. The same circumstances applied in March 2015 on 26 shifts over 12 days and up to 19 April 2015 on 13 shifts over eight days. This resulted in the 'care grouping' of patients.

Medical staffing

- Medical staffing in all Critical Care units was provided in line with Critical Care standards.
- Eleven consultants worked in five-day block patterns on the Intensive Care Unit, ensuring continuity of care. An additional consultant would also work a short day and cover the night shifts. A 12th consultant had recently been appointed and was due to start work in September.
- Consultants conducted a ward round twice a day and were free from other clinical commitments whilst working on the unit.
- Consultants were supported by specialist trainees, clinical fellows and foundation year doctors on the unit.
- At night, two dedicated registrar grade doctors covered the Neuro-Critical Care Unit and two covered the Intensive Care Unit. In addition, there was one registrar who was part of the Rapid Response Team who was available to support either team.
- There was always a practitioner with advanced airway skills present on the unit. Where the doctor on call did not have advanced airway skills, support was provided by the anaesthetic team.
- On the Neuro-Critical Care Unit, consultant cover was provided by two consultants through the day and one at

night. Consultant cover during the day was not being provided in a block pattern but continuity was maintained through effective handover between consultants.

- We confirmed through discussion with the clinical leads for both units that all consultants had received advanced training in intensive care medicine.
- Nursing and medical handover took place jointly on a daily basis and was structured, including details of the patient's admission, allergies, clinical progress, clinical plans and a review of pressure points. Patients with difficult airways were clearly signposted during handover and with a sign over the patient's bed.
- Medical handovers between doctors took place twice a day.

Major incident awareness and training

- The trust has a major incident plan, including plans for the provision of additional Critical Care beds where required.
- There was a local emergency preparedness and response policy, which included a flow chart for the Critical Care unit. This was in line with the trust's major incident policy.

Are critical care services effective?

Good



The effectiveness of the critical care service was good despite the trust had problems with the completeness of ICNARC data which had been not been submitted for two years. There was some local mitigation, through the collection of critical care minimum data sets; however, they were unable to benchmark their data against other units over this period.

The critical care minimum data sets showed a lower than expected risk adjusted mortality for the Neuro-Critical Care Unit and a risk adjusted mortality within acceptable range for the Intensive Care Unit. The critical care units were compliant with national guidelines including National Institute for Health and Care Excellence (NICE) guidelines, Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines and the use of care bundles. These were

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audited regularly, with good evidence of compliance. There was a strong focus on the early identification, assessment and treatment of patients with sepsis and the role of rapid response team was effective in managing these patients.

The online education resource developed within the Neuro-Critical Care Unit is seen as an example of outstanding practice. The Neuro-Critical Care Unit team had a built an online educational platform which was made available to all local trainees and to trainees nationally and internationally. Best practice guidelines, including regular journal clubs to review new evidence for best practice was held on this website and was available for local, national and international trainees.

We saw a strong ethos of multidisciplinary working amongst all members of the team within critical care. Staff worked collaboratively, supporting each other on a daily basis in delivering care. There was regular access to allied health professional staff during the week, however this service was not being provided over the weekends. Both units were supported by a pro-active nutritional team who reviewed all patients and provided dietician input. Additionally, they carried out regular audits across the units and produced newsletters highlighting areas for improvement of practice. Work done had been presented nationally at conferences and had won awards.

A recent recruitment campaign had helped increase the nursing numbers, but left a more dilute skill mix with 40% of nursing on the John Farman Intensive Care Unit and 47% on the Neuro-Critical Care Unit completing their certificate in critical care. Funding and the ability to release staff on training were seen as the major challenges in achieving the national standard of 50%. New staff were supported on starting work in the unit, with a dedicated mentor identified to aide induction and training.

All patients admitted on to the NCCU received a capacity assessment, and decisions on their care taken accordingly in line with legislation.

Evidence-based care and treatment

- Care within the intensive care units was being provided in line with best practice guidelines with care bundles including ventilator care bundles and central line care bundles in use.
- Use of care bundles was audited and showed 81% compliance with the use of ventilator care bundle. The various care bundles have been incorporated electronically on to the trust electronic record system.
- All patients admitted to critical care received an assessment on rehabilitation requirements in line with the NICE Clinical Guidance 83 – ‘rehabilitation after a critical illness’.
- The NICE Rehabilitation after critical illness audit in 2014 showed that 100% of patients at risk of physical and non-physical morbidity received a comprehensive clinical assessment and had a subsequent structured rehabilitation program prescribed including short and medium term goals. These goals were agreed with the patient prior to discharge. The audit did find however those patients were not being provided written information on discharge. As a result all patients are to be given a copy of the ‘ICU Steps’ booklet and an exercise diary on discharge along with their discharge summary. This was due to be implemented shortly.
- We saw evidence of a review of the most recent AAGBI guidelines at the clinical governance meeting in March 2015, confirming a move to invasive blood pressure readings at the ear level to allow an accurate measurement of blood flow to the brain. An observational audit was carried out in April 2015 which showed 100% compliance with the recommendations.
- We reviewed the notes of a patient with sepsis on the medical ward. Care was given in line with best practice guidelines with the entire sepsis 6 bundle completed. The patient was escalated to the critical care outreach team and the patient was moved in a timely fashion to the Intermediate Dependency Area for further management. A retrospective audit of antibiotic therapy for sepsis in the Intensive Care Unit is currently underway.
- The Neuro-Critical Care Unit team had a built an online educational platform which was made available to all local trainees and to trainees nationally and internationally. Best practice guidelines, including regular journal clubs to review new evidence for best practice was held on this website. Innovative ways to approach journal reviews, via means of a blog had been trialled and received excellent feedback. A registrar, who had trained abroad, told of us that he had used this website prior to coming into the country.

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- All patients who were potential organ donors were contacted by a specialist nurse in organ donation. A review of referrals and the case mix on Neuro-Critical Care Unit revealed that 100% of patients eligible to be donor's had been contacted by the nurse.

Pain relief

- A standardised pain tool was used for the assessment of a patient's pain on the ward. Patients requiring analgesia were provided this in a timely fashion.
- We saw evidence of the pain tool in use and the subsequent prescriptions of analgesia to support this.
- The critical care unit was supported by the pain team. Though the service was not provided out-of-hours or over the weekends, staff reported that they received sufficient support from the service.
- Relatives of two patients we spoke to felt that sufficient importance was given to the pain management of their next of kin.

Nutrition and hydration

- The critical care service had access to a dedicated dietician. We examined the records of 15 patients across critical care and saw that all patients had been assessed for the risk of malnutrition on admission. Audits of the nutrition screening tool were carried out by the nutrition team and results shared to raise awareness of the importance of regularly weighing patients on the Intermediate Dependency Area.
- The dietician worked closely with the nursing staff and doctors to identify nutritional requirements of patients. Patients requiring nutritional support had prompt access to emergency feeds and bespoke feeds to meet their nutritional requirements.
- Strict fluid monitoring systems were in place to monitor the amount of fluid given to patients and their hydration status was reviewed daily on the ward round.
- The nutrition team carried out an audit to compare practices of feeding critically unwell patients and compared the Neuro-Critical Care Unit and Intensive Care Unit. Results from this audit were presented and received national recognition and the results heightened awareness of feeding and fasting practices on both units. They also produce regular newsletters to promote education in the department with issues such as feed interruptions and a summary of recent research, critical care protocols and service improvements highlighted.

Patient outcomes

- The critical care department last submitted data to the Intensive Care National Audit and Research Centre (ICNARC) case mix program in 2012/2013. The trust had problems with the completeness of ICNARC data which had not been submitted for two years. Locally there was some mitigation in the collection of local data sets. This meant that there was no benchmarking of the unit in comparison to similar sized units in other trusts.
- We were informed that the reason for non-submission was due to staff changes and secondments around the new electronic records system. The data collection within both critical care units was therefore not collated during this period and staff were not confident of the quality of the data being collected.
- The trust had started submitting data to ICNARC in December 2014. The first report from ICNARC would be available to the trust around May 2015.
- The units were collecting the critical care minimum data set which allowed the units to review patient mortality, re-admissions within 48 hours and the median length of stay over this period. There was no trend analysis done on this data and no thematic reviews performed on the reasons for re-admission. Risk adjusted mortality during the entire two year period remained low on the Neuro-Critical Care Unit (0.56) and within an expected range on the Intensive Care Unit (0.94). In March 2015, the median length of stay on the John Farman Intensive Care Unit was 3.75 days and on NCCU was 4 days (national average of 5 days).

Competent staff

- The education, training and development of nursing and health care assistant staff across the 3 critical care units (Neuro-Critical Care Unit, Intensive Care and the Intermediate Dependency Area) is supported by a critical care practice development team, led by a senior education nursing lead and supported by practice development nurses on each unit. There are 7.5 whole time equivalent clinical educators to support staff across all units which is more than the national average.
- The Intensive Care Unit and Neuro-Critical Care Unit do not currently meet the core standard of 50% of registered nurses having a recognised critical care course. 40% of nursing on the JF unit and 47% on the Neuro-Critical Care Unit had completed their certificate in critical care. Funding and the ability to release staff on

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training were seen as the major challenges in achieving the national standard of 50%. The recent recruitment campaign has helped bolster the nursing establishment, but has left staff with a more dilute skill mix.

- All new staff undertake a foundation in intensive care programme during their first year. Prior to commencing shifts, all new nurses are supported through a period of being supernumerary on the rota with a designated mentor. New band 5 nurses have a 3 month preceptorship course. Nurses recruited from other ward areas without critical care skills are supernumerary for a month and nurses with known competence in critical care, for 2 weeks.
- We spoke to a recently qualified band 5 nurse, who confirmed this process and was complimentary of the support they had received when they started working on the unit.
- There was a drive to promote leadership within senior nurses, who were given opportunities to do education courses, mentorship training and formal management and leadership courses.
- Staff on the Neuro-Critical Care Unit have access to an advanced trauma workshop, which had been endorsed by an associated university.
- All new Healthcare Assistants (HCA's) within critical care are now required to complete the 'Care Certificate' in line with the recommendations from the Cavendish report and Health Education England. Existing HCA's are provided training through modules in infection control training, confidentiality and nutrition.
- All staff we spoke to have either an up to date appraisal, or had one booked in. Staff were encouraged to identify their learning needs and these were discussed during the meetings.
- Junior doctors were appointed an educational supervisor who appraised their performance during placements. Data from the annual GMC survey shows supervision provided for junior doctors in line with national averages.
- All consultants on both units had regular appraisals done locally and were up to date or had a date set for re-validation.

Multidisciplinary working

- We observed collaborative working within the multidisciplinary team. Nursing staff attended the morning handover with the doctors and the entire multi-disciplinary team had a daily meeting to discuss all the cases on the unit.
- Critical care pharmacists, microbiology teams and physiotherapists and occupational therapists attended the daily meeting, to provide their clinical input.
- The rapid response team provided a valuable outreach service into the wards to support the care of unstable patients on the ward and to provide follow up for patients recently discharged from critical care.
- The Intermediate Dependency Area worked as an open unit, allowing various specialities to transfer patients for increased monitoring on the unit. Patients on IDA would remain under the care of the consultant under whom they were admitted to hospital and would continue to be reviewed regularly by them.
- The rapid response team were available to provide support to nursing and medical staff for these patients, providing an easy pathway for critical care review, and admission, when necessary.

Seven-day services

- Critical care services were consultant led seven days of the week on the Intensive Care Unit and Neuro-Critical Care Unit. All patients were reviewed twice daily, on all days of the week.
- The rapid response team was led clinically by a middle grade doctor and an outreach nurse with training in critical care. This service was provided 24/7. There are plans to make this service consultant led, seven days a week, from September 2015 when a newly appointed consultant will commence their contract.
- Physiotherapists worked a dedicated critical care rota, five days a week. There was no routine access to physiotherapy services over the weekend. However, if a physiotherapist was urgently required, the on-call physiotherapist (who covered the rest of the hospital) could be paged for assistance.
- Pharmacy services within critical care also provide a five-day service. Consultant Leads on the JF Unit recognised a need to have seven-day services. An emergency supply and advice service is available via the on-call pharmacist outside of pharmacy opening hours and via the inpatient dispensary services at weekends and bank holidays.

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- Radiology services, including access to urgent CT scans were available 24/7. Staff on Neuro-Critical Care Unit spoke highly of the service provided by the radiology team.

Access to information

- All patients admitted on to the critical care unit had their medications reviewed by the pharmacist and compared to the medications they were on, prior to admission. A robust process of data sharing had been established with general practitioners in the local community to ensure that information required for the management of patients was available.
- All patient discharged from the unit had a detailed discharge summary completed, outlining key events on the unit and outstanding issues requiring management.
- All patients admitted on to the unit were offered a follow up appointment on discharge. Results from this review were shared with the general practitioner, including information regarding the psychological well-being of the patient in order to aid on going management within the community.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards)

- All patients admitted on to Neuro-Critical Care Unit received a formal mental capacity act assessment. Patients who were found, not to have capacity to make decisions had decisions made in their best interest (if the treatment was seen to be lifesaving).
- We saw evidence of a patient who had a head injury who, during the observation period, wanted to leave the department. A formal capacity assessment showed that they did not have the capacity to make a decision regarding discharge. A second opinion was sought from the psychiatry team, following which deprivation of liberty safeguard was appropriately put in place.
- Where possible, when a patient lacked capacity, family were involved early in the decision making process to ensure that they were involved in all decisions taken.

Are critical care services caring?

Outstanding



Overall we rated caring throughout the critical care service as outstanding. Whilst staff shortages to provide care were

frequent staff were dedicated to providing compassionate care to patients. Staff were regularly seen to be going the extra mile to provide care to patients and considered providing good care to patients and their relatives their highest priority. We found staff to visibly compassionate, with widespread examples of good care including talking to patients and explaining procedures, even if heavily sedated.

Relatives were welcomed on the ward and their role in looking after patients was recognised by staff. Carers were encouraged to help looking after patients, if they wished to and medical and clinical staff alike took the time to ensure carers were kept abreast of progress in their loved one's condition.

Staff were insightful on the emotional impact of admission on to critical care for patients and carer's alike. We saw examples of staff calling relatives at home to check on their wellbeing and when a relative was dying the staff who had the relationship with the family stayed until they were ready for them to go despite their shift finishing hours earlier. Patients and carer's alike were very complimentary of the dedication and compassion shown by staff in providing care.

We shadowed a nurse during a consultation with a patient in the follow up clinic. The impact nightmares were having on the patient's health were explored and recommendations for further psychological support made.

Compassionate care

- Staff were compassionate and caring towards all patients. We saw staff talking to patients, even if they were heavily sedated to explain all aspects of care being delivered.
- Even though they were restricted on the amount of time they could spend with patients when activity was high, members of the team identified with the caring aspects of their job as a high priority in delivering patient care. This was visible in the staff interactions with patients and relatives.
- We observed staff taking time to communicate with a patient who was too unwell to talk; staff interpreted their facial expressions and provided care accordingly.
- Curtains were drawn when providing personal care and staff always introduced themselves to patients prior to delivering care, even if they were sedated. Mouth-care was provided regularly for all patients.

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- We observed multiple examples of very caring staff and doctors on the Intermediate dependency area, including one doctor who stopped to re-arrange a patient's bed space to ensure that she could reach her call buzzer.
- We observed only one poor example of caring on the Intermediate Dependency Area, when a doctor walked into a cubicle which had curtains drawn around it with junior doctors and proceeded to have a short conversation with a patient who was on the commode. The patient's privacy and dignity was not respected and the conversation uncaring, simply stating that the patient was going to be stepped down from the Intermediate Dependency Area to a ward. We observed after this that the medical staff from the unit went to speak with the surgical team about their behaviour and addressed the situation immediately.
- On the Intermediate Dependency Area, we saw staff assisting patients feeding and drinking. They were patient and unhurried and engaged in conversation with the patients throughout the interaction.
- One patient's relative told us that when staff heard a patient being referred to by an alternative name that a patient liked being called by, they made a note of it and ensured other members of the team were aware of this.
- Feedback from patients through follow up clinics and questionnaires highlighted staff going the extra mile, with one patient writing "thank you for the wonderful care, especially the hair wash".
- On the Neuro-Critical Care Unit, we saw staff explaining to relatives the need to shave the hair off a young woman to facilitate surgery and to explain what she might look like when they next came to visit her, post operatively.
- Relatives were encouraged to help nursing staff with basic care, if they wanted to do so. We saw evidence of a patient's relative staying with them when they were being rolled, and constantly talking to her and re-assuring her through the process.
- One relative informed us of their experience in highlighting to staff that they felt that their relative's lips were dry and cracked and that afternoon and they observed the nurses applying lip balm to the patient. They highlighted the staff's responsiveness to their concerns in their feedback to us.

Emotional support

Understanding and involvement of patients and those close to them

- We saw staff taking time to welcome relatives on to the wards and provide detailed updates on the progress in the care of their loved one. They avoided technical jargon during the explanation, checked understanding and were patient with questions asked. Relatives told us that they were, "made to feel welcome" when they visited, and were, "well looked after by very caring staff".
- We were also told about how staff took time to explain every procedure to them, as well as to the patient (even though they were unconscious) and would tell relatives what they should expect to see when they next came back.
- Staff on all 3 units spoke to us, around the emotional impact of admission to critical care on the mental health for patients and carers. They told us about the importance on the one-to-one interaction and recognised their role in supporting patients and families during their admission.
- A relative on the Neuro-Critical Care Unit, with a background in healthcare, praised the staff on the unit and shared their experience of conversations with doctors and nurses on the telephone and in person from the time they arrived on the unit to now. They shared that staff spoke with them in an unhurried and patient manner and that staff gave them "all the time they needed" to understand the events leading to admission and to ask questions.
- Another relative shared how staff had called them pro-actively when their relative was admitted to check on their wellbeing and ensure that they were okay.
- We sat in with the lead nurse during the follow up appointment of a recently discharged patient. With the aide of the patient's diary, the nurse re-visited the patient's stay on the unit. The nurse had detailed discussions with the patient on their emotional health, and the impact of recurrent nightmares on their well-being. A detailed discharge letter was provided to the patient's general practitioner, recommending further psychological support for the patient.
- The nurse told us, that they had put forward a plan for dedicated psychological support with the clinic and was hopeful that this would be implemented in the near

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future. The patient was very complimentary of the clinic interaction and told us that they were “very glad” that they came for the appointment, and praised the critical care team for their attention to detail in providing care.

Are critical care services responsive?

Requires improvement



Overall, we rated the responsiveness of the critical care to the individual patient's needs as requiring improvement because there was a high bed occupancy across critical care with delays in the discharge of one in three patients admitted to critical care. As a result, patients were being discharged out of the unit during the night from both the Intensive Care Unit and Neuro-Critical Care Unit. There was a poor flow through the hospital which contributed to the delayed discharges from the unit due to a lack of bed capacity throughout the hospital. Patients discharged out-of-hours were reviewed by the rapid response team on the ward on the same night of discharge with continued reviews the following day. Whilst we found no evidence of high bed occupancy and delayed discharges having a significant impact on elective or emergency admissions to either unit, they did have an impact on patient experience, which was well recognised by staff and senior management alike and was on the risk register.

We saw examples of the modification of services offered to meet the needs of local people, captured through twice yearly focus groups. Through this focus group, real change had been implemented including improving the transition of care from Intensive Care Unit to the ward, establishment of a quiet/interview room for doctors to speak to relatives on the Neuro-Critical Care Unit, re-design of the relative's room and the design and pilot of an application for a mobile tablet to help patients with a tracheostomy in place to communicate.

Patients discharged from the critical care unit were invited to a follow up clinic to review their progress. A summary of this consultation is then provided to the patient's general practitioner to facilitate on-going care within the community. Through the use of patient diaries, staff were able to document the patient journey through critical care. This was reviewed during their follow up appointment to aide memory and recall.

We saw innovative practices aimed at helping patients communicate with staff including trolleys with various communication aides like letter boards, pictures, words and the aforementioned mobile tablet application. Relatives visiting their loved ones in hospital were allowed flexible visiting hours and given discounts coupons for parking charges.

Patient complaints were dealt with promptly through organised meetings with the patient liaison team and written replies back to patients.

Service planning and delivery to meet the needs of local people

- Staff and patients on the unit worked collaboratively to identify the needs of local people and design services to correspond to this. An interview/quiet room had recently been fitted on the premises within the Neuro-Critical Care Unit to provide a private environment for staff to speak to relatives. The relative's room was also refurbished to ensure comfortable seating for carer's.
- On the Intensive Care Unit, a junior doctor jointly developed an application for a mobile tablet called “My ICU Voice” to enable patients who had a tracheostomy in place to communicate with staff. Funding for the tablets was jointly secured through the trust and through a charitable donation. We saw the use of this application during our inspection which was an example of outstanding practice in response to patient needs.
- One relative shared with us that they found the “fact sheets” that had been printed out and left for relatives in their waiting room as helpful and informative for them during their time in critical care.

Meeting people's individual needs

- The unit had good links with the learning disabilities nurse. The nurse was being called pro-actively when a patient was identified to have a learning disability and an individualised care plan being formulated as a result. We observed this on the Intensive Care Unit where the staff identified that a person who had come to them unconscious had woken up and staff recognised that they had a learning disability and would require the support of the specialist nurse.
- All patients on the Intensive Care Unit and Neuro-Critical Care Unit were asked to complete a depression scoring

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tool during their rehabilitation period to identify specialist requirements in a timely manner. Patients who were identified as requiring further assessment were referred to the psychiatry team and their progress was reviewed during the follow up clinics.

- Patients were invited to a follow up clinic with plans in place to include a clinical psychologist within the service offered. We followed patients through this service and found it to be an extremely well run service. Feedback was collated within the clinic and was very positive and detailed the caring nature of the nurse running it and the support they have received as a result.
- Patient diaries were developed across the service. Staff filled in details of daily events, which patients got to take home. This helped patients orientate themselves with the care they were provided and featured strongly in the positive feedback received. The patient diaries were reviewed during their follow up clinic appointment.
- The Speech and Language Therapy team (SALT) had designed and implemented a trolley system that contained various communication aides to help patients communicate with staff. This included letter boards, individual alphabets, words and pictures.
- Within this trolley there were different types of call buzzers that patients could use to alert staff to particular needs. For example, on Neuro-Critical Care Unit, a buzzer was developed to be attached on to the side of a patient's head, if they had lost function of their arms.
- On both critical care units, staff were flexible about visiting times. Relatives told us that, on the day of admission they were allowed to be with their loved one all through the night. They never felt pressured to leave the ward and were provided refreshments through the night.
- Relatives of patients admitted to hospital were also given car parking discounts to allow for them to visit their relatives more frequently.
- Patients were offered a variety of meals on the Intermediate Dependency Area to meet specific dietary requirements. For example, we saw patients being offered Halal and Kosher meals on request.
- Length of stay and delayed discharges had a significant impact on the flow of patients from the critical care unit. The hospital bed occupancy was at 98% at the time of our inspection which impacted on the timely discharges of patients to the ward areas. .
- Trust wide, length of stay for patients and delayed discharges was seen as a significant risk to flow. This was having an adverse impact on the critical care unit with more than 1 in 3 patients on both units having a delay in discharge over the calendar year in 2014. Thrice a day, the bed capacity was reviewed trust wide and on the critical care units. . Patients on the unit ready for discharge were identified early; however this was not having a significant impact on aiding patient flow.
- Bed occupancy for the critical care service was high. In March 2015, bed occupancy on the Intensive Care Unit was 93% and 95% on the Neuro-Critical Care Unit. In February, the average occupancy was 113% on the Intensive Care Unit and 109% on Neuro-Critical Care Unit. This meant that patients were occasionally being provided care by the critical care team in areas outside of the critical care unit.
- Data was being collected locally to ascertain the impact on of bed occupancy on delays in admission of patients on to the unit and cancellations of operations owing to lack of critical care beds. During January and February 2015, the Intensive Care Unit had 14 elective admissions in each month. There were no cancellations of any elective surgery in either month owing to an unavailability of beds.
- During the last six months, two emergency surgical procedures were cancelled owing to the lack of availability of a critical care bed. Data reviewed between February and March 2015 showed there were 152 patients admitted to the Intensive Care Unit. All of these patients were admitted within four hours of a decision taken to admit, in line with the Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units (Edition 1) standards. In April, two patients have had to wait longer than four hours for admission. On the Neuro-Critical Care Unit, 163 patients were admitted in February and March 2015. All patients were admitted within four hours of a decision to admit. In December 2014, it was documented in the admissions book that one patient had to wait for 18 hours in the emergency department for admission and one patient waited for four hours in January. The trust clarified that

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on review of the patients' medical records they believed that the patient only waited for two hours once the decision had been made to admit to an intensive care bed..

- An internal audit was carried out within the Intensive Care Unit between January to March 2014. The notes of 102 patients were reviewed. The median time to admission to the JF unit from referral was 102 minutes.
- As a result of the difficulties in flow, patients were also being discharged later on in the day. In March 2015, 16 out of 65 patients (25%) on the Neuro-Critical Care Unit and 15 out of 54 (28%) were discharged between 22:00 and 07:59. In February, 36% of patients on the Neuro-Critical Care Unit and 21% on the Intensive Care Unit were discharged out of hours. .
- Patients discharged out-of-hours were reviewed by the rapid response team on the ward on the same night of discharge with continued reviews the following day. However the delays overnight did have an impact on patient experience, which was well recognised by staff and senior management alike and was on the risk register.
- In March 2015, there were three non-clinical transfers out from the Neuro-Critical Care Unit to the John Farman Unit. There were no non-clinical transfers from the Intensive Care Unit in this month.

Learning from complaints and concerns

- Over the last year, critical care services at Addenbrooke's hospital have received only one formal written complaint. Feedback, provided informally to the department included anxiety around the discharge process for patients and the transition to ward based care. In response to this, the staff have started planning discharges in advance including preparing patients for the transition to ward based care.
- Complaints that came through the Patient Advice and Liaison service (PALs) were flagged up to the consultant staff and would have a lead nurse and doctor assigned to the complaint. Meetings were organised with the family to attempt local resolution. Minutes were taken during these meetings and a formal written response provided to the families.

Are critical care services well-led?

Requires improvement



Whilst we found strong leadership at ward level, there was a clear disconnect between the local leadership and leadership at divisional management level and between the division and the executive team. There was a drive from the executive team to devolve leadership responsibilities to the divisional level. This resulted in a significant re-structure of the leadership to critical care services. Whilst progress has been made, the critical care lead recognised that there was more work to be done with shared learning and consistency within the governance processes of both units. A new clinical director had been appointed to the Intensive Care Unit to improve inter-departmental working.

The nurse staffing issues and lack of data submission to the ICNARC case mix program had been escalated at divisional meetings but presentations had not been made at board level. However, over a period of 2 years, neither issue had been appropriately responded to and ultimately there was a risk to patients and staff within the service and to the contracting of intensive care services at Addenbrooke's hospital with in the absence of robust and comparable clinical outcome data. Both critical care units have since started submitting data to the case mix program, however staffing within the unit continues to remain a significant challenge

The nursing and medical staff displayed a strong culture of placing patient needs first was visible from all staff members. Staff described the team as "one family", who always looked to help and support one another. They did however acknowledge that the lack of staffing and the lack of importance given to this was having an effect on the morale of staff.

We found a strong culture of innovation and improvement within the department. Both critical care units had been and continue to be involved in a number of research studies, furthering the reputation of the hospital as a centre for cutting edge research. The online educational resource developed by the Neuro-Critical Care Unit team is seen as an example of outstanding practice with educational resources aimed not only at local trainees, but trainees

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nationally and internationally. Work done by the nutritional team around the management of multiple trauma patients has been presented at an international conference and won awards.

Clinical Governance meetings and business meetings were held regularly, and in various formats to engage all staff members. During these meetings a range of topics, including clinical incidents, risk assessments, feedback and complaints were reviewed with learning disseminated to the staff.

Vision and strategy for this service

- Medical and nursing staff spoke unanimously of recognising the trust's vision of 'Together –safe, kind and excellent' and applying this on a daily basis to the care they were providing. Staff on all units were committed to providing excellent care for patients and worked together collaboratively to achieve this.
- Going forward the clinical leads identified the need to improve the collaborative working between the critical care units through joint business meetings and clinical governance meetings. A new clinical director has been appointed for the JF unit with a primary objective to improve inter-departmental working.
- A new consultant with a research portfolio has been appointed to commence work in September 2015 with a view to help, the rapid response team aim to provide a seven day consultant led service and to improve the profile of research opportunities within critical care through the establishment of a lung injury lab.

Governance, risk management and quality measurement

- Business meetings are across the critical care service and the Intermediate Dependency Area fortnightly between senior clinicians and nurses and include a review of activity on the unit and identify any problems or concerns over the preceding fortnight with a forward look ahead to the upcoming fortnight. Staff found this a useful meeting to exchange ideas.
- Morbidity and mortality meetings were held 1-2 monthly and reviewed all the deaths on the JF and Neuro-Critical Care Unit. Minutes from the last meeting included discussions around the impact of human factors, the work environment and individual behaviour in the provision of care.

- Clinical Governance meeting were held quarterly, separately for the Neuro-Critical Care Unit and Intensive Care Unit. These were well attended by the clinical directors, senior clinicians, matron, senior nurses and operational managers within the division.
- During each meeting, there was a review of clinical incidents, risk assessments and the risk register, feedback from the most recent patient focus group, a review of morbidity and mortality within the services and a review of education and training provision.
- Concerns from these meetings are taken forward via the risk register and actions are reviewed monthly, with evidence of actions being completed and risks mitigated and reduced. There was however, minimal sharing of learning between the two units providing critical care services. There was recognition at the divisional level that this was required, however this had not been put into place.

Leadership of service

- We found evidence of strong leadership at the local level on the Intermediate Dependency Area, Neuro-Critical Care Unit and Intensive Care Unit, but staff expressed frustration of escalating issues through the clinical division to get action. We reviewed examples of concerns relating to bed occupancy, discharges, and staffing numbers which had been escalated with little or no action taken.
- Nurse staffing issues and lack of data submission to the ICNARC case mix program had been escalated at divisional meetings and presentations made at board level, however over a period of 2 years, neither issue received sufficient traction. Both critical care units have since started submitting data to the case mix programme. Issues regarding staffing had been consistently raised with senior management. Staff had identified the need for the nursing establishment to be increased to 22 whole time equivalent staff; however they were told that they would first need to recruit to existing vacancies and the staffing establishment would be reviewed in the bi-annual review, next in May 2015.
- During the implementation of the trust's electronic record system a decision was taken locally within critical care to send clinical, nursing and administrative staff to help in the design and implementation of the system. As a result, when the system was launched, the critical care unit staff were well trained and ready to make the move on to the new system.

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- The critical care unit had a higher turnover of nursing staff than they would have liked over the past year. Senior management worked with the human resources team to ensure all staff leaving had an exit interview. This identified that a majority of staff left to re-locate to another geographical area or to take up a more senior position.
- A staff well-being questionnaire identified staff stress as an issue. Regular debriefs with the staff were arranged post this questionnaire. Staff we spoke to recognised the work that had been done with regards to their well-being and were very complimentary of the educational opportunities and support they received. Since the questionnaire, staff retention has remained stable within the service.
- There was a drive at trust level to devolve leadership accountability and responsibilities to the divisional level. Prior to the move, clinical directors would individually be in charge of the Neuro-Critical Care Unit and Intensive Care Unit. With the appointment of a divisional team, clinical leads expressed a view that there was decreased access to the medical director as a result of the re-structuring. This was not seen to be negative, but acknowledged that the structure was still in its infancy and needed time to embed.
- The multi-disciplinary team worked effectively together, recognising the varying skill mix and working efficiently together. Staff from around the hospital identified the open culture within critical care and their willingness and approachability in helping out with patient care.
- Patients were very complimentary of the care provided and highlighted the strong teamwork within critical care in their feedback to us.
- There was an open culture with regards to staff feeling able to raise concerns they had about the service and they provided us with examples of when they had raised concerns they had about staffing or equipment with support from their managers. However there was a disconnect with staff raising concerns and those concerns being acted upon by the senior divisional management team.

Public and staff engagement

Culture within the service

- There was an open culture within the service with staff visibly placing the needs of the patient at heart of their work. This was visible amongst all staff members.
- Nurses and doctors supported one another and worked collaboratively to ensure provision of safe and effective care. Staff described the team as “one family”, who always looked to help and support one another. They did however acknowledge that the lack of staffing and the importance given to this was having an effect on the morale of staff.
- Staff felt frustrated and expressed concern that they were working very hard and were not able to regularly take breaks in their shifts without compromising patient safety. Senior nurses told us that the practice of care grouping was becoming “normal working” now, and they found this concerning as it “had been going on for a long time.”
- There was culture of learning within the department, with staff encouraged to report clinical incidents and evidence of learning from them.
- We saw examples of outstanding practice with the organisation of twice yearly focus groups within Neuro-Critical Care Unit and Intensive Care Unit to capture feedback from patients and relatives who had used the service. Feedback sessions for the service were well attended and feedback was that the service was highly rated amongst patients and relatives.
- Examples of feedback from the focus group included patients feeling ‘abandoned’ when they were discharged from the critical care service to the ward. As a result of this a new patient information sheet was developed to prepare patients and relatives for the transition to ward areas and a project group had been established to review transition for patients and relatives when they leave critical care.
- Concerns regarding the relatives’ room were also raised within this group, as a result of which a new interview/quiet room was fitted on the premises within Neuro-Critical Care Unit and the relatives’ room refurbished. Feedback post the refurbishment highlighted the good facilities made available for relatives.
- Nurses and doctors spoke very highly of the senior nurses on the ward and the consultants and identified the support they have received in providing care with limited resources. Senior nurses organised regular “Band 5” meetings to engage with junior nurses. Nurses highlighted the effectiveness of this meeting in voicing concerns and the support they received from senior staff to do so.







Critical care

- Staff were encouraged to contribute towards quality improvement within the department. We saw evidence of innovation and service improvement projects which were led by staff on the unit. Junior doctors had, in collaboration with patients, developed a communication aide to assist patients with a tracheostomy in situ to communicate their needs to staff.

Innovation, improvement and sustainability

- A full time nurse with a specialist interest in medical research had recently completed studies within the department including a study on the cost effectiveness of early nutritional support, the HARP 2 (a study to reduce the impact of acute lung injury) study, IMPRESS study (a study on lung cancer) and ISOC 2 study (a study into clotting disorders).
- The units were involved in a number of on-going studies including the LEOPARD (a study of sepsis), and PEACE (a study of kidney failure) studies showing their commitment towards research and development.
- Work done around the nutritional management of multiple trauma patients was presented at the international Society of Physical and rehabilitation medicine conference in 2014 and the team won a prize for this work.
- All units are required to submit data to the East of England Critical Care Network as an exercise in continuous improvement of services provided; however the service did not submit all the required data sets from the ICNARC programme. Within the group, there was exchange in performance data and information sharing across the educational leads from each hospital. Hospitals within the network worked collaboratively to share learning.

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

Information about the service

The Rosie Hospital is a purpose built women's and maternity hospital which is located adjacent to Addenbrooke's Hospital in Cambridge. The Rosie Hospital serves the local population of Cambridgeshire, extending to parts of North Essex, East Hertfordshire, Suffolk and Bedfordshire, and specialist services in high risk obstetrics and fetal and maternal medicine are provided to the whole of the eastern region. Women's and maternity services are provided under one directorate, led by a divisional director, supported by a divisional lead nurse, and associate director of operations, divisional finance lead and a divisional workforce lead.

Women's services include general, emergency and specialist gynaecology services delivered from an inpatient gynaecology ward (Daphne ward) and numerous outpatient gynaecology clinics. Maternity services include an early pregnancy unit, maternal and fetal medicine outpatient department, maternity assessment unit, antenatal ward (Sara ward), delivery unit, birthing centre, two maternity theatres, post natal ward (Lady Mary ward), ultrasound department and an obstetric physiotherapy department. There are 91 beds dedicated to the women's and maternity directorate and during April 2014 and March 2015 the hospital had 5729 deliveries.

During our inspection we visited all areas listed with the exception of the physiotherapy department and the IVF unit, which is provided by the trust but at another location. We spoke with 17 people who used the service and 70 members of staff including senior managers and service

leads, managers, midwives, consultants, doctors, nurses, anaesthetists, sonographers, support workers, administrators and domestics. We also reviewed 12 people's care records.

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Summary of findings

We found serious concerns regarding the safety arrangements in the maternity services which were not replicated in the gynaecology service. These related to the environment, equipment, lack of recording of risk assessments and substantial midwife shortages. There were continued thematic incidents reported, relating to fetal heart rate (FHR) monitoring, with limited evidence of changes in practice to improve safety. We found that the suitability, safety and maintenance of many types of equipment throughout maternity services were unsuitable. In the birthing unit, the environment was also found to be unsafe owing to poor ventilation whereby high Nitrous Oxide (gas and air) levels exceeded the safe “Work Exposure Level” (WEL) which the trust had known about since 2013.

In maternity, numerous and essential patient risk assessments including venous thromboembolism (VTE) and early warning score (EWS) assessments were not being completed. Staff raised concerns to us that the maternity record system was potentially unsafe due to a combination of electronic and paper records being in use and being used inconsistently. However in gynaecology services risk assessments were undertaken in a timely and comprehensive manner. Across both services there were substantial and frequent staffing shortages, for all disciplines, which further increased the risk to people who used the service. This included medical and midwifery staffing numbers which were below national standards.

Whilst there were up-to-date evidence-based guidelines in place, we were concerned that these were not always being followed in maternity. This included FHR monitoring, VTE and early warning score guidelines. Staff were competent and understood the guidelines they were required to follow, however, lack of staffing and familiarity with the computer system (EPIC) made this difficult. Since the introduction of EPIC, outcomes of people’s care and treatment was not robustly collected or monitored. For example, there was no maternity dashboard available since December 2014. However, we

did observe good practice in terms of audit, effective multidisciplinary team working and that staff consistently had the right skills, qualifications and knowledge for their role.

Termination of Pregnancies (TOPs) for fetal anomalies took place on labour ward after 12 weeks of pregnancy. Therefore women experiencing this service were cared for throughout in rooms without sound-proofing. This meant they were often next door to laboring women and crying babies. However, we found that people were consistently treated with dignity, kindness, and respect throughout services.

There was a lack of service planning across the directorate in relation to workforce planning, capacity to meet service demand and because there was no long-term plan to address the high levels of maternity closures. The maternity unit was closed 37 times between July 2013 and April 2015 mainly due to a lack of capacity or insufficient staffing. Referral to Treatment Times (RTT) for gynaecology patients were not being met in relation to national expectations, but we found that this was being addressed appropriately.

At unit level we observed examples of excellent leadership principles; however, leadership of the directorate overall required improvement. This was because senior managers had not responded appropriately or in a timely way to known and serious safety risks, there was a general lack of service planning, and because key performance data was not being collected robustly and therefore not being analysed. We recognised that EPIC was the root cause of the problems with data collection, and that prior to its introduction in October 2014 many of the data collection issues were not apparent, however, improving this issue was not seen as a priority.

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Are maternity and gynaecology services safe?

Inadequate



We found that the current safety arrangements in maternity and gynaecology services were inadequate due to the issues we evidenced in the maternity service. There were continued thematic incidents reported within the maternity service, relating to fetal heart rate (FHR) monitoring, with limited evidence of changes in practice to improve safety. Both services used an “NHS Safety Thermometer” throughout, which generally demonstrated safe care. However, this was not displayed in public areas. Also maternity services did not use a maternity specific safety thermometer. Some equipment we found was not fit for purpose. Throughout maternity services we found an significant amount of equipment which was not maintained according to manufacturer’s recommendations and trust policy. There was also no cleaning regime for some of this equipment. Sonographers shared concerns that ultrasound equipment was dated because most of the machines were over eight years of age and therefore potentially not reliable.

We raised serious concerns to senior managers about the poor Nitrous Oxide ventilation in the birthing unit where high levels of Nitrous Oxide exceeded the safe Work Exposure Level (WEL) since 2013. Whilst the trust had known about this for two years and had taken steps to mitigate the impact work on installing low level extraction in each of the birthing rooms commenced in late April 2015. Medicine prescribing and administration was good however we found three examples in maternity services where medicines, including a controlled drug, had expired. In gynaecology services we found that risk assessments were undertaken appropriately and as required and that the records management system was good. However in maternity we were concerned that essential patient risk assessments were not always being completed and that the maternity record system was potentially unsafe because there were numerous, inconsistent maternity record systems in use.

Compliance with mandatory training across the directorate was 89%. In gynaecology services we found that Early Warning Score (EWS) systems were in place and being used

correctly. However in maternity services we escalated concerns to senior managers as EWS completion was poor, we observed three incidences where high EWS had not been calculated or escalated appropriately. Staffing levels across the directorate were unsafe. Medical and midwifery staffing numbers did not meet national standards and our concern was heightened given the length of time this had been going on.

Incidents

- The directorate had not reported any 'never events' in the past 18 months. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between February 2014 and January 2015 there were five serious incidents reported. This included two confidential information leaks, unexpected admissions to the neonatal unit, and a safeguarding concern. We reviewed the root cause analysis reports and found that these incidents had been investigated fully and lessons learnt.
- The trust had an electronic incident reporting system in place. Staff said that they could access the hospital’s incident reporting system, and understood their responsibilities in regard to this. Staff could describe to us what constituted an incident and when they would raise one. Staff raised concerns to us that they often stayed over their contracted hours to complete incident forms due to staff shortages.
- Whilst the trust provided us with a copy of its ‘perinatal incident trigger list’ for maternity services, staff told us that they were not aware of this list nor were there copies of this trigger list in clinical areas to prompt staff. Staff told us that this list would be very useful if it were in clinical areas.
- There was evidence that learning from incidents took place and changes in practice agreed subsequently. For example, following a series of near miss drug incidents, staff told us they were encouraged to change their checking practice when administering medicines, in view of EPIC medicine charts and last doses.
- In June 2013 an incident occurred in maternity services regarding FHR monitoring practice. The monitor used was a cardiotocograph (CTG). There was a coordinating complaint to the incident which had been not upheld by the Parliamentary and Health Service Ombudsmen who recommended that CTG practice needed improvement

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at the trust. The trust stated that this practice is now in place. During our inspection we found that CTG monitoring still remained a concern despite changes in practice being agreed and good communication with staff about this. This was because CTG practice was not always in line with the trusts fetal monitoring policy.

- We reviewed two sets of patient records and noted that there was no documentation to confirm that a regular hourly systematic review occurred—for over two hours in one case. In both cases there was no evidence that a ‘fresh eye’ check was undertaken at all, throughout labour. A senior midwife confirmed our findings. Fresh eyes practice means that another midwife, usually the labour ward lead, reviews CTG traces hourly.
- Staff also told us that ‘fresh eyes’ practice was not always possible due to staff shortages and because the lead midwife for labour ward was usually counted in the midwifery numbers and was too busy. A senior lead midwife confirmed this.
- We were also informed that there had been two serious incidents reported which involved poor CTG monitoring practice in the two weeks prior to our inspection. At the time of our inspection these incidents were under investigation. The outcomes of the investigations into these incidents reflected the difficulty of CTG interpretation which is a recognised complication.
- We saw one high risk antenatal woman on the labour ward who had attended for CTG monitoring, who had been monitored for more than two and a half hours without any observation. In the end the woman walked away from the machine as staff had left her unattended. We asked a senior midwife why a review of the woman and the fetal trace had not taken place and they told us that the midwife allocated was too busy.
- Subsequent to the PHSO concerns, the service had introduced a Thursday CTG meeting, which was an opportunity for staff to learn from CTG analysis. However, staff told us that they were not able to attend these meetings due to high workloads. One midwife told us, “We don’t regularly get to go as we are too busy”. The service also introduced an online training module for CTG interpretation, in addition to the annual CTG training session run by the trust. Several staff told us that they had not started this module. Senior managers confirmed that compliance with this training was not measured. Therefore it was unclear which staff had completed this training.

- The trust’s CTG policy reflected the “The National Institute of Health and Care Excellence; Intrapartum care 2014” guidelines. We found evidence prompting staff to ensure their practice was in line with this policy, through risk newsletters and team meetings. We also found staff were familiar with this guidance but observed their compliance with the policy was poor at times because of staffing shortages.
- We reviewed minutes from the monthly perinatal mortality meetings. These reflected discussions and case reviews by multidisciplinary team members to consider any changes in practice needed to improve outcomes for patients. Gynaecology mortality and morbidity meetings also occurred regularly.
- Senior managers showed awareness of their responsibility in relation to Duty of Candour and could give us examples of when they would instigate Duty of Candour practice.

Safety thermometer

- The NHS Safety Thermometer was used for Daphne, Sara, Lady Mary and labour ward and the birthing unit and results demonstrated safe practice. Results for March 2015 demonstrated 100% harm free care across the services.
- NHS Safety Thermometer results however were not visible to patients and visitors throughout the service.
- Maternity services did not use the maternity specific NHS Safety thermometer which is now available nationally. A Maternity Safety Thermometer allows service providers to determine harm-free care but also records the number of harm(s) specifically associated with maternity care.

Cleanliness, infection control and hygiene

- In the past 12 months there were no reported Clostridium difficile infection and no MRSA Bacteraemia incidents.
- Records confirmed robust domestic cleaning schedules and all clinical areas we visited appeared visibly clean.
- Support workers, nursing and midwifery staff had responsibility for certain daily cleaning tasks, which included daily birthing pool checks and staff performed these. However, daily equipment checks did not incorporate cleaning of some equipment. There was a sticker system to determine what equipment had been cleaned and when but we found this was not consistent

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across the directorate. For example, on Lady Mary Ward we observed that the neonatal resuscitaire was dusty around the sheet area and on top of the machine and there was no daily cleaning system in place.

- Staff complied with the trust's infection control policies and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately, and wore their uniforms above their elbows.
- Every unit had a monthly hand hygiene audit, which demonstrated good hand hygiene. In March 2015 Daphne, Sara and Lady Mary ward scored 100% for compliance

Environment and equipment

- Each inpatient area had a buzzer entry system. Visitors had to use the intercom and identify themselves upon arrival before they access the ward. Staff had swipe card access.
- Most areas we visited were bright, clear of clutter, and well organised. Some units had been recently renovated including the birthing unit three years ago and Lady Mary Ward more recently. Staff shared concerns with us that the Labour ward in particular needed renovation. We observed this area was dated and cluttered. However, it had been painted recently and some renovation completed, including newly fitted bathrooms.
- Resuscitation equipment was in line with national guidance and was checked regularly.
- We were concerned about poor Nitrous Oxide (Entonox) ventilation on the birthing unit. The maternity risk register stated; "Following annual environmental monitoring, high levels of nitrous oxide were detected in the Rosie Birthing Centre [and that] levels exceed the safe Work Exposure Level (WEL) for Nitrous Oxide". There was no suitable ventilation system to mitigate this risk. For over two years senior managers were aware of this concern. They told us the issue was; "Reported ages ago", and they considered the situation to be; "Very dangerous". They advised staff to open windows to aid ventilation, where possible. At the beginning of our inspection maintenance work to resolve the problem had started, in one of the 10 birthing rooms. However, we were concerned that action had not taken place sooner, despite staff continually raising concerns and the risk of high levels of Nitrous Oxide continued in the remaining rooms. Also the trust had not provided staff with occupational health screening in view of prolonged

exposure. We asked to see the trust's risk assessment report regarding this but this was insufficient because the record did not demonstrate thorough assessment of the risk nor when action would be taken and by when. We brought this to the attention of the trust board and senior managers and asked them to take immediate action.

- Some equipment was not fit for purpose. On the labour ward we saw that the material on the lithotomy legs (bed stirrups) of two beds were broken and repaired with adhesive tape. This meant that the beds could not be cleaned effectively, posing an infection control risk. The issue of faulty beds was added to the maternity risk register on 02 May 2012. There were efforts to decommission some faulty beds but staff told us that they did not perform regular checks to determine the continued safety of the beds. A senior manager confirmed no action was taken to develop a maintenance plan or business case to replace the beds. These issues were on the risk register for over two years with no change. However, the trust supplied a maintenance schedule which demonstrated that beds were classified as low risk and only 70% of planned maintenance had occurred. The schedule showed only 17 beds on the schedule of which 7 were behind on their planned maintenance.
- We became more concerned when a senior midwife informed us of an incident which occurred on the morning of our inspection. During an emergency delivery a patient was on a bed with broken lithotomy legs. In order to safely perform manoeuvres required to deliver the baby safely they called a maternity support worker, who had to hold the patient's legs in position for 15 minutes. This was not safe moving and handling practice, which puts both the member of staff and the woman at risk of injury. We immediately brought this to the senior midwife's attention who assured us that they would remove the bed from labour ward and complete an incident report form. We later raised the issue of delivery beds with a senior manager and asked them to take immediate action.
- We also saw that some of the neonatal resuscitaires did not have front guards on; therefore, there was risk of new-borns falling if they were not continually supervised. Again this was on the maternity risk register, since April 2014, but no appropriate action taken to mitigate risk had been taken.

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- We looked at various pieces of equipment throughout the directorate and found that it was not always properly maintained. On the birthing unit in the equipment room alone we counted nine pieces of equipment that either had not had a Portable Appliance Testing (PAT) or a maintenance service for over one year since it was due. This included baby scales, a blood pressure machine and a neonatal resuscitator. A senior manager confirmed our findings and then contacted the trust's equipment library. They were unclear whose responsibility it was to ensure these checks were conducted. The following day we observed that appropriate action had been taken to ensure equipment was safe.
- Staff raised concerns to us that some of the scanning equipment in the ultrasound (USS) department was dated and needed replacement. One member of staff told us the unit had difficulty getting new machines despite raising these concerns. Another member of staff told us they used one of the scanners only to determine presentation (position) of babies in the uterus because they were concerned about reliability, given that it was nearly 10 years old. At the time of the inspection, the ultrasound machines were out to tender as part of the equipment replacement process.
- We found that three of the nine USS machines were more than eight years old. The Royal College of Radiologists; Standards for the provision of an ultrasound service standards (2014) recommend that a review of equipment is typically undertaken between four to six years following installation, and determine if it should be replaced. Sonographer staff told us that equipment needed replacing. This issue was not on the departmental risk register. The trust stated that at the time of the inspection, the ultrasound machines were out to tender as part of the equipment replacement process.

Medicines

- Records confirmed that staff regularly checked controlled drugs. Medications for resuscitation were also checked with the emergency equipment.
- Medicines were stored securely throughout the directorate. We checked fridge temperatures and saw they were monitored appropriately.
- However, across maternity services we noted that some medicines had expired, including some carried by the community midwives. These included Peptic liquid,

Methadone, and Vitamin K injection solution. We brought this to the attention of the senior midwife for each area who assured us they would dispose of the medicines appropriately.

- We observed safe prescription and administration of medicines. Staff kept up to date medicine records and completed them accurately.

Records

- In the gynaecology service we found that patients' risk assessments were completed in care records. In maternity services, although the majority of risk assessments we looked at were completed, we found that patient's Venous Thromboembolism (VTE) risk assessments were not always completed after delivery. We looked at five patients' maternity care records and found three without completed VTE risk assessments. A midwife confirmed our findings. We saw a maternity newsletter dated March/April 2015, which raised the issue that staff had not completed VTE assessments in the past and they must take action. However, it also confirmed that the service, "Had an increasing number of women who are missing their treatment" because the assessments were not done.
- Staff raised concerns to us about the maternity records system. Previously women had paper antenatal maternity records but following the introduction of EPIC some women had hand held records, others electronic, and others a folder with a print out of their antenatal history. During labour all women had electronic maternity records and post-delivery women had paper post natal records which they took home. This inconsistency was largely because community midwives could not always access the EPIC system outside the hospital. Staff told us that they were concerned about the record system and they thought it was unsafe because it was complicated and inconsistent. We reviewed full sets of maternity records, including antenatal, labour, and post-natal records. We found it difficult and time consuming to identify the patient's obstetric history from start to finish.
- Between February 2014 and January 2015 four confidentiality breaches were reported in terms of patient records. The directorate could demonstrate they communicated this to all staff to prevent a future occurrence. However, we were concerned to see that patients' antenatal records were not always secure because paper records were loose in patient folders.

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Safeguarding

- There were up-to-date safeguarding policies and procedures in place which incorporated relevant guidance and legislation. Staff told us they could access these via the intranet, and staff we spoke with were knowledgeable as to what constituted a safeguarding concern, and knew how to raise matters appropriately. Midwives also gave us examples of where they had appropriately managed a safeguarding incident.
- We checked that staff had the appropriate level of safeguarding training and found that staff classified as additional clinical services had lower rates of compliance with this training than nurses and midwives in a number of clinical departments.
- Between January and December 2014 278 safeguarding alerts were raised, most of these did not require social service referral but raised the need for additional support for patients, which was provided. We felt confident that staff raised safeguarding alerts appropriately.
- We checked the minutes of the last two safeguarding meetings. These meetings were held monthly and were well attended by nurse, midwife and paediatric leads. The minutes demonstrated they discussed serious safeguarding cases at each meeting.
- The team of midwives that care for vulnerable women midwives consist of five members; named midwife and lead for safeguarding across the trust, mental health midwife, teenage pregnancy midwife, substance misuse midwife and a lead for safeguarding midwife.

Mandatory training

- There was 89% compliance with mandatory training across the directorate. Mandatory training subjects included safeguarding adults and children, moving and handling, infection control, health and safety and information governance. Compliance with certain mandatory training subjects needed improvement. This included safeguarding training level 2 (88%) and moving and handling (83%) which were below the trust's target (90%).
- Maternity staff received additional mandatory training which included obstetric emergencies, domestic abuse, breastfeeding and CTG training. This was delivered annually. Records confirmed that 98% of staff had completed this training within the past 12 months.

- Obstetric emergencies were also practiced by live skills and drills on the labour ward and on the birthing unit during quieter times.

Assessing and responding to patient risk

- The trust provided a Rapid Response Team (RRT) to enhance the care of acutely ill patients in hospital. The team were available 24 hours a day to attend any medical emergency or unwell patients in the hospital. Staff were aware of the RRT and we observed posters throughout the directorate which detailed the RRT's contact details.
- Gynaecology areas were using the National Early Warning Score (NEWS) system and we found staff accurately completed patient observations and scores. When completed early warning tools generate a score through the combination of a selection of routine patient observations, such as heart rate and blood pressure. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation.
- In maternity services the Maternal Early Warning Score (MEWS) and Neonatal Early Warning Score (Neonatal EWS) system was in place for babies. We were concerned that staff did not always calculate these scores and did not conduct full observations where required. We checked three babies' observation records and found that one of these babies' staff had not calculated their Neonatal EWS score on 22 occasions. This baby was at high risk of infection, on intravenous antibiotics, and had an abnormal temperature reading on one occasion. Records for another baby, requiring four hourly observations, showed staff had made nine sets of observations without recording Neonatal EWS scores. In addition, on one night shift, staff had not completed an observation for over 10 hours. The midwife in charge of the shift reviewed these records with us and confirmed our findings.
- We asked a senior member of maternity staff why these scores and observations were incomplete and they told us that staff were too busy. They also told us the service had recently introduced a hand held electronic device, which staff entered patient observations into and that this automatically uploaded results on to EPIC. However, we were told that this machine did not

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calculate early warning scores and that staff did not have time to then go to EPIC and input this information. We raised our concerns to senior managers and asked them to take action.

- The “World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery” was in place throughout the directorate. We checked and found staff used the tool correctly.

Midwifery and gynaecology nursing staffing

- Twenty-seven staff members, across the directorate and from various professions, told us that staffing was a serious concern. One senior doctor said the lack of midwifery staff was a, “Big risk” and another senior member of staff told us that [staffing generally was], “Concerning and unsafe”.
- Staff across all units raised concern to us that they were often unable to take their breaks, even if staff were on a 13 hour shift (long day), due to being short staffed and too busy.
- The directorate had planned its workforce on an establishment agreed over two years ago. The total whole time equivalents budgeted for the maternity hospital was 122.26 and whilst the current vacancies were only 2.58 whole time equivalent this was insufficient for the numbers of births at the unit. This issue was not on the units risk register. Working from this establishment, of the seven maternity units in the trust; four of the units were operating with less Whole Time Equivalents (WTE) than expected. On the gynaecology ward (Daphne ward) the actual WTE in post (15.95) was lower than the total establishment planned (20.12). Nursing and midwifery staffing numbers were not safe across the directorate as there were insufficient midwives to provide safe care to women as outlined in this report. Furthermore, senior managers specifically told us that more staff were needed across the directorate and that a thorough analysis was required.
- We checked recruitment progress and were told that 3.76 WTE midwives would be commencing work in May/June 2015 and that recruitment was underway for a further 4.42 WTE.
- Handover of patients between nursing/midwifery staff was well-structured and staff communicated effectively with one another.

- Average staff absence rates for maternity and gynaecology (2.8%) were similar to the trust average (2.7%) and much lower than the national average (4.3%).

Maternity staffing

- The midwife to birth ratio (1:33) was worse than the nationally recommended workforce figure (1:28). The Royal College of Obstetricians “Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007” standards state that, “The minimum midwife-to-woman ratio is 1:28 for safe level of service to ensure the capacity to achieve one-to-one care in labour”. Staff confirmed that one-to-one care for women in labour on the labour ward was often not always possible and potentially unsafe. On the labour ward the establishment for midwives was eight per shift however on the day of one of our inspections there was one midwife short on each shift. Furthermore, there were 15 labour beds and staff confirmed that sometimes the unit was full. One senior midwife told us that, “It is very rare we have rota cover for eight midwives for [the] labour ward”.
- Senior managers confirmed that they reviewed midwifery staffing numbers over two years ago along with a business case but this business case had been rejected since, “The outcomes for women and babies was good”. Given that staff repeatedly voiced their concerns about staffing numbers, inspectors expressed concern that a more recent review of this and support for the business case was not conducted. For example, in the final quarter of 2014 midwives reported 30 incidents about poor staffing levels or high workload impacting on the standard of care they could give. Examples of the impact of care included delayed CTG monitoring, missed visits by community staff, delays in providing advice and support to women and the delivery of a multiple birth by one midwife. A senior manager told us that they had highlighted staffing concerns to the trust board more recently but could not provide us with evidence of this.
- We also attended a Supervisor of Midwives (SOMs) meeting called by the SOMs who invited the Head of Midwifery and Finance Manager, to discuss their continued concerns about maternity staffing numbers being unsafe. SOMs told us that they had raised this issue time and time again.

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- Maternity services did not use agency staff at all. They used bank staff regularly where possible who were appropriately inducted to the area. However we saw from the information the trust sent us that the delivery suite had used 15 % agency staff.

Gynaecology staffing

- We reviewed the duty rotas and were able to see that generally there was a good skill mix for each shift.
- In the last 18 months agency and bank use was often higher than the trust average (13.45%). The highest use of bank and agency was on Daphne (15.54%) and Lady Mary Ward (14.69%). Agency staff were inducted to the wards on which they worked.

Medical staffing

- The directorate employed 52 WTE medical staff. In relation to middle grade and junior doctors, there was a good skill mix on duty at all times.
- The service however was non-compliant with “The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007” standards which state that, any unit with more than 5000 deliveries per year requires 98 hours of consultant presence per week. On average The Rosie Hospital had 5,700 deliveries per year and 60 hours of consultant presence was provided per week. Therefore the trust did not meet this standard. However, staff did tell us that consultants worked over their hours daily, meaning that the hours of consultant presence was probably higher than 60 hours per week but this was not recorded.
- During weekday mornings there was an allocated consultant for elective caesarean sections.
- Between July 2013 and December 2014 monthly medical agency and locum use for obstetrics and gynaecology was marginally higher (5.5%) than the trust average (4.4%). The department had a policy in place in relation to induction and orientation for locum doctors. The service agreed a three month locum contract for one doctor, which ensured locum consistency, and doctors told us that locums were well supported and received a comprehensive induction.
- Handover between medical staff was well-structured and well-attended.

Sonography and administration staffing:

- Sonographers raised concerns to us regarding a lack of sonographers in post in the USS department. Staff told us that the WTE establishment should be 8.1 but currently the department was running at 6.32, although 1 WTE post was out to recruitment. Staff told us that insufficient staff often meant appointments were rushed and there were often two to three week delays in appointments being offered. This issue was also highlighted on the services risk register. The trust stated that there were actually 7.27 WTE in place and gaps were filled with agency staff.
- We were concerned that the front desk at The Rosie Hospital was not always staffed. This led to concerns about women’s safety especially of those women in labour. We observed a poster, which indicated the desk was only open between 8-2pm Monday to Friday. During this time there was a contact number women could call for assistance, or they could press the call bell at the birthing unit, which was opposite the desk. During our inspection we noted several occasions when the reception was not staffed during its opening hours. We observed four patients who were waiting at the desk and did not know where to go, one lady was in labour and another did not speak English. We had to intervene and contact the relevant department to ensure these women got to the right department.

Major incident awareness and training

- Maternity and gynaecology services followed the trust’s major incident and escalation policy. Staff had access to information about major incidents on the trust’s intranet.

Are maternity and gynaecology services effective?

Good



Maternity and gynaecology services were good in terms of effectiveness. Audit at both local and national level occurred regularly, with action plans which were embedded into practice. Staff had the right qualifications, skills, knowledge and experience to do their job. Multi-disciplinary team work across disciplines was very

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good, and consent to care and treatment was obtained in line with relevant legislation and guidance. There were also policies and procedures in place which were based on up-to-date evidence-based guidance.

Prior to the launch of EPIC, we were assured that the intended outcomes for people were being achieved, and where there were concerns, for example, increased caesarean section rates, we found that the service was actively addressing this by investigating and pursuing action plans. However the current lack of data collection impeded monitoring of outcomes and on-going projects such as aiming to reduce the trust's increased caesarean rate. Staff did not always have all the information they needed to deliver effective care and treatment. Again staff reported that this related to EPIC.

Evidence-based care and treatment

- There was some evidence that staff assessed patients and provided care and treatment in line with recognised guidance, legislation and best practice standards. For example termination of pregnancy care was delivered in line with the "Abortion Act 1967" and supporting guidance issued by the Department of Health. In maternity services, obstetric emergency practice was in line with guidance issued by the "National Institute for Health and Care Excellence" (NICE) which included post-partum haemorrhage guidance. In maternity services we however were concerned that not all practice was based on recognised guidance.
- There was a range of trust wide evidence-based policies which staff told us they could access via the intranet. However we found that some of the trust's policies and guidance had not been recently reviewed.
- In gynaecology new national guidance or research was discussed at governance meetings, where it was considered for implementation and as part of a multidisciplinary team discussion. In maternity a similar system existed and there was an appointed research midwife whose role it was to lead maternity research within the directorate. New trust guidance was communicated to staff via unit meetings, email and through the "Maternity Risk Matters" quarterly newsletter.
- There was an audit programme for maternity and gynaecology which was comprehensive including local clinical audits and participation in national clinical

audit. Audits allow providers to determine if healthcare is being provided in line with national standards, if their service is doing well in relation to these standards and where there could be improvements.

- There was a clear process in place for deciding what to audit including risk-based audit. The directorates audit data base made it easy to identify who the project lead was and progress of audit.
- Local audits included monthly hand hygiene audits on each inpatient area, antibiotic audits, audit of length of stay following elective caesarean section, women delivering with a body mass index greater than 30 and major post-partum haemorrhage. We were assured that audits were thorough and that improvements required were recognised. We reviewed the trust's "Length of stay following elective caesarean section" audit which was carried out in July 2014. There was a clear conclusion and the correlating action plan had been fully achieved by September 2014.

Pain relief

- Patients told us that staff assessed their pain regularly, offered them choice of pain relief when required and that these medicines were given in a timely way. When we looked at care records we found that pain scores were not being used in maternity however they were in gynaecology.
- Staff confirmed that anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals.
- We observed birthing plans in maternity care records which included discussion about analgesia in labour, and there were supporting patient information leaflets available in paper format and on the trust's website for before, during and after labour.

Nutrition and hydration

- There were regular meal times with a variety of food choice. Patients all had a jug of water beside them and told us that food choice and availability was good.
- We requested breastfeeding statistics in terms of initiation, at 10 days and 6-8 weeks after delivery; however the trust were not able to provide us with accurate data owing to issues with data collection and EPIC.
- Antenatal records confirmed that staff discussed infant feeding choices with women prior to birth and after.

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There was an infant feeding midwife who worked full time and we observed extensive feeding information on display throughout the service, this included the advertising of additional supportive services.

- We did however note that expressed breast milk was not always dated correctly in refrigerators. Therefore we could not be assured that breast milk was stored safely nor in line with trust guidelines. We brought this to a senior member of staff's attention and they took appropriate action.

Patient outcomes

- We did not identify any outliers relating to maternity and gynaecology care. An outlier is an indication of care or outcomes that are statistically higher or lower than would be expected. They can provide a useful indicator of concerns regarding the care that people receive.
- The directorate participated in national clinical audits included multiple pregnancy, domestic violence and individualised post natal care plan audits.
- During April 2014 to March 2015 there had been five unplanned maternity admissions to intensive care and four readmissions from home to the maternity unit.
- We requested proportions of delivery methods including from the last six months from the trust, however, because there was no maternity dashboard since December 2014 it made it difficult to ascertain this. Therefore the following information represents the proportion of delivery methods from July 2013 and June 2014: elective caesarean section (13.2%); emergency caesarean section (16%); normal vaginal delivery (59.3%); low forceps (8.6%); other forceps (0.3%); ventouse (0.3%).
- The trusts total caesarean section (CS) rate for the past year was higher than expected (25%). Recent data demonstrated that this continued to be an issue in January (27.8%) and March (29.2%) 2015. The trust however was taking action to address this which included: a steering group which continued to focus on reducing the CS rate; a project board was reviewing LSCS workforce and induction of labour; a proforma was being used on the delivery unit on a daily basis to review decision making; there were daily reviews of CS done facilitated by consultant and the practice development midwife; community midwives were being trained in Vaginal Birth after Caesarean Section (VBAC) and were undertaking VBAC assessment and discussion with

relevant women; women who requested a CS now see the consultant midwife and there was a consultant midwife clinic for women with complications who need a plan of care. Staff did however raise concerns to us that these projects were impeded at times owing to the inability to collect certain data from EPIC, for example, VBAC related statistics.

- In the past 12 months there had been 137 unexpected admissions to the Neonatal Intensive Care Unit (NICU) reported. This equated to approximately 11 admissions per month. The NICU is a regional referral centre, and this information excludes ex-utero transfers from other centres.
- The service had completed a dashboard up until December 2014 when the new IT system had been introduced this showed that 3% of women having a first time baby having an unassisted vaginal delivery experienced a 3rd or 4th degree tear. This percentage rose when having an assisted vaginal birth to 9% on average. This was seen to be higher than average. 38 women had experienced a post-partum haemorrhage between January and November 2014. The still birth rate was less than 0.8% until November 2014. However most of these were diagnosed before the mother went into labour.

Competent staff

- Records confirmed that 100% of staff had completed an appraisal in the past 12 months.
- The annual Supervisors of Midwives (SOM) report for 2013-2014 showed that the ratio for SOMs to midwives was 1:14 making the trust compliant with national expectations. The trust employed 15 trained SOMs. We requested the Local Supervising Authorities' (LSA) SOM report however the trust only provided us with their self SOM annual report.
- Staff told us that they were supported to gain additional qualifications and to maintain their continual professional development.
- We spoke with newly qualified midwives who told us they had undergone a local induction including the completion of a competency framework and that they were allocated a mentor and SOM during this period. They told us that they felt well supported as did student midwives.
- All support workers underwent trust competencies which included newborn feeding and clinical

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observation competencies which were completed prior to practice. Since the recent introduction of the national “Care Certificate”, maternity support workers (MSW) were additionally supported to complete specific role related competencies within 12 weeks of induction. Some MSWs were also undertaking band 3 training whereby they were trained in additional tasks such as blood sugar monitoring and venepuncture. All MSWs were on target to complete their training within the agreed time frames.

Multidisciplinary working

- We observed that staff across all disciplines worked effectively together, both inside the hospital and in the community. There were detailed multidisciplinary (MDT) team meetings and discussions where required which ensured effective care and treatment plans and handover of patient care.
- Care and treatment plans were documented and communicated to relevant health care professionals, such as GPs and health visitors, to ensure continuity of care.
- We spoke with staff from other directorates including from NICU. Staff here told us that the two directorates worked well together and that support from maternity was good. Staff from these areas all participated in the monthly perinatal mortality meetings and communicated with one another regularly each day. The neonatal resuscitation team were available 24 hours a day 7 days per week when neonatal resuscitation was anticipated or occurred.
- There were regular “Maternity Service Liaison Committee groups” which included GP and health visitors from the local area which enhanced MDT working.

Seven-day services

- There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on-call rota system which ensured that midwives had access to a SOM at all times. In addition there was a site manager available at all times.
- There was an anaesthetist and consultant available 24 hours a day 7 days per week.
- There was a consultant on call and anaesthetist available 24 hours a day 7 days a week for both maternity and gynaecology services.

Access to information

- Staff told us that they did not always have all the information they needed to deliver effective care and treatment. Staff reported that this related to EPIC.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act.
- Training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards (DOLs) and learning disability was part of mandatory training for all staff. The trust had policies in place regarding these subjects and they were accessible to staff via the intranet. Staff we spoke with told us that they could access the intranet, and demonstrated adequate knowledge about these subject areas.

Are maternity and gynaecology services caring?

Good



We observed that people were treated with dignity, kindness and respect throughout the service. One person told us that staff were, “Wonderful, nice people”, and another said that their care was, “Amazing” and that staff were, “Very caring”. Friends and Family Test scores were generally in line with national averages, and people who used the service and those close to them told us that they were well informed, and felt involved in decision-making processes regarding their care. There were numerous systems in place to meet people’s emotional needs which included exceptionally good bereavement support following discharge.

Compassionate care

- We observed ward areas, listened to focus groups and individual staff who were involved in patient care and found that staff responded compassionately when people needed help, and supported them to meet their needs.

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- Patients we spoke with across the directorate were consistently positive about staff. One person commented that the midwives and staff were, “Wonderful, nice people”, and another said that their care was, “Amazing” and that staff were, “Very caring”.
- “Friends and Family Test” (FFT) scores for recommending antenatal and birth services varied but trust scores were better than the England average for most months. Scores were in line with national averages for postnatal services but postnatal community services were slightly lower than the national average.
- Trust scores in the “CQC Woman’s Experience of maternity services survey” were the same as other trusts for 11 measures and better than other trusts for 6 measures.
- We observed display boards in some areas which contained numerous and recent thank you cards from patients and families for the care they had received.
- On the ward areas we found that staff ensured patient’s dignity and respect. We observed that patients could close their curtains around their beds in bays for privacy and that staff knocked on doors before entering patient rooms.

Understanding and involvement of patients and those close to them

- The antenatal records we checked all had birth plans in place and confirmed that pregnant women had been involved in the development of their birth and infant feeding plan.
- Across the directorate patients told us that they were well informed and felt involved in decisions about their care or treatment. One patient told us that they felt well informed, and another said, “They [staff] explain everything”.
- There were parent education classes run by the trust’s midwives which were held at numerous local children’s centres across the Cambridge area. These included information about labour, birth and the postnatal period.

Emotional support

- There was a trust wide spiritual care and chaplaincy team available to patients, families and staff of all faiths and none. This was available 24 hours a day 7 days per week.
- There was a bereavement support team of specialist midwives available. Their contact details were given at

the time of bereavement by hospital staff and were also easily accessible via the trust’s website and included a confidential phone line. This service was available for all pregnancy losses.

- The directorate also worked with a local bereavement charity called, “Petals”, who worked alongside the clinical team at The Rosie Hospital to deliver specialist and approved counselling services where required. Women and partners were also signposted to numerous other support groups and charities that were specific to their needs, for example, an ectopic pregnancy charity.
- There was a bereavement care follow-up service too which offered the opportunity for the patient and their loved one to meet with the consultant who cared for the patient and to answer any questions.
- Maternity services offered a “Birth Afterthoughts” service which was a listening service available to any women who had given birth, or was planning to give birth at the trust. It was a confidential service that provided the opportunity to discuss and enhance understanding regarding labour and birth.
- The antenatal records we examined confirmed that assessments for anxiety and depression were undertaken for patients, and that appropriate action was taken in terms of support offered when subsequent concerns were highlighted.

Are maternity and gynaecology services responsive?

Requires improvement



Maternity and gynaecology services required improvement in regard to the responsiveness of the service to meet patients’ needs. Since November 2014 the service was not meeting national expectations in regard Referral to Treatment Times (RTT) for gynaecology patients, although this was being addressed appropriately and the service had seen an influx of patient referrals due to new commissioning contracts. Further, we had concerns about the Termination of Pregnancy (TOPs) service. This is because TOPs for fetal anomalies were being carried out on labour ward after 12 weeks of pregnancy and women using this service were cared for throughout on the labour ward within rooms that were not sound proofed and often were next door to labouring women and crying babies. This was not responsive to their needs.

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The service had closed 37 times in a 22 month period due at times to shortages of staff and capacity. Although senior staff were aware of these closures there was no action plan or strategy to reduce the incidence despite the Rosie Hospital being the centre for complex birth. In these incidents women who were having potential complex births would have to travel to London to deliver. There was a lack of addressing key issues such as the high midwife to birth ratios, a lack of capacity to meet service demand, and because there was no long-term plan to address the high level of maternity unit closures. We were also not assured that people could access or be discharged from the service in a timely way. This was because data relating to pregnant women booking was not accurately measured, the service did not monitor the timeliness of assessment for women presenting in labour or with complications nor did it measure discharge delays in maternity despite staff having concerns about this.

The service took account of the needs of different people including those in vulnerable circumstances. There were numerous specialist midwives and nurses in post, and specialist clinics were provided to support people with complex needs. We observed that individualised pathways of care were delivered accordingly. Complaints were handled effectively and where appropriate lessons were learned from complaints and action was taken to improve the quality of care provided.

Service planning and delivery to meet the needs of local people

- There was a “3 Year Divisional Business Plan 2015-2018” for the directorate which detailed aims and action plans in regard to service expansion, including being “able to offer access to Magnetic Resonance Imaging (MRI) within the Rosie, offering imaging for women, perinatal indications, as well as for fetal and neonatal research”. We however were concerned that this business plan, and the current delivery of service provision, was being delivered without appropriate workforce analysis in view of service demand.
- The Birthing Unit which was situated within The Rosie Hospital had facilities that were outstanding and state of the art. They included 10 birthing rooms all with en-suite bathrooms, mood lighting and music systems, a fold-down double bed, birthing balls, slings, birthing stools, floor mats and comfortable seating. Many of the birthing rooms have direct access to the sensory garden,

which was a well maintained garden area. There was also a communal kitchen and seating area in the unit. The birthing unit provided a calm and homely environment.

Access and flow

- The majority of staff and patients we spoke with confirmed that people were able to access services in a timely way for initial assessment, diagnosis or treatment. Staff however told us that there were frequent delays in induction of labour and that there were “significant” delays in discharge from Lady Mary Ward due to the EPIC computer system discharge process being lengthy. We asked the service for figures in relation to delayed discharges from Lady Mary Ward and delayed induction of labour. This information however was not being recorded.
- We requested the current percentages of women seen in the labour ward within 30 minutes by a midwife, and the percentage seen by a consultant within 60 minutes, to determine timeliness of assessment. This information however was not being recorded.
- The trust had a policy which outlined planned actions in the event that the maternity unit required closure. Between July 2013 and April 2015 the maternity unit had closed a total of 37 times. 14 of these times the unit was closed due to a lack of capacity and 8 times because of staffing numbers being low. The high number of closures was concerning although the trust was reporting these closures correctly and acting to keep women and babies safe. We asked senior managers to provide us with an action plan to prevent further occurrence, however, we were told that there was not one.
- There were regular call bell audits which determined length of time it took for staff to answer patient call bells which showed good outcomes. The most recent “CQC Survey of Women’s Experiences of Maternity Services 2013” demonstrated that the length of time it took for staff to answer patient call bells (8.0 minutes) was in line with the national average (8.1 minutes). Local audits, for example on the Lady Mary Ward, which had been completed more recently demonstrated that the response time had improved greatly since the 2013 survey.
- Bed occupancy during 2013 to 2015 was higher than the England average.

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- In gynaecology services since November 2014 the Referral to Treatment Time (RTT) for both admitted and non-admitted patients was below what was expected (90%). In March 2015 the service met 88% RTTs for admitted patients and 92% for non-admitted. RTTs mean that patients have the right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral. We spoke with a senior manager who told us that this non-compliance was due to EPIC not being able to capture data accurately and an increase in service activity which was being investigated to determine where improvements could be made. The trust informed us that the EPIC system was able to capture all elements of RTT pathways and report relevant performance.
- The service monitored the percentage of women accessing antenatal care within 12 weeks and six days of pregnancy. The “National Institute of Health and Clinical Excellence; Antenatal Care 2008” guidance states that booking is ideally achieved by 10 weeks of pregnancy; therefore the trust were not using national benchmarks for monitoring. Furthermore there were concerns with the reliability of this recent data collection due to EPIC and we were told that discussions were still taking place with IT to resolve this. In January 2015 according to the data we were given only 46.8% of pregnant women were booked within 12 weeks and six days. We were not assured that women were being booked in a timely way.
- Staff raised concerns to us that there were delays, of approximately 2-3 weeks, for antenatal USS for Down’s syndrome and anomaly screening and growth scans. This was because there were an insufficient number of sonographers employed. This was rated as a ‘red’ risk (the highest type of risk) on the maternity risk register. This risk was last reviewed in December 2014. The service had however subsequently introduced a “Patient Tracking List”, to monitor compliance with the offering of NHS antenatal screening at the appropriate time.
- We were concerned when staff told us that termination of pregnancies (TOP) for fetal anomaly was regularly carried out on the labour ward after 12 weeks of pregnancy. During our inspection we observed this practice. We were shown two rooms at one end of the labour ward which had a separate small room with a door prior to access, meaning that there were two doors to go through before entering either room. Staff told us that these rooms were going to be used for sensitive

admissions such as TOPs. At the time of our inspection these rooms were not in use as they were being renovated. A senior midwife told us that the two allocated rooms have been out of service for, “Sometime” and that they were likely to be finished in two weeks as the service was awaiting an equipment delivery. Therefore women undergoing TOP were being cared for throughout labour ward. Furthermore, we were concerned that the new rooms were not sound proofed, one of which was neighbouring a delivery room. We were concerned that women undergoing TOP at the time of our inspection and later when these allocated rooms were available, would be able to hear pregnant women in labour and babies crying, which could cause them unnecessary distress during an incredibly emotional time. We raised these concerns to a senior manager who told us that they were not aware that this practice was occurring and that they too were consequently concerned about this issue. “Guidance in Relation to Requirements of the Abortion Act 1967”, which were published by the Department of Health in 2014 state that TOPs, “Have traditionally been carried out in a gynaecology wards and day care units”.

- We reviewed the trust’s TOP policy dated November 2014, which related to fetal anomaly, we found that there was not a clear admission criteria to the labour ward for TOP in terms of stage of pregnancy.

Meeting people’s individual needs

- The maternity service delivered a range of specialist obstetric-led clinics for women. This included a diabetic, hypertension, Vaginal Birth after Caesarean Section (VBAC), Lupus and autoimmune and drug and alcohol clinic. Women were further supported by specialist midwives such as the consultant midwife, safeguarding, teenage pregnancy, substance misuse, mental health and a diabetic specialist midwife, where required.
- The service appointed a specialist smoking cessation midwife who was funded by the local authority in view of 6.4% of booked women who smoked during 2013-2014.
- The trust had 24 hour access to a translation service and further support services were available for those who were visually impaired, blind or deaf. Staff we spoke with were aware of how to access these services if needed.
- The service provided women and visitors with a wide range of supportive health education literature

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including leaflets, posters and via the trust's website.

Patient information leaflets can be translated into alternative languages if required. The amount of literature available and its content were impressive.

- The service had a variety of mobilisation aids to support normal birth and aid comfort. This included birthing mats, birthing ropes, 10 birthing pools, piped gas and air and birthing balls.
- Women were given the choice to birth at home, in the birthing unit or on the delivery suite.
- The trust offered special diets which met people's individual needs, such as vegetarian, vegan, gluten-free and halal meals.
- There was a specialist midwife for mental health and a learning disability nurse specialist for the trust. Staff who were aware of the support this midwife and nurse specialist offered and knew how to access this support.
- The Birthing Unit, which was situated within The Rosie Hospital, provided state of the art facilities. They included 10 birthing rooms all with en-suite bathrooms, mood lighting and music systems, and a fold-down double bed, birthing balls, slings, birthing stools, floor mats and comfortable seating. Many of the birthing rooms had direct access to the sensory garden, which was a well maintained garden area. There was also a communal kitchen and seating area within the unit. The birthing unit provided a calm and homely environment.
- Staff also raised concerns to us that there was insufficient administration staff for the ultrasound department. Patients told us that they had difficulty getting through to book or amend an appointment. One patient told us that they had spent, "Hours waiting on the phone" to chase up their nuchal translucency scan, in the end they had to make a complaint and only then were they offered an appointment.
- The Rosie Hospital had been accredited level one "Baby Friendly Status" from UNICEF and the World Health Organisation, and were working to achieve level two. The infant feeding team from the hospital had worked hard recently to improve breastfeeding awareness education and rates by participating and talking at local community support groups and providing further in house midwifery training.
- A senior manager had approached the local authority recently for funding and subsequently had got funding for two new specialist midwife posts, a smoking cessation and an infant feeding midwife. These midwives were in post and it had recently been agreed that this funding would continue.
- The amount of patient literature available for both maternity and gynaecology services was outstanding. This included information leaflets, display boards and The Rosie Hospital website. The information provided was succinct, it signposted patients to further support, it was up-to-date and based upon evidence-based practice. Patients told us that they found this information very useful.
- We observed plentiful information for women, dads and partners regarding their pregnancy and baby needs, which covered pregnancy, birth and after birth. There were also posters displaying Supervisor of Midwife (SOM) information and contact details, should parents wish to have further support from the SOM team. This meant that parents were encouraged to be involved in their care and were provided with additional information to enhance their understanding of care and treatment.
- The directorate's website had important information about key members of staff that may be involved in patient's care; this included the names and photos of gynaecology consultants, nurses, midwives and allied health care professionals.
- Throughout the directorate there was information encouraging patients and their loved ones to be involved in the service. For example, we observed "Have your say" information online and there were similar examples on ward areas, which encouraged people to give their opinion about the service.
- The directorate worked closely with voluntary and other organisations to improve services for women and babies. In November 2014 Lady Mary Ward re-opened after three months of major reconstruction work which was funded by the "Addenbrooke's Charitable Trust (ACT)." Daphne Ward had been refurbished one year prior to Lady Mary Ward. Recently the hospital had been donated new style birthing balls, used to assist comfort and delivery during labour, and pumps, from the local Doula group. A Doula is a non-medical experienced person who offers emotional and practical support to women and their birthing partner before, during and after birth.

Learning from complaints and concerns

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- There were posters displaying how to make a complaint and comment boxes in most areas.
- We observed display boards on ward areas reading, “You said, we did” which demonstrated that the service learnt from complaints and concerns where possible.
- Staff described the value of dealing with people’s concerns straight away before they developed into more significant complaints. From the complaint responses we examined we found that complaints were handled effectively, within appropriate timescales and in line with trust policy.

Are maternity and gynaecology services well-led?

Inadequate



We rated the service as inadequate in the well led domain as the risks identified which placed women and staff at risk of avoidable harm had been known about for some time and yet action had not been taken to mitigate these risks. Senior staff were aware of the challenges in collating figures to maintain a dashboard to monitor performance but there were no plans to provide a workaround therefore the unit could not tell how well it was performing and how effective services were. At unit level we observed examples of excellent leadership principles; however, senior leadership had not addressed the issues which were known to them and did not have plans in place to ensure that women were cared for safely and in a responsive manner. Issues which were well known within the division included concerns regarding low staffing levels across the service, a lack of service capacity, equipment maintenance issues and poor Nitrous Oxide ventilation in the birthing unit. Risk registers were lengthy, not up-to-date and in some cases there was no clear ownership or mitigating actions decided.

Key performance data was not being collected robustly and therefore not always analysed which meant that responsibilities were unclear and that quality, performance and risk were not fully understood. We recognised that EPIC was the root cause of the problems with data collection, and that prior to its introduction many of the data collection issues were not apparent, however, EPIC was introduced six months prior and improving this issue was not seen as a priority as appropriate action had not

been pursued to resolve it. For example, there was currently no maternity dashboard for the service as the last one had been reported in December 2014 and senior managers were not able to tell us when this would be resolved.

Leadership and culture did however encourage openness and transparency. Staff told us they were well supported by their managers and many, “Loved their job”. Staff across all levels also told us that senior managers were approachable and visible, but staff were also clear that they were frustrated that action to address concerns, such as staffing, had not been actioned appropriately nor in a timely way. Staff told us that, “The good will of staff will run out shortly, we are exhausted”, and that, “We are on burn out here”. Staff and the public were encouraged to engage with the service, and despite our concerns we observed numerous examples of outstanding practice in relation to innovation, improvement and sustainability.

Vision and strategy for this service

- The trust vision and strategy was visible throughout the wards and corridors. Staff knew and could quote this vision.
- The directorate had a clear vision, to provide “Women’s and maternity services in a safe, clean, comfortable and friendly environment”. Whilst we found that the service had a strategy, we were concerned that it lacked defined objectives and strategic goals in relation to the concerns known by the service. This included the ongoing risks relating to low staffing levels, service capacity, equipment maintenance issues and the birthing unit environment. There was also no evidence that suitable action plans and business cases had been pursued to address these specific issues either. We were therefore not assured that the service could demonstrate how it was being planned, developed and improved accordingly.
- There was a “3 Year Divisional Business Plan 2015-2018” for the directorate was being delivered without appropriate workforce analysis in view of service demand.
- Whilst there were short-term plans to respond to staffing and capacity issues, such as closing the maternity unit, we were concerned that there was no long-term plan to address these concerns. This meant that services were not planned or delivered to meet the needs of local people.

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Governance, risk management and quality measurement

- Senior manager's told us about the difficulties currently being experienced in relation to governance, risk management and quality measurement across the directorate, owing to the implementation of the EPIC system, which had been introduced in October 2014 and the inability to capture specific data. Although managers told us that, "Every day this was improving slightly".
- We asked to see the current maternity dashboard. We were concerned that the service could not provide us with maternity dashboard data for the periods January 2015 to February 2015 - since EPIC was introduced. The service was able to supply a dashboard for March 2015 however not all indicators were captured on the EPIC system. Senior staff we spoke with shared concerns that this lack of data collection in maternity was, "Dangerous" and a "Risk". Prior to November 2014 we did see evidence of a robust maternity dashboard; however we were concerned that suitable action had not been taken to ensure that a maternity dashboard had continued post EPIC, and that this had been unchanged for nearly six months.
- This lack of data collection impacted governance arrangements, risk management and the ability to effectively measure quality of service provision. However the EPIC system did not collect data to ensure a complete dashboard of care. We were therefore concerned about the limited measurement and monitoring of safety performance overall.
- There was a risk register for both maternity and gynaecology. We were concerned that the risk register for maternity service was lengthy with risks entered back in 2011 still presented and not actioned. There was a lack of action plans and a lack of accountability or ownership for risk identified.
- There were regular governance meetings in both maternity and gynaecology. We reviewed the minutes of these meetings which confirmed that discussions about complaints, audit outcome, risk and incident analysis was occurring.
- Maternity services used Commissioning for Quality and Innovation (CQUIN) framework to set its Key Performance Indicators (KPIs), which are a type of performance measurement. These included breastfeeding, caesarean section, bookings before 12

weeks of pregnancy and smoking cessation rates. We reviewed the most recent CQUIN report and found that the service was not clearly demonstrating whether or not they were meeting the KPIs due to poor data collection from EPIC. For example, in the bookings section the March 2015 report reads that only 46.8% of pregnant women were booked before 12 weeks and that this, "Data is inaccurate". This inaccuracy of data was a theme throughout this report.

- There were numerous and excellent examples of good governance in terms of information sharing. Every four months the midwife risk manager distributed, "Risk Matters" to all staff which was a newsletter containing key service messages including risks within maternity and updates on new guidelines and current research. Staff told us that they found these newsletters very useful.
- There were additional newsletters on some ward areas, including Lady Mary Ward, which consisted of an analysis of recent complaints, incidents and necessary updates.
- Every weekday morning at 8am there was a five minute session on labour ward whereby senior managers communicated risk and key information to maternity staff, who were present from different units. Staff told us that they were able to attend the five minute session and they praised the Head of Midwifery for introducing this.

Leadership of service

- All staff we spoke with told us that leadership at unit level was, "Good" or "Excellent" and that their managers were approachable, supportive and pro-active. We observed that staff in charge of each unit demonstrated clear leadership principles and the trust values.
- Ward managers had achieved training in leadership and management, and we observed that more junior staff were being supported to develop their management skills in view of future promotion opportunities.
- Staff told us that senior managers were friendly and visible, and they commended senior managers for certain improvements that had been carried out in view of the recently renovated Lady Mary Ward, new transitional care ward and the introduction of the five minute session held on labour ward in the morning. On

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the other hand, however, the same staff also shared concerns and frustration that suitable action had not been taken by senior managers to address issues like staffing and EPIC.

- Each unit, including the community midwifery team, had regular team meetings or newsletters distributed. We saw that minutes and newsletters were circulated to all staff.
- We were concerned that there was no midwifery manager on call rota for maternity meaning that often the unit was closed based on a decision made by a band 7 midwife (bleep holder), SOM, hospital site manager, and the obstetric and neonatal consultant. Whilst this was in line with trust's maternity escalation policy, it meant that band 7 midwives had to put processes in place for closure with no senior maternity management support.

Culture within the service

- Staff were very open and honest with inspectors because they told us what worked well and what did not work as well.
- Staff were enthusiastic and strived to provide high quality care, they worked beyond expectations in spite of immense service pressures.
- All staff told us that they felt able to speak openly if they had a concern, although with some aspects of the service provision they felt that senior managers within the hospital were not taking appropriate action to support them to deliver a better service. Staff across all disciplines told us that the good will of staff will run out in view of lack of staffing, and that they were tired of, "Firefighting".
- Leaders within the service celebrated staff success. On the trust's website we observed that the directorate was proud sharing news that three student midwives had been had made the shortlist of six for "The Nursing Times; Student Midwife of the Year Award 2015".

Public and staff engagement

- A Maternity Services Liaison Committee (MSLC) was held regularly which was made up of local user representatives and health professionals from different organisations. The committee advises the trust on the maternity service provision.
- There were numerous groups which supported The Rosie Hospital and demonstrated public engagement with the service. For example, there was a "Friends of

the Rosie Hospital" charity which frequently raised money to buy additional medical equipment and equipment to make a more comfortable environment for mothers and babies during their stay, including knitted baby wear.

- The Rosie Hospital underwent extensive structural development in 2012 costing £30 million, which included the opening of the new birth centre and the close observation ward. Prior to the birth centre being developed there was a consultation which included a forum whereby patients and staff were involved in design. Staff showed us around the unit and gave us examples of how the unit had been built in view of what women wanted. For example, the walls were curved in some areas which made the environment less clinical.
- Patients, families and carers were encouraged to engage with the service. There were posters displaying how to do this and suggestion boxes were observed throughout the units. The Friends and Family Test questionnaire and patient feedback forms were distributed daily.
- Staff were encouraged to attend regular unit meetings and were provided with up-to-date literature about the service through newsletters and email. Staff were also invited to join in on forums including the reducing caesarean section forum.
- The SOM network at the trust was outstanding. There were posters displayed throughout the service reminding staff and patients about the service and encouraging them to get in contact. SOMs raised their concerns and on behalf of other staff openly, we observed this through the SOM meeting we attended during our inspection. SOMs also held regular breakfasts whereby staff were encouraged to drop in to regular open sessions to discuss any issues, good or bad, that they may have.

Innovation, improvement and sustainability

- Recently "The National Institute of Health Research (NIHR)" had recognised one of the doctor's clinical research from over the last five years and titled them an, "Expert in women's health".
- A recent study which had been conducted by the safeguarding specialist and the lead midwife for safeguarding demonstrated that 85% of women at high risk of post natal mental illness, who were offered a care planning meeting prior the birth, took up the offer, and therefore safeguarding the welfare of their new-born child. This study comes at a time when nationally there

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are concerns that women at risk of postnatal mental illness are not offered support. The vulnerable women support system at the hospital is well established and this research demonstrates considerable achievement.

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

Information about the service

The service provides a regional facility in Cambridge and surrounding counties for sick children and children locally, and was an overflow for London hospitals. For its 3,500 patients a year, the service had:

- main children's outpatients department
- five wards plus a paediatric day unit
- a paediatric intensive care unit,
- the Rosie Hospital on the same site (with neonatal intensive care unit and a special care baby unit)
- endocrine and diabetes clinics in the Weston Centre.

Some adult clinics, such as the eye clinic, also saw children. Pressure on beds meant the service sometimes put children from the age of 15 on adult wards. The children's service fell within Division E, which included women's services.

We:

- visited all the children's wards and outpatient areas,
- examined adult outpatient clinics, that saw children
- talked to 13 parents, five children, and 69 members of staff – including support workers, nurses, senior managers and senior clinicians.
- observed care, and looked at patient and service records
- reviewed performance information from, and about, the service.

Summary of findings

Children's services were protected from avoidable harm and effective, with a culture of reporting and learning from incidents.

Staff understood their responsibilities for safeguarding children, and acted to protect them from the risk of avoidable harm or abuse. There were enough medical staff but there were nursing shortages in some areas, such as in the day unit and in the neonatal unit. The new 'EPIC' (a records management system) computer system added to pressures on staff but effective temporary solutions helped to protect patients. Multidisciplinary working was effective, and care was evidence based. Staff monitored patient outcomes and participated in national audit. They also gained appropriate consent before interventions.

Staff morale was high, they had outstanding standards of patient-focused care, and they worked hard to meet children's and families' needs. Staff were caring, compassionate and empathetic. Children and parents felt well-informed and said staff were friendly and caring. Results of an external survey, and the many cards and letters expressing thanks, confirmed our findings.

Staff tailored services to meet individual needs and provided them in an attractive and child-friendly environment. Families could use translation facilities. Patients made few complaints but staff had a robust procedure and made appropriate changes to respond to

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concerns expressed. There was pressure on bed capacity with children as young as 14 occasionally having to be placed on adult wards by staff. Lack of adequate bed space across paediatrics was identified as a risk and was on the trusts risk register. The wait between being referred to the hospital and being seen was longer for most paediatric specialities than the 90% target. Senior managers provided clear direction and staff knew the trust's values. Staff keep up to date risk registers, incident records and audits and acted on areas for improvement. Staff, patients and families worked well together, to improve services.

Are services for children and young people safe?

Good



We rated service safety as good because staff reported incidents and implemented learning from them and protected patients from the potential of harm through safe systems of working.

The service had a good culture of reporting and learning from incidents. The service was open, honest and ready to acknowledge any shortcomings. Problems caused by the new EPIC computer system had been quickly identified by staff and acted to address these so that people were safe. Staff were clear about their responsibilities with regards to safeguarding children and young people. Staff followed safe medicine practices, there were good cleaning and infection control regimes and equipment was safety checked.

There were enough doctors on duty to ensure safe and effective care. However nursing vacancies in several areas were proving a challenge for the service. This was being well-managed by senior staff with staff already working for the trust being called in to help cover nursing shortages and only occasionally used agency nurses who were inducted onto the ward. Staff generally kept records up to date and included assessments of risks that could affect individual patients. Business continuity plans were in place.

Incidents

- Staff and managers were clear about their responsibilities in reporting and reviewing incidents.
- Staff reported incidents and discussed them at patient safety and governance meetings.
- There had been no 'never events' or serious incidents impacting on patient safety reported for the service in the year up to February 2015. The division reported 2,375 incidents in 2014 of which 304 were classed as moderate and 5 as major. However it was not possible to disaggregate those relating to children and young people's services from those relating to maternity and women's services from the information provided by the trust.

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- Staff noted a series of errors generated by the EPIC computer system regarding medication. Managers told us that the prescribing module had been trialled for adult patients and that the need for lower doses of some drugs for children had not been taken into account. However the trust informed us that 2,500 medications were configured in Epic with paediatric specific configurations at the time of system go-live. Staff vigilance had ensured that no children were put at risk and procedures were in place to double-check prescriptions. This demonstrated effective learning from incidents to protect patients from avoidable harm.
- There were regular learning meetings, for example in the neonatal unit where we saw that incidents and the lessons learned were displayed on a public noticeboard.
- Regular perinatal and morbidity meetings were held and there were also discussions with obstetric staff about 'near misses'.
- Staff were open, honest and ready to acknowledge any shortcomings. For instance, where drugs errors occurred parents were informed and a face-to-face meeting was held. Any potential problems were discussed and the parents were invited to contact the medical staff at any time if they had further questions or concerns.
- Staff within the children and young people's service would readily meet with families who felt concerns regarding their children's care. This was confirmed by the hospital's patient advice and liaison service.
- Hand hygiene audits monitored compliance, with the results being displayed on ward noticeboards. We noted good levels of compliance.
- Senior managers told us that all children's wards moved wards annually for deep cleaning. The risk register noted that the children's oncology and haematology ward needed to move wards regularly so that work on the ongoing issues with the ward cooling system and water pipes did not put patients at risk of dust inhalation.
- Full deep cleanse of the Children's Oncology and Haematology Day Unit was not possible as hydrogen peroxide vapour fogging was not viable due to ventilation constraints. However, the risk from not being able to carry out this procedure was assessed as being low. There was a similar issue on the children's oncology and haematology ward.
- There had been no recent incidents of hospital-acquired *Clostridium difficile* or MRSA in children's services.
- Provision for children in the Children's Oncology and Haematology Day Unit who needed to be kept in isolation due to infection, or to avoid infection, was limited. The areas used were at a distance from nursing staff and lacked oxygen or suction equipment.

Environment and equipment

Cleanliness, infection control and hygiene

- All waiting and clinical areas we saw were visibly clean.
- There were cleaning routines to ensure, for example, the regular cleaning of toys and confirmation that they cleaned equipment each time after use.
- Cleaning staff kept cleaning audits, which they noted and tackled, which showed areas that needed attention, for example where dust was found on a ventilation grille.
- There were plentiful hand-cleansing stations. Signs reminded visitors to clean their hands and this was reinforced by staff.
- We observed that doctors and nurses of all levels complied with key trust policies such as hand hygiene and use of personal protective equipment. Barrier nursing was used when caring for babies at high risk of contracting infections.
- The buildings, although dated in part, looked well maintained.
- We saw that there was secure access to children's wards, with the use of swipe cards or entry intercoms.
- Although there was pressure on space most areas were tidy and uncluttered. However cluttered corridors in one ward (C3) made it difficult for patients' beds to be moved to other areas without bumping into equipment stored in the corridor. This had a potential safety impact if patients beds had to be moved in an emergency.
- All resuscitation equipment that we looked at was documented as checked regularly and stocked appropriately. However, there was no adult resuscitation in the transitional care unit where mothers stay with their babies. This would be brought by the resuscitation team should it be required.
- Most other equipment, such as monitors, had been checked in line with their testing requirements. However, labels on a blood pressure monitor and a height measure indicated that checks were overdue. In

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the milk bank pasteurisation room we noted that the pasteuriser was overdue for a check by a week at the time of our inspection. Otherwise facilities and storage arrangements for breast milk were of a good standard.

- Staff told us that the "workstations on wheels" used for capturing information for the EPIC computer system only had a battery life of about three hours. This meant that they were sometimes not available for use if they had not been plugged in to recharge, for instance overnight. As a result information recorded at the bedside then had to be entered on a terminal rather than being noted and uploaded direct from the hand held device.

Medicines

- Medications in all the areas that we inspected were stored securely in locked cabinets. There were appropriate arrangements in place for the storage and use of controlled drugs, for example we saw evidence of daily checks in the neonatal intensive care unit.
- We carried out a sample check of medicines in the day unit. These were all in date and the controlled drugs' records matched the medication stored in the controlled drugs cupboard. A log book noted when chemotherapy had been administered and the records had been completed and signed by two nurses at the bedside.
- All refrigerators used to store medicines had regular temperature checks recorded. This meant that a temperature outside the acceptable range was quickly identified in a refrigerator in the children's outpatients department. This enabled the paediatric pharmacist to identify which drugs could still be used and which needed to be discarded.
- We saw that medicine administration records were carefully completed and were up to date.
- Several prescribing errors were identified when the EPIC system first went live. The system was allowing dispensing sooner than it should have done and/or at wrong level. This was quickly identified by staff and staff had reverted to paper records while awaiting a fix on the system. Risks associated with the prescribing of the antibiotic, gentamicin, are recorded on the service's risk register. We saw that problems caused by the EPIC system were being tackled by careful double-checking and the use of paper records so that the guidelines from the National Patient Safety Agency were being met. However, staff had to remain alert to other prescription

issues, for example the dosage for children of the blood pressure drug amlodipine is not immediately clear from EPIC and is not visible on the initial screen on the hand-held devices.

Records

- Staff told us that there were benefits from EPIC. They no longer needed to decipher handwriting and the recent status of treatment of a patient could be ascertained within 20 minutes where it used to take up to four hours. This meant that if there was a query or a complaint staff could quickly pull up the information and deal with the issue.
- We found that patient records stored on the EPIC system were clear. We were able to follow details for a patient on EPIC from admission to planning for their discharge from hospital.
- The information was generally up to date. However, staff reported that there could be a time lag between information being recorded on hand-held devices and appearing on the monitors. Staff reported that they had encountered some instances of information 'disappearing'. They were mitigating the risks by carefully double-checking that information entered was present on the system, and re-entering data where necessary. The trust assured us that all such reported incidents are investigated.

Safeguarding

- Responsibilities for children's safeguarding were clearly assigned and understood. We were given an example that showed that where the cause of injuries was uncertain staff would ensure that a proper investigation was carried out.
- Staff felt well supported in reporting any safeguarding concerns. They knew where to receive guidance and their knowledge of safeguarding contacts was audited. A new member of staff knew where to get advice when foster parents had asked for information concerning a child to be changed.
- Appropriate safeguarding supervision arrangements were in place.
- Staff stated that safeguarding training was in place and that completion was monitored. All nurses and health care assistants working with children were required to have Level 3 safeguarding training, which was refreshed every three years. We saw evidence of the monitoring and we were told that this was also checked in

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appraisals. All the safeguarding training records that we saw were up to date, with any delays in training being due to long term absence, for example maternity leave. However the divisional report for January 2015 shows that children's surgery and critical care staff had met the trusts 90% target for level 1 safeguarding while medical paediatrics had only achieved 85%. None of the three areas achieved 90% for level 2 or three safeguarding training with the worse being Medical paediatrics in Level 2 (78%) and for level 3 safeguarding training paediatric critical care achieved only 75%.

- In response to a self-harming incident, training by a mental health nurse was planned for nurses, healthcare assistants and play specialists in May 2015.
- Following the accusation and conviction of a doctor for indecent assault on children the service had tightened procedures including greater use of chaperones. The trust's chaperone policy specified that, "No child, young person or vulnerable adult should be seen or examined without a chaperone being present". We did, however, note that a clinician had reported that there was not generally another member of staff available to act as a chaperone in their clinic. This was recorded as an incident but designated as 'minor'.
- The trust's safeguarding children policy had last been updated in 2012, but a revision was in process. However, we noted that there was still limited guidance for staff if they were concerned about the actions of a colleague.

Mandatory training

- Mandatory training courses included moving and handling, safeguarding, infection control, and health and safety. Information from the divisional meeting in January 2015 shows that over 90% of staff in medical and surgical paediatrics had completed fire and resuscitation training, however in critical care these percentages fell to 78% and 86% respectively.
- We saw that progress in completing training was monitored for each member of staff and a ward manager explained how reminders would be sent to managers when training became due for any of their team.

Assessing and responding to patient risk

- The paediatric early warning score system was used to assess risks to patients.

- Our scrutiny of records and conversations with staff confirmed that patients at risk of, or suffering, deterioration were referred immediately for re-assessment.
- Risks to patients in wards and those using the outpatient's department were assessed and mitigated where possible, for example with parents being asked not to have hot drinks in the children's outpatients waiting area.

Nursing staffing

- Acuity tools were used to identify the required nursing levels in specialist areas. Senior management confirmed that staffing levels had been increased slightly in the neonatal intensive care unit and in two wards in response to increased complexity and levels of patients' needs. A ward nurse confirmed that staffing levels were constantly reviewed, including by peer review.
- However, we found that there were nursing vacancies in several areas, such as in the day unit and in the neonatal unit. The latter, for example was funded for 133 nurses. There were 124 nurses in post with a further 14 overseas nurses awaiting their personal identification numbers from the Nursing and Midwifery Council.
- Staff recruitment events were proving successful. 28 potential recruits had recently been shortlisted.
- We noted that a third of the 31 'moderate' incidents reported between September and December 2014 related to insufficient nursing staff levels or skills mix. This had resulted in staff having to take their breaks later and for a shorter time. In one instance this resulted in patients' medication being delayed. The risk register also noted that there were insufficient trained specialist nurses in oncology. An incident report noted a shortage of specialist nurses in dispensing chemotherapy. This was confirmed to us when we talked with staff.
- A shortage of qualified speciality nurses in the neonatal intensive care unit was noted on the risk register. This was monitored on a weekly basis, with bank staff being called in when needed. Steps were being taken to tackle these shortages for example by using secondments and training to help staff gain the skills and experience needed in the neonatal intensive care unit.
- Problems in nursing staff retention were reported as being due to the cost of housing and living in the Cambridge area as well as to nurses moving on to

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different roles. Some nurses experienced 'burnout' due to nature of their work and we were told that the trust was trying to address this by funding a half-time psychologist post from 1st April 2015.

- There was little use of agency nurses, with senior managers explaining that the hospital's own staff were used to provide 'bank' cover. On the few occasions when agency staff were needed it was requested that the same nurses should be sent to the hospital. This helped ensure continuity of care and that all temporary staff were conversant with the systems and practices within the service.
- We observed nurse handover sessions. These were clear, efficient and effective. A brief overview and update was given by the nurse in charge followed by a detailed nurse to nurse handover for each patient.

Medical staffing

- There were sufficient doctors on duty to ensure safe and effective care. We found all rotas fully covered, with consultants attending at night and weekends when needed.
- Handovers were held regularly. They were attended by consultants and were documented.
- No use was made of locums, with junior hospital doctors providing any additional cover.

Support staff

- The team of play specialists, who supported children in understanding their illnesses and treatment and who helped patients keep entertained and at ease were enthusiastic and committed. Play specialists told us, however, that the work that they could undertake was limited due to the continuing vacancy for a manager. This had also resulted in staff not having regular supervision meetings, although they felt well supported by children's outpatients' management.

Major incident awareness and training

- We saw that appropriate measures were in place for preventing and dealing with fires. Staff confirmed that they had received appropriate training.
- The trust had major incident and business continuity plans in place, for example protected computers that contain back up data and would continue to function if the rest of the system went down.
- We saw that each area, for example the children's outpatients service, had plans in place to deal with

incidents affecting that part of the service which resulted in the need to evacuate the area. However, the paediatric day unit, in which anaesthetics are used, does not have a back-up for its generator if this has to be brought into use and fails. Other areas of the hospital have a third power supply and these could be used for anaesthetics if required.

Are services for children and young people effective?

Good



We found good team work and multidisciplinary working embedded within the service, with other services in the trust, and with external organisations. This ensured that patients received continuity of care. Care was being provided in line with evidence-based practice and trust policies and procedures were being followed. Consent to care and treatment was being appropriately obtained. Patient outcomes were monitored and the service participated in national audits. Consultants were available at all times and services such as imaging were available out of hours.

We observed staff working in a competent and professional manner and they told us that they felt well supported by their managers. They had regular appraisals, and good learning and development opportunities to support them in their roles. Information regarding each patient's care and treatment could be quickly accessed from the EPIC computer system, although staff were still waiting for system changes to enable full nursing care plans to be held electronically. Other issues with the EPIC system were hampering effective care.

Evidence-based care and treatment

- We noted that policies were in place based on National Institute for Health and Care Excellence guidelines and guidance issued by the Royal College of Paediatrics and Child Health.
- Local policies and procedures were followed and audits carried out, for example in relation to infection control.
- Chemotherapy was stored and dispensed following national protocols. However, as shown by the incident

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records, the service was not meeting the standard at all times regarding two qualified registered chemotherapy nurses being on duty to check and dispense chemotherapy.

Pain relief

- The FLACC (face, legs, activity, crying and consolability) score chart was used to assess and monitor pain and neonatal nursing and medical staff were trained in use of the new-born Brazelton Assessment to identify signs that babies were experiencing pain.
- Assistance was available from a specialist pain control team.
- Nurses told us that the EPIC system was helpful in providing immediate access to information about the pain relief that could be provided to patients. This meant there was no need for a delay for patients in pain, as had happened in the past if a patient's records were with the pharmacy.
- We reviewed the EPIC records for 4 patients and saw that pain was noted on a scale of 1-10, with the pain team reviewing pain relief for individual patients.

Nutrition and hydration

- Patients' nutrition and hydration was documented on EPIC. However, problems with EPIC on the children's oncology ward had led to staff documenting fluids manually. There was, however, a written protocol to protect patients until EPIC was able to fully support oncology treatment and enabling the recording chemotherapy and fluid balance data. The trusts stated that this was a conscious decision to place paediatric oncology outside of EPIC until approval of the transfusion staff.
- We saw evidence of dietary assessments to ensure that children received appropriate nutrition.
- If a child on a ward missed a meal and was hungry hot food or a cold snack would be provided at any time.
- The children's oncology ward had its own chef who prepared food especially for children who had little appetite.

Patient outcomes

- The children's service participated in national audits, for example for paediatric diabetes and asthma, with performance showing as better than the national average. Action plans to address areas highlighted in

these audits were submitted by the trust. These showed in respect of paediatric diabetes that the trust was encouraging staff to be more proactive in maintaining a relationship with the hard to reach children.

- Non-elective paediatric readmissions were better than the England average, for example for medical oncology. However, elective readmissions for this area and multiple readmissions for epilepsy were both higher than the England average.

Competent staff

- We observed staff working in a competent and professional manner. We noted, for example, that extra care was taken in checking details for blood transfusions as some problems had been encountered with the EPIC system.
- All the staff with whom we spoke confirmed that they had good support from their managers and colleagues, for example through one-to-one sessions and team meetings, and had received the training they needed to carry out their work.
- Staff had access to counselling services such as from 'Care First' and from a recently created half time psychologist post to support them, for example, when caring for dying children.
- Appraisals were in place. Managers showed us how the computer system recorded training and appraisals. Staff received reminders when renewal dates were approaching for individual members of staff. Most services had reached 100% of appraisals apart from the medical staff in general paediatrics and paediatric surgery who had 78% compliance as at December 2014.
- Junior doctors confirmed that they had appropriate supervision and appraisals, and we found that doctors' revalidations were up to date.
- Staff were able to undertake further training in areas of personal interest that contributed to their work. Staff were required to formally share the learning from this training with their colleagues.
- Radiologists had undergone training in child development and in distraction techniques to help them understand and support children undergoing treatment.
- Staff felt that EPIC training had been insufficient.

Multidisciplinary working

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- We found effective multidisciplinary working between specialities and with health professionals across the trust. For example, consultants would respect the views of therapists regarding the suitability for discharge home of specific patients.
- There was generally good access to specialist input, although we were told that the neonatal unit had limited access to inpatient physiotherapy support..
- Paediatric oncology specialists worked with the multidisciplinary team that looked after adult cancer patients.
- We noted the effective liaison and/or referral to other specialities within the hospital and in the community to provide support for bereaved families.
- External liaison, for example with community nurses, GPs and other hospitals was effective. Multidisciplinary meetings and psycho/social meetings were held weekly to review the latest results and progress for individual patients and to jointly plan intervention care and discharge arrangements.
- We witnessed good multi-agency working and communication in the child development centre. Access both to EPIC and to Systm1 (the computer system used by many GPs) enabled more seamless communication between the hospital and community services.
- Effective liaison was in place with schools for children who had to spend extended time in hospital.
- "There was a well-organised and effective Acute Neonatal Transfer Service (ANTS) based at the hospital. This service is commissioned to undertake Neonatal Transfers for the East of England and undertakes around 1200 transfers a year including those from Great Yarmouth and King's Lynn. The Children's Acute Transfer Service (CATS) based at Great Ormond Street is commissioned to undertake all the paediatric transfers to a PICU in the East of England and due to the distances involved and the location of the CATS team it could take some time to reach certain hospitals. We spoke with a parent whose child had been transferred to the paediatric intensive care unit from one of the other main hospitals in the region. They told us that there had been a long wait for the transport but that there had been a good handover with treatment fully explained
- Each speciality transferred children to adult services at the age of 16, although children with complex needs were referred at between the ages of 16 and 18. Transition clinics were held for young people to prepare them for transfer to the adult services
- Referrals were made to psychiatrists if required, for example if children had eating disorders or severe mental health problems.
- The neonatal unit employed a psychologist and all paediatric units had access to psychologist support.
- Play specialists provided an excellent service. They made home visits to help children understand their treatment and get prepared for the experience. Sensitive and child-focussed strategies were enabling children as young as three years old to undergo radiotherapy without anaesthetic. We saw that play specialists had designed a poster based on the interests of a young child who was receiving radiotherapy. The poster bore the child's name and was there to greet them on visits to the radiotherapy department. It preceded the child as they moved around the department, giving a sense of familiarity. The child had been able to choose a ribbon to hold while undergoing treatment, secure in the knowledge their parent was holding the other end. The parent confirmed that the child was relaxed about their visits and the treatment. We saw that the young patient was happily playing with stickers that had been provided to go on their poster.

Seven-day services

- Consultants were available at all times to meet the needs of babies and children throughout the service. Staff confirmed that consultants would come in out of hours and we saw that registrars and consultants were on evening and night time rotas. A junior doctor commented that consultants were often in at night. The parent of a child receiving outpatient care from the service recounted an instance on Christmas Eve when their child was admitted to the emergency department. The consultant was contacted and was ready to come immediately to the hospital.
- Services such as imaging, pharmacy, occupational therapy and physiotherapy were all available out of hours when needed.
- The general paediatric day unit (F3) opened out of hours, for example to keep children on overnight observation.
- Play specialists were only on duty Monday to Friday.

Access to information

- Guidance was in place on the EPIC computer system for each patient's medical and nursing care, but the ability

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to hold nursing care plans on the system was still in development. As a result nursing staff had to be especially careful and vigilant to ensure that each patient received the care that they needed.

- There was not a consistent and efficient system for enabling bank and agency staff to access the data from EPIC that they needed to provide effective patient care.
- Together with other problems, for example oncology drug prescribing and a risk in the way that transfusions were ordered, we found that EPIC was hampering staff in the safe and effective delivery of care and treatment. By reverting to paper records and double-checking staff had ensured that no harm had come to any patient.
- We heard from doctors that some information seemed to disappear from EPIC records. This problem was echoed by play therapists. The trust assured us that all such reported incidents are investigated.
- Staff had noticed that the transfer of information from hand held devices, such as drugs given at a specific time, was sometimes delayed. To mitigate the risks no complex or intravenous drugs were being recorded on hand held devices. Staff had recorded the problems with EPIC as incidents, but were still waiting for satisfactory resolution of the issues six months after the installation of the system. The trust assured us that all such reported incidents are investigated.

Consent

- Consent would be sought from families and/or children as appropriate prior to any procedures or tests being undertaken. Children would routinely be asked if it was alright to weigh them or measure their height. For intimate examinations the trust's chaperone policy specified that the procedure must be explained and consent secured before it was carried out.
- Staff described how they would deal with children or parents who had reservations about a procedure. An example was given of a 14 year old needle-phobic who needed a blood test. Staff worked with parents to get the patient to relax and to obtain their consent. Staff with whom we spoke had not encountered any faith issues when seeking consent, but said that if they did they would explain what the medical reasons for the request were and also investigate other ways of obtaining the required data or health outcomes.
- We saw that consent forms were used, for example for lumbar puncture. Conversations with patients and their

families confirmed that consent was sought for treatments as appropriate. These included bone marrow transplants and participation in drug and treatment trials.

- We heard a discussion with an eleven year old and her parent regarding insertion of a nasogastric feeding tube. The patient's wish to be allowed a little more time to try to eat was respected.
- Specialist doctors asked young teenagers if they wished their parents to be present during their consultation. Children over the age of 14 were able to raise complaints without having to involve their parents.

Are services for children and young people caring?

Outstanding



We found outstanding standards of patient-focussed care, with staff going to great lengths to meet the needs of children and their families both in work time and in their own time. Children and their families were truly respected and valued as individuals and were empowered as partners in their care. We observed that staff were caring, compassionate and empathetic. The children and parents with whom we spoke felt well-informed and told us that staff were friendly and caring. There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promotes people's dignity. The results of an externally conducted survey and the many cards and letters expressing thanks confirmed our findings.

Compassionate care

- All the children and families with whom we talked expressed their strong appreciation of the kindness, consideration and friendliness that they received from staff at all levels across the service and from other parts of the hospital.
- The patient advice and liaison service stated that the most recent (2014) survey of families' and patients' views showed very positive responses regarding friendliness of staff and feeling that children were safe. 97 children responded to the survey and the trust performed better than other trusts in England for the

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question regarding staff not talking in front of children as if they were not there. The trust did not perform worse than the England average in any question on the survey.

- We observed sensitive and patient focussed care, for example anticipation that a young wheelchair user would want to move position and freshen up after a long journey. A hoist was brought from another part of the service so that it was in place to assist them.
- We saw that doctors, nurses and other staff treated patients and their families with respect and compassion. Friendly relationships were quickly established, for example by the first names of the doctors and nurses on duty being displayed in the day unit.
- One parent told us that their young child had a phobia of doctors but related well to staff here. They commented, "It is nice when you meet a member of staff that really knows how to look after children and is on their level".
- An inpatient described the care they had received as, "Absolutely wonderful".
- We noted that conversations with patients and their families were courteous and that telephones were answered promptly and in a friendly manner.
- Patients' privacy and dignity were maintained, for example with the use of privacy curtains when children were receiving personal care.
- We saw that the service received many letters and cards expressing thanks from patients and their families. Comments included, "Lovely staff who were only too happy to reassure us and offer super care".
- We saw that the service was considerate about families' needs as well as those of the patients, for instance a sign invited parents to ask if they needed a bottle or food warming up. Free meals were provided to breast feeding mothers with babies on a ward and we saw that there were excellent facilities for expressing breast milk.
- Patient confidentiality was respected, for example with computer screens closed down to avoid other people seeing confidential details.
- A parent we spoke with echoed comments by staff that the provision of care had been affected by the introduction of the new computer system as staff seemed to be spending time looking at the screens rather than with patients.

Understanding and involvement of patients and those close to them

- Staff had set up an ACTIVE Children and Young People's Board that enabled current and former young patients, and any other children who were interested, to meet and share ideas. The ACTIVE Children and Young People's Board was involved in producing child friendly information and in projects, such as Teens in Hospital which was looking at ways of improving the experience of young people, especially those on adult wards. Staff participated in this club and raised funds in their own time.
- The hospital ensured that it kept patients and their families well informed. Parents told us that medical and nursing staff discussed treatment and care and kept them updated. The family of a child in the paediatric intensive care unit expressed their appreciation of the way that they received a detailed update twice a day about the treatment and progress being made. A parent visiting in the outpatient's clinic told us that they never felt rushed in an appointment and that consultants and all other medical staff were friendly and gave clear and helpful explanations.
- Children and young people with whom we spoke told us that proposed treatments had been clearly explained to them and that they had been involved in decisions relating to the treatment. A teenage oncology patient was able to tell us the details of their diagnosis and the treatment plans that had been agreed with their consultant.
- Children and young people were empowered to make decisions, for example we were told that children could make decisions about the time of day that they would prefer to have chemotherapy treatments. An eleven year old stated that they were able to make decisions about pain relief. The ward teen room had a notice that stated, "Parents may be invited by young people to join them".
- Parents and their families were involved in decisions about their treatment and care. We saw that parents were involved in planning their children's care on the day unit. We observed that staff first had a conversation with the parents and then involved the child in the discussion to reach agreement about their care and treatment.
- Staff were responsive to children's and parents' needs for reassurance, for example a parent told us that an eye clinic consultant had given them their work email and

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responded promptly if they expressed any concerns or had queries. A young teenager said that, "Everybody is really friendly" and that staff were supportive if they felt distressed. Everything had been explained to them and their parents. Staff had put them in contact with another young person with similar health issues who had undergone the surgery that this young person was facing. The resulting conversation and peer support was valued by the patient.

- There were no set visiting hours on the children's wards although the service requested that only parents or carers should visit after eight o'clock in the evening to help keep down noise levels when children were trying to sleep. We did, however note that noise levels were often high in the neonatal intensive care unit. The unit had an ear symbol that indicated the noise levels and we noted that this was flashing red (high level) for much of the time during our observation.

Emotional support

- Staff were sensitive to children's and families emotional needs. Brazelton Assessment techniques were used to gain insight into infant behaviour and identify signs of stress in new born babies. Where babies had to be supported in intensive care parental bonding was encouraged. Parents were able to help change nappies, touch their baby and cloths with their parental smell were placed in the cot or incubator. A cloth with the baby's scent on it was given to mothers to help encourage breast milk production. Staff kept memory boxes of items from the babies' care. They told us, "We make little books so that they can see how their babies are improving".
- Effort was made to enable young people to take on responsibility for their treatment and to support each other, for example through the ACTIVE Children and Young People's Board and in clinics, such as the diabetes clinics. These clinics were age-banded to help children and young people to make more of a social event of their visits. Programmes developed elsewhere to encourage attendance and healthy living were used. Clinics were sometimes enriched by the presence of a medical assistance dog, trained to alert its owner to the signs of impending hypoglycaemic attacks.
- We observed that timely and sensitive support was given to families or patients who had received upsetting news. A ward manager described the approach to breaking bad news to a parent. Forewarned by the

consultant, the ward manager would be present at the meeting with the parent. In a recent example the consultant had then made a cup of tea for the parent who had been given the opportunity to telephone their spouse. The ward manager provided emotional support and the consultant returned to check that the parent was coping and the information had been understood. The next day there was a meeting with the parents to plan their child's care and treatment. We saw that the kindness of staff was appreciated for example a nursery nurse and a paediatric pharmacist were cited in the 'You made a difference' awards for offering emotional support when needed.

- There was a sensitive and measured approach to potential child abuse by parents. We were told of an example of where staff had concerns. These were investigated jointly with social care and it transpired that the issue was health-related and not the result of any parental abuse. A good relationship was maintained with the family during this difficult investigation.
- Emotional support and bereavement services and counselling were provided for parents and siblings. For example, the neonatal intensive care unit had a counsellor available for two days a week, access to a clinical psychologist and support was available from the chaplaincy and from the local hospice.
- Staff told us that more counselling support would be valuable and expressed their wish to be able to spend more time themselves with patients and families.

Are services for children and young people responsive?

Good



Services to children and young people were well-tailored to meeting patient's individual needs and were provided in an attractive and child-friendly environment. Translation facilities were available for families whose first language was not English. The service received few complaints but had a robust procedure in place and appropriate changes were made in response to concerns expressed.

The main issue for the service was pressure on bed capacity. Although accepted as not being ideal, the service could only cater for children up to the age of 16, with children as young as 14 occasionally having to be placed

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on adult wards. Lack of adequate bed space across paediatrics was noted as a red risk on the risk register as it had the potential to impact on the responsiveness of care, for example with operations being delayed but not cancelled. The wait between being referred to the hospital and being seen was longer for most paediatric specialities than the NHS standard. Strategies to tackle the pressure on beds included conversion of office space to clinical use on wards. Parents reported that they usually spent some time waiting in clinics, but told us that appointments were not often cancelled.

Service planning and delivery to meet the needs of local people

- Children's services provided an attractive and child-friendly environment through wall decorations, the provision of toys and use of distraction devices such as a projector and hanging mobiles in the children's outpatients' clinics to help children relax and keep them entertained. The parent of a nine year old who had to make frequent visits to remarked that their child was, "Happy to come because it is a nice environment".
- A range of facilities helped make a stay on a children's ward more enjoyable. We saw an attractive ward garden that children and their families could use. Children had access to free bedside television until 7.00 pm.
- A teen room was provided on the ward that catered for older children, and the teenage oncology ward provided very good facilities, with access to television and a range of computer games for patients.
- Whilst there was a dedicated children's outpatient department, children were also still seen in various other outpatient areas, such as the fracture clinic, eye clinic, and ear, nose and throat clinics. The adult clinics that we visited had dedicated play areas and toys available, although when we spoke to play specialists they told us that not all areas where children were treated had play provision or staff with the knowledge and skills to support children in adult areas.
- Play specialists supported children throughout the children's services and when they had to go to other areas within the hospital. Combined with the friendly and informal approach of specialist staff at all levels, parents told us that this helped children to feel at their ease while receiving treatment.
- The hospital's challenge of being a regional centre as well as providing district general hospital facilities for local people was well illustrated in children's services.

We found that several families travelled from across the eastern region and further so that their children could be treated at the hospital. One parent told us that they frequently made a round trip of over three hundred miles.

Access and flow

- Children's services only catered for children up to the age of 16. Patients aged between 16 and 18 were placed within adult services, with access to the hospital school teachers. Occasionally children as young as 14 had to be placed on adult wards. Between November 2014 and March 2015 there were 490 times that children between the ages of 14 and 18 were accommodated on adult wards. Senior managers stated that this was not ideal, but dictated by the pressure on beds in the paediatric wards.
- Lack of adequate bed space across paediatrics was noted as a red risk on the risk register as it had the potential to impact on the responsiveness of care, for example with operations being delayed but not cancelled, the inability to transfer patients out of the paediatric intensive care unit and the need to sometimes move patients within and out of the hospital late in the evening. Parents were advised to telephone the hospital before bringing their child to a ward prior to a medical procedure to check that a bed was available.
- We found, however, that the service had effective strategies to deal with the high levels of bed occupancy, including conversion of office space to clinical use on wards. The day ward was sometimes used overnight and evening rounds reviewed children who had been identified as nearly ready for discharge to see if they were well enough to go home.
- It was obvious, though, that resources were often stretched, with 7 of the 31 'moderate' incidents recorded between September and December 2014 being categorised as capacity issues due to shortage of beds. There were three instances of operations being delayed as a result. One child had to be temporarily accommodated in a treatment room while others were unable to move onto the wards from the paediatric intensive care unit.
- The paediatric intensive care unit had to refuse to accept 80-100 children per year due to lack of beds.
- Data for the year April 2014 to March 2015 showed that the wait between being referred to the hospital and being seen was longer for most paediatric specialities

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than the NHS standard, for example for ear, nose and throat problems where only 55.7% of inpatients and 73.7% of outpatients were seen within the required timescales.

- Between January and March 2015 an average of 10% of children and young people under the age of 18 waited in excess of the six-week NHS standard for diagnostic tests.
- Parents and patients told us that there was some waiting in clinics, for example up to two hours in the eye clinic, but generally not more than half an hour in the main children's outpatients' department.
- Appointments were not often cancelled, although one parent had experienced four changes in rapid succession for the appointment they were attending with their child and they had to ring to clarify as it was getting confusing.
- Parents of a baby told us that they had been called back for more blood tests, but the reasons had not been explained. They had not had the expected telephone call about the initial results, and when they queried this they were asked to come in again for blood samples to be taken.

Meeting people's individual needs

- We found that services were well-tailored to meeting patient's individual needs. There were specialist paediatric nurses employed, for example in diabetes and endocrinology.
- However, we noted that there could be a delay in some patients receiving their required medication due to the EPIC system 'locking' drug prescriptions, for example post theatre. This meant that nurses had to obtain renewed authorisation from a doctor before the medication could be dispensed.
- Play specialists helped make children's visits more enjoyable by involving them in activities. There was good provision of toys and we saw older children using computer games while they were waiting for treatment.
- We observed that the range of services in paediatrics worked in a co-ordinated and considerate way, for example to support and treat an oncology patient with learning disabilities and hearing loss. The parent of another child confirmed that their child's complex needs were met in an efficient, well-organised and considerate way.
- A language service was available by telephone to help communicate with people whose first language was not

English. We also noted that the welcome sign in the child development centre was in a range of languages and welcome leaflets for wards were available in several languages as well as in large print or audio formats.

- People from different cultural backgrounds were treated with equal regard and their beliefs and needs were catered for, for example with the provision of halal meals. Families from different ethnic groups assured us that their requirements were met in a considerate and respectful way.
- Attention was paid to making children's visits as enjoyable as possible. We spoke with a nine year old who had attended a children's' outpatients' clinic. They told us that they looked forward to their visits and their parent confirmed that the child was reluctant to leave. Music therapy was used in the child development centre, which also had a sensory garden for patients and families relaxation and enjoyment. When children needed to have a CT or MRI scan effort was made to help children relax, for example play specialists used a model of the scanner to explain how it worked. The light would be dimmed for younger children and parents were able to stay until the child was ready to be scanned.
- A well-equipped parents' room enabled parents to relax and to make themselves meals and hot drinks. A parent or carer was allowed to stay overnight in a bed next to their child, and provided with breakfast the next day. A nearby facility run by the Sick Children's Trust provided some free accommodation for parents and families. We spoke with two family members of a child in the paediatric intensive care unit and they told us that a room had been provided for them.
- Transition clinics helped young people make the move to adult services, for example a transition nurse and transition educator supported young people in the endocrine clinic. Young people could make decisions about when they wanted to see the doctor on their own and at what age they wanted to make the transition to adult services.
- There was provision within the hospital for children to receive teaching and continue their studies.
- There was no Wi-Fi available throughout the trust however there was an externally funded Wi-Fi funded by the Teenage Cancer Trust.
- When we visited the children's development centre we noticed that access was difficult for people using wheelchairs or with buggies. A doctor we spoke with in

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the unit confirmed that this was an issue, and resulted in people having to negotiate varying road and pavement surfaces to use the lifts near the Rosie Hospital and gain access to the centre.

Learning from complaints and concerns

- Patients and families told us that they had not had any reasons to complain about the service, but were confident that if they did mention any concerns these would be promptly and effectively addressed.
- Information about how to complain was on display and there were complaints and compliments boxes in clinical areas. Generally people would raise any concerns verbally and these would be dealt with by staff at point of occurrence. They would be referred to the hospital's patient advice and liaison services if the patient or their family were not satisfied with the response.
- The number of formal complaints regarding children's services was low. We found that the hospital had a robust approach to investigating complaints and were told that the service for children and young people fully co-operated with any investigations. If patients or families remained dissatisfied they would be invited to a meeting with all the staff involved in the patient's care. An independent clinical review would be offered if needed and details provided of the health service ombudsman.
- Any comments or complaints were discussed regularly at staff meetings and any learning was implemented as appropriate.
- We saw that ward noticeboards displayed details of any complaints and issues of concern and the service's response.
- Senior staff would discuss any complaints with staff as appropriate, for example complaints about a specific member of staff would be discussed in a one-to-one meeting with the staff member.
- Changes had been made in response to complaints. For example families and patients said they were not told of delays in clinics or how long they might have to wait. In response, clinics were allocated to specific staff who were required to monitor flow and inform patients of any delays. Patients to whom we spoke confirmed that this was happening and they felt better informed.

Are services for children and young people well-led?

Good



Staff at all levels were committed to excellence in the care and treatment of children and young people. Senior managers within the service provided clear direction and staff were able to tell us the trusts agreed values. Risk registers, incident records and audits were in place and we saw that action was taken where areas for improvement were identified. There was effective team working and staff, patients and families were involved in service development.

We noted that the service was ready to collaborate with other hospitals and was at the forefront of care and treatment of babies. The service felt under-supported and overlooked by senior trust management and there was no 'champion' for the service on the trust board. But clear focus on improvement had led to plans for a dedicated children's hospital receiving approval.

Vision and strategy for this service

- The trust had an agreed set of values that had been discussed with staff. These were known and understood by children's services staff with whom we talked.
- The clear focus on improvement had led to plans for a dedicated children's hospital receiving approval.
- Within the service we found a clear commitment to excellence in care from staff at all levels.

Governance, risk management and quality measurement

- The service had regular governance meetings and we saw that these included discussion of incidents and learning to be shared.
- An annual audit programme was in place. This included audits of patients' experiences of, for example, the transition service for young people with epilepsy. Responsibility for ensuring the audits were completed was assigned to named individuals and target dates and completion dates were recorded.
- We saw evidence that where results for the service varied from the national average the reasons were investigated.

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- Risk registers were in place. These recorded actions taken to mitigate risks, and we saw that there was appropriate referral to the trust's executive and regular review to identify any outstanding actions or changes in risk levels. The risk to provision of high quality care due to pressures on bed space had been appropriately retained as a 'red risk'. However the staff took action to mitigate this risk on a daily basis.
- Monitoring of service quality, for example of nursing care, was in place.

Leadership of service

- The service was led by four clinical directors with dedicated leadership time. They provided clear direction and were well liked and respected by staff.
- All staff with whom we talked told us that they received good support from their managers, although the vacancy for a lead in the play service was affecting the co-ordination of this service.
- We were told that the executive team were not visible within the service. There was no champion of children's services at board level and staff from all levels in the service told us that they felt little regard was paid to the service by the top levels of management.

Culture within the service

- There was a very positive culture among all those dealing with children, including in the adult outpatients' clinics. Staff told us that managers were approachable and supportive, morale was high and that the culture was open and transparent.
- Staff from other departments within the hospital confirmed that there was an open and honest response from the service regarding any complaints or concerns.
- Teamwork was cited as a strength, for example a student nurse told us that they felt well supported by all the members of their team and would have no hesitation in raising any concerns. Another member of staff told us that it was, "Like a family". Despite the Weston Centre being on the other side of the hospital from the main children's outpatients department, staff there felt part of the team and mentioned the camaraderie that existed.

- We noted good, friendly team dynamics, for example at handover sessions.
- A 'raising concerns' number was available if staff preferred not to approach their line manager.
- Senior staff felt any concern about a doctor or nurse would be reported to their line managers and the response would be supportive.
- Team meetings were regularly held at different levels and for whole teams across the children's service. Staff found these meetings useful, for example in sharing concerns. However, neither a manager nor a doctor whom we asked could confirm that this feedback reached trust senior management levels.







Public and staff engagement

- The 'ACTIVE' children's and young people's board was involved in a range of projects including getting involved with patient led assessments of hospital wards and clinics. We saw displays of the work of this group, which also has a page on the hospital website.
- Surveys of patients' and families' views were undertaken for the service by an external organisation. Action plans were put in place to tackle any issues.
- Staff and the public had been involved in designing the neonatal unit.

Innovation, improvement and sustainability

- Board approval had been secured for a children's hospital to be built. The service was beginning to formulate plans to secure the funding to translate this approval into reality.
- The neonatal intensive care service is at the forefront for provision of care for babies. The neonatal transfer team (ANTS) was the first such team to formally and consistently enable parents to travel with their sick babies. ANTS have in place equipment to "cool" infants with hypoxic brain injury that need transfer between one hospital and another. Information about this was published in the American Journal of Paediatrics in 2013. An MRI scanner had been installed in the Rosie Hospital with the aim that this will support research into brain injury in new-born babies. Pulse oximetry screening was carried out on all new born babies.

End of life care

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

Information about the service

The specialist palliative care team supported people affected by life-ending or life-limiting conditions and their families, including patients with complex symptom management with cancer. It received referrals from other hospitals and the community for other life-threatening or life-limiting conditions, from Cambridge and East Anglia.

Between April and September 2014 the team had received 705 referrals. In the previous year the split was 75% cancer and 25% non-cancer related referrals.

The trust had a special palliative care team six days a week, 9am to 5pm Monday to Friday, and 8.30am to 4pm on Saturdays. There was also a breathlessness intervention service which ran four days a week and saw an extra 350 patients at home. Nurses and doctors provided end-of-life care to patients on wards in the hospital. In the previous six months, 695 patients had died in the hospital.

The team comprised 15.35 whole time equivalents which were split by 2.7 whole time equivalent consultants, 3.65 whole time equivalent clinical nurse specialists and 9 whole time equivalent of other staff. The whole team provided medical, nursing and allied healthcare professions training, formal and informal sessions to students and trainees, and trained staff at all levels. There was a 0.6 whole time equivalent end of life care nurse educator in post.

The mortuary service had the capacity for 102 patients and supported other facilities for capacity in the area. However, eight fridges were out of use at the time of the inspection.

The team undertook routine hospital post mortems as well as forensic work for the local coroner. This service operated seven days a week with on-call cover for bereavement and viewings available.

The chaplaincy service provided a multifaith support service to patients and staff, with counselling services available to staff who cared for patients and families. This service operated five days a week with extra hours provided through an on-call service.

We:

- visited 12 wards and spoke with seven people who used the service and nine relatives
- spoke with members of the palliative care team and 49 other staff within the hospital who referred people to the palliative care service
- spoke to the chaplaincy and bereavement team, organ transplant co-ordinator and resus officer, and visited the mortuary.

End of life care

Summary of findings

Staff provided an end-of-life care service that was outstandingly caring. The palliative care team, mortuary and chaplaincy team locally were effective, responsive and well led. However, in the wider trust there were concerns with 'ceilings' of care around treatment at the end of a patient's life when they were not for resuscitation. This was not always well documented on the electronic medical record. Despite a clear flag on the electronic record staff were not always clear about who was or was not for resuscitation. Local teams were responsive to patient needs. However, the electronic records system (EPIC) created significant numbers of delayed discharges that impacted on patients receiving end-of-life care. We had concerns about how the service worked with community services to fast track discharges for patients at the end of their life.

The trust had introduced the "Last Days of Life" document to assist in caring for patients at the end of their life which had been uploaded within the electronic patient in January 2015. However we saw that staff continued to use the paper record. There were therefore two systems which directed nurses in how to care for patients. We found that where "Last Days of Life" was used this was poorly completed. The electronic record did not provide a holistic care record for patients as there was no care plan at the end of life. The trust had not participated in the National Care of the Dying audit as this was focused on the Liverpool Care pathway which was no longer used at the hospital. This meant that it could not benchmark its performance against other services.

The service provided person centred care to patients through support of people and their families for example with 'The wedding box'. This was a box of donated items to assist with patients getting married whilst in hospital. The specialist palliative care service was providing effective care through innovation, national and international acclaimed work. However improvements were necessary to ensure that people received effective pain relief and that ceilings of care met their individual needs. The chaplaincy "Perry unit" support of bereaved friends and relatives has won

national acclaim and had been adopted by other hospitals. The Breathlessness intervention service had won national and international acclaim as an area of excellence in palliative care.

Staff throughout the hospital knew how to make referrals and referred people appropriately. The palliative care team assessed patients in good time, to meet patient needs. The hospital's new integrated technology system (EPIC) had improved efficiency within the department giving staff better access to patient information. However there was much work to be done for the system to reach full potential. Many staff said they had struggled with EPIC and it was time consuming. The specialist palliative care team found patients dropped off the system, so kept two lists to avoid losing patients. Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end-of-life care.

The chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards. This work had won national acclaim and is being used in other hospitals. However, the mortuary was dated, in need of repair and had potential capacity issues while awaiting the hospital's expansion.

End of life care

Are end of life care services safe?

Good



End-of-life care services protected patients from avoidable harm. Do Not Attempt Cardio Pulmonary Resuscitation decisions were available on the front screen of the electronic patient information system. However, not all staff were aware of this. Poor handovers meant that some staff were unaware as to which patients may have a DNACPR order in place. When patients were discharged into the community they were discharged with the NHS standard template for the East of England. The hospital electronic flag was removed from the electronic patient record following discharge.

There had been no 'never events' or serious incidents requiring investigation reported. We saw that when patients had a Do Not Attempt Resuscitation (DNACPR) order in place this was easily accessed as it was stored in the EPIC electronic system and shown on the front page of the care record. The palliative care team analysed and learned from incidents and had processes for planning and monitoring the safety of the care provided. They had clear referral processes and effective arrangements to assess and coordinate people's care.

The mortuary was in a poor state of repair with key pieces of equipment broken. Specialist palliative care training, though available, was not always accessed. Staff reported time constraints due to shortages of staff across all inpatient areas.

Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place) reported for the palliative care service.
- Staff were confident in reporting incidents and 'near misses' on the hospitals incident reporting system. Feedback was given back through e-mail at ward meetings during handover and weekly updates.
- There were no incidents reported which specifically related to the care of patients at the end of their life.

Cleanliness, infection control and hygiene

- We spoke with nine relatives during the inspection of end of life care of those we spoke with two told us they felt the wards were clean and they saw staff wash their hands before they came into contact with people. The same two relatives told us the waste bins were emptied frequently during the course of the day.
- The mortuary, due to its poor state of repair was challenging to keep clean. We observed blood splatters on the floor and on one wall.
- We observed that the mortuary adopted appropriate protocols for high risk post mortems by restricting access and securing rooms whilst procedures took place. This minimised the potential spread of any infectious disease.

Environment and equipment

- There was sufficient equipment available to meet the needs of people on the wards at all times.
- Syringe drivers in use were T34 McKinley and were standardized to one type which would help minimise the risk of human or training error.
- Equipment in the mortuary including the bariatric table and lifting device were broken and the floor and wall tiles were in a poor state of repair with an area of wall tiles missing from the wall. These faults had been reported to the maintenance department for four months prior to our inspection however they remained unrepaired. This made the mortuary challenging to ensure that it was clean though the staff endeavoured to maintain cleanliness of the area.
- Due to the age of the building which was built in 1962 the drainage underneath the mortuary with aged pipes had been an on-going concern for the service. There were reports that the drains had blocked causing the mortuary to flood two to three times a year. However, the trusts stated that this had not happened for two years since cameras had been put down to check for cracked pipes and the pipes were cleared.

Medicine

- Anticipatory medicines for patients nearing the end of their life were prescribed appropriately by medical teams. Doctors were aware how to access guidance on intranet
- There were clear guidelines for medical staff to follow when writing up anticipatory medicines for patients. This is medication that patients may need to make them more comfortable.

End of life care

- We spoke with 49 members of staff we spoke to six with regards to anticipatory medicines. These staff told us that patients requiring end of life care were written up for anticipatory medications. We examined the records of nine patients receiving end of life care and found that anticipatory medicines had been appropriately prescribed.
- The e-hospital EPIC medicines administration page was hard to see on the “Rovers” (Hand held electronic recording devices). This required staff inputting medicines administration data directly onto a WOW, (work station on wheels) as they had larger screens. As the WOW’s were hard to access due to ward demand, this resulted in medications appearing as if they had been given late.

Records

- During our inspection, we examined nine sets of records on the electronic records system EPIC. All the records we looked at were legible, signed and dated, easy to follow and gave details of people’s care and treatment. However individualised care plans were not in use for end of life patients. We were told that they were in development.
- We saw risk assessments in patients’ records including infection control risks and, risks of falls due to decreased mobility. We saw discharge risks regarding home environment for example “patient has 10 steps to their front door”. We saw little evidence of advanced care planning in use in the hospital.
- While visiting the ward areas we reviewed 34 patient medical records on the EPIC system containing “Do not attempt cardiopulmonary resuscitation” (DNACPR) forms. We found that of the 34 reviewed all had been completed within the Resuscitation Council UK guidelines.
- The trust used the online system UFTO on the electronic record system to record decisions of DNACPR. When patients were discharged into the community they were discharged with the NHS standard template for the East of England. The trust had a system which flagged who was not for resuscitation on the electronic record. This flag disappeared two hours after the patient was discharged.
- In the records of the 34 patients we found that clear and comprehensive records were taken of the discussions between staff and patients (where possible) and their

- families. We spoke with two family members and two patients about their conversations. We found that people’s accounts of conversations matched what was recorded in their records.
- We saw that when patients had a Do Not Attempt Resuscitation (DNACPR) order in place this was easily accessed as it was stored in the EPIC electronic system. A member of staff demonstrated within the EPIC system where a DNACPR was located and we saw that this was on the front page of the system.
 - There was a lack of clarity on C7 ward around who was for resuscitation with the EPIC system. We were informed by a member of senior nursing staff that due to the problems with EPIC at times they have not been able to determine who is for resuscitation because they were unable to access the information and have had to proceed with DNACPR. We were told by a senior nurse that on more than one occasion that the patient who had been resuscitated had DNACPR orders in place. The staff did not report these incidents or events therefore there was no method of reviewing these concerns available.

Safeguarding

- We spoke with three members of staff in the specialist palliative care office about protecting people from the risk of abuse. The specialist palliative care team knew how to contact the safeguarding team via the Rainbow Centre. They also knew they could contact the local safeguarding team in and out of hours.
- 89% of staff trust wide had received adult safeguarding training within the last two years.

Mandatory training

- Syringe driver training was not part of mandatory training but new nursing staff at induction were required to complete it prior to using the syringe drivers. All staff we spoke to on the wards and within the specialist palliative care team told us they were trained, assessed and competent in syringe driver use however there was no data available in relation to this. New staff received half an hours training on end of life care and care on induction as a part of the mandatory training.
- A consultant told us, the specialist palliative care team offered a rolling education programme on “The

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standards of end of life care". However the lack of opportunity for particularly nursing staff to be released for a 30 minute session on the ward was limiting on-going education.

Assessing and responding to patient risk

- The hospital used a recognised national early warning score (MEWS) to monitor patients at risk of deteriorating clinical conditions. This was monitored through the electronic records system.

Nursing staffing

- Staffing levels within the SPCT were up to full complement of 15.35 WTE including 3.65 WTE Clinical nurse specialists and 9 part time staff. There was also a 0.6 WTE clinical educator for palliative care.
- There was a shortage of nursing staff throughout the inpatient areas with many nurse vacancies noted. There is a risk that patients who receive care at the end of their life may not receive the required level of care.

Medical staffing

- The SPCT had 2.7 WTE consultants in post. These were substantive doctors who provided cover over the six days with an on call service out of hours. There was no agency or locum use for medical staff within the palliative care team at the trust.

Major incident awareness and training

- The trust had a major incident awareness plan which detailed how all departments to respond in the event of a major incident.
- The mortuary had a specific part of the response major incident plan for which they had received awareness training and had a clear plan of action in place.
- The trust had contractual arrangements in place with an external company to provide refrigerated storage units should demand exceed capacity. However this could not be seen as a long term solution to their capacity issues.
- There was a lack of contingency planning in place by the trust at senior level relating to the mortuary. The local team at the mortuary were very aware of the concerns regarding the merger of two mortuaries in Cambridge and the impact it would have on capacity and increased service demand however no action had been taken by the trust to include the mortuary teams in the contingency planning of this merger.

Are end of life care services effective?

Requires improvement



End of life care services were required improvement on effectiveness. We found that the trust used a "Universal Form for Treatment Options" (UFTO) through the electronic records system which was being completed. This form enables the clinicians to discuss with the patient and if necessary their family the treatments they would agree to at the end of their life. However we saw that inappropriate ceilings of care were being given on the Do Not attempt Cardio Pulmonary Resuscitation (DNACPR) forms as a result of using this form. We saw limited information which supported that pain evaluation was recorded post analgesia administration. There was a recognised need to provide a seven day palliative care service at the trust however the business cases for this had not been granted and the service remains funded for six days per week.

Locally the teams providing end of life care including the specialist palliative care team mortuary and chaplaincy service were very effective in their delivery of services. Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication such as pain relief was readily available. People were being adequately hydrated with nutrition given high importance especially within the Specialist palliative care team. Mental capacity assessment were not always completed with some staff unaware that this tab existed on the electronic system.

Evidence-based care and treatment

- The palliative care team used a combination of National Institute for Health and Clinical Excellence (NICE), End of Life Quality Care Strategy and Royal Colleges' guidelines and quality standards to determine the care provided.
- The staff spoke about the "Gold Standards Framework" but we saw no evidence of it being used. The trust stated that it does not use the Gold Standards Framework but makes reference to it in their literature.
- The trust had introduced the "Last Days of Life" document to assist in caring for patients at the end of their life however due to the move to electronic recording this document had not been uploaded within the electronic patient record until January 2015. We saw that the staff continued to use a paper record. There

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were therefore two systems which directed nurses in how to care for patients. We found that where “Last Days of Life” was used this was poorly completed. The electronic record did not provide a holistic care record for patients as on this system orders are recorded rather than a plan of care.

- There was variable completion of the “Last Days of Life” as this had not yet been embedded nor was it being used consistently. Furthermore there was no evidence of individualised care plans seen for patients at the end of their life. We were informed by the EPIC team that these care plan models were still being built into the online records system and were not yet available.
- The breathlessness intervention service provided specialist input for people with chronic breathlessness who had received maximal medical treatment. The service was backed by rigorous research into interventions and had been recognised nationally and internationally as an area of excellence in palliative care.
- Medical researchers had designed the “Universal form for treatment options” (UFTO). This was to provide information and guidance for patients, relatives and staff to encourage discussion regarding plans of treatment including decisions on resuscitation at the end of life. Although we saw evidence that these were being completed there no evidence that treatment arrangements (ceilings of care) had discussed with patients. We also noted inappropriate ceilings of care on the DNACPR forms for example for one patient opting to be transferred to intensive care treatment and be resuscitated despite there being a DNACPR in place.

Pain relief

- Anticipatory medicines were being prescribed and equipment to deliver subcutaneous medication such as pain relief was readily available.
- We saw evidence that pain relief was being given. However little evidence that its effects were being monitored, for example site, intensity and type of pain. Some wards used pain thermometers but these were not always appropriately completed.
- The specialist palliative care team contributed to a trust-wide monthly pain forum where they assessed the management of pain through a multi-disciplinary approach to pain management. This meant that

patients could expect their pain management to be looked at by a number of clinicians who would coordinate an agreed approach to controlling their symptoms of pain.

Nutrition and hydration

- We saw that people were being adequately hydrated and nutrition was given high importance, especially within the Specialist palliative care team.
- One of the SPCT consultants ran a weekly feeding issues multidisciplinary team meeting which included. Gastroenterology, dieticians, speech and language therapists, nutrition nurses and the department of medicine for the elderly. People with complex feeding issues and those who may require artificial nutrition both within and outside of the hospital were discussed. It was clear that the SPCT placed a high emphasis on patient nutrition.
- Medical staff involved in the provision of end of life care were aware of the General Medical Council (GMC) requirements for nutrition and hydration at the end of a person’s life; this included the option of clinically assisted feeding.

Patient outcomes

- The trust had participated in national clinical audits they were eligible for including the “Care of the dying audit” in 2013. However they did not participate in the “Care of the dying audit” for 2014 as the trust had removed the Liverpool Care Pathway from its system on which this audit is primarily based.
- The National Cancer Patient Experience Survey showed that the trust’s performance on most questions improved between the 2012/13 and 2013/14 surveys and the trust was in the top 20% of participating trusts for more than a third of the questions asked. In the 2013/14 results, 93% of patients had had a choice of treatment types. 94% of people knew the name of the clinical nurse specialist (CNS) in charge of their care. 84% of people said they had received clear explanation of their results. 92% of people rated their care as excellent or very good. 88% of people were confident in what doctors told them and 89% of people said that staff did everything they could to help control pain all of the time. The trust was in the worst 20% for “Patient’s health got better or remained about the same while waiting”. In 2013/14 the trust scored 76%.

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- The trust was in the top 20 trusts for choice of treatment types. 90% of people knew the name of the clinical nurse specialist (CNS) in charge of their care. 92% of people said they had received clear explanation of their results. 81% of people rated their care as excellent and 92% very good. 88% of people were confident in what doctors told them and 88% of people said that staff did everything they could to help control pain all of the time.
- The SPCT was set to take part in a “Public Health England” pilot aimed at “Measuring the difference we make for our patients and their carers” in 2015.
- We saw audit data which showed that 95% of people were seen within 24 hours of being referred to the specialist palliative care Team (SPCT).
- The trust had not undertaken a DNACPR audit for 2014 or 2015 to date so the trust was unable to evidence how they had improved on the completion of DNACPR for patients.

Competent staff

- The specialist palliative care team nurses told us that they currently received end of life e-learning, group supervision and external supervision six weekly from a psychologist or counsellor.
- The Specialist Palliative Care Team ran a rolling “End of life” education programme. They employed a band seven nurse “End of life” teaching co-ordinator who provided a 30 minute core training session for new nurse’s induction. A 60-90 minute session induction session for overseas and European nurses. The trainer teaches Health Care assistants (HCA’s and student nurses. They have trained 406 nurses over the past 12 months.

Multidisciplinary working

- We saw good evidence of multidisciplinary team (MDT) working such as the monthly pain forum, which involved the SPCT, inpatient and outpatient adult and paediatric pain services. There was also the breathlessness clinic and weekly feeding forum where many specialities took part.
- The multi-disciplinary team available worked well together to ensure that patients care and treatment was planned and co-ordinated.
- We spoke to four families who were positive about the care they received and the support they were given.

Seven-day services

- At the time of inspection the SPCT did not provide a seven day face to face assessment service.
- A six day service was provided with 24 hour a day consultant cover. The SPCT were managing the six day service with the same staffing numbers they had to run a five day service.
- Although the SPCT were up to complement with their staffing numbers, they had submitted business plans to the trust for five consecutive years to obtain two band six nurses and one band seven nurse to enable them to extend the service to cover seven days a week which had not been granted.
- We were told by a specialist palliative care consultant that patients were receiving timely access to the SPCT. They told us, “I am proud of our speedy response to referrals” and quotes 95% of patients are seen within 24 hours after referral.

Access to information

- All permanent staff had access to patients records including the palliative care team. However agency staff, we spoke with, did not have access and had to rely on the trusts staff to allow them access. The trust stated that they had provided specific training to agency staff and new agency staff were offered this through the planned training programme.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Universal Form for Treatment Options (UFTO) had clear links to the Mental Capacity Act (MCA) guidance. Whilst there was a mental capacity assessment section on the EPIC system we did not see that this had been completed by staff and some staff were unaware that the tab existed This meant that we could not be assured that patients with whom UFTO had been discussed had been assessed as having capacity to make decisions.
- We examined nine records and 34 DNACPR forms of which 17 had a mental capacity assessment form completed appropriately. There was no evidence on the other 17 forms that mental capacity had been considered.
- We reviewed the care provided to seven patients receiving end of life care during the inspection. When reviewing end of life decisions to determine appropriate treatment options in respect of nutrition and hydration

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medical staff are required to follow the GMC's clinically assisted nutrition or hydration clinical decision model for adult patients who lack mental capacity. During our review of the seven records we saw no evidence that this was undertaken in five cases.

Are end of life care services caring?

Outstanding



Palliative and end of life care services were delivered by caring and compassionate staff. We observed that care was planned and delivered in a way that took the wishes of people into account. It was very evident throughout the inspection how staff went the extra mile to provide care for patients who were nearing the end of their life and despite limited resource in some areas the level of dedication was obvious to all including friends, families and patients who could not fault the caring nature of the staff.

We spoke with seven patients and nine relatives about the care received at the end of a patient's life and all provided very positive comments about the care received from the palliative care teams and the bereavement and mortuary service. These teams went above what was required of them to support and include families in care and it was clear that there was a strong culture of person centred care for patients and their families. Emotional support was available for people, their families and carers. The support available for families following the death of their relative was outstanding and innovative with their model of bereavement care being now used in other hospitals.

Compassionate care

- We spoke with seven patients and nine relatives during the inspection specifically about care received at the end of life. All people we spoke with told us that members of the palliative care team were caring and compassionate and did everything they could for their patients.
- The bereavement and chaplaincy service was available to support staff when they had provided care to people through the end of their life. There was a strong support for the staff counselling service available throughout the trust with staff, particularly in critical care areas, able to provide us with details of how supportive the staff counselling services were when they had provided care in traumatic cases.

- Mortuary staff were trained in bereavement counselling and provided flexible out-of-hours viewing for relatives and families.
- We were shown an excellent example of end of life compassionate care. Staff saw that the families of people who wanted to marry in the last days of life had little time to get wedding items. The oncology staff decided to start a "Wedding Box" to which they contributed money from their personal earnings to help facilitate weddings for patients in the last days of their life. They approached local businesses and the staff at a large local department store agreed to help. The department store, John Lewis, now also contribute to the wedding box and refresh this when items are used free of charge.
- People and families we spoke to told us unanimously that the care and they received was "fantastic" and that the nurses went "Above and beyond the call of duty to make people feel valued and respected".

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they felt involved in their care and treatment. Their families and carers told us they also felt involved. One family member told us that medical staff had fully explained the care and prognosis of their loved one. Another family member told us "At least we will have some quality time together when I get home." This family member told us they had been given time to gather the equipment required to get their loved one back home to their preferred place.
- We spoke with one person who told us "I didn't think I would make it this time. The staff involved us all as a family and explained everything regarding my DNACPR status. But look at me I'm still here so I didn't need to bother". Their family members told us "we can't thank the staff enough for what they have done and what they continue to do on a daily basis".

Emotional support

- The pastoral team were available to provide support for families and carers, including an on-call service out of hours. The team provided a dedicated service which supported people through the end of life process and recognised that they needed to support the emotional wellbeing of families after they had left the building and

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invited them in six weeks after the death of their relative to provide emotional support and answer any questions they may have. They also followed this up with letters to the family.

- Most wards had end of life care facilitators (Bereavement Care Champions) on them. They had all received training in “breaking bad news”.
- There was availability of counsellors and psychologists to offer support for people families and staff who required them.
- One of the chaplains was a trained psychotherapist and made themselves available to offer staff support in a quiet area away from the wards.
- The emotional support provided by the chaplaincy and mortuary staff at the bereavement suite was outstanding. There was an early intervention for bereavement for patients and families who had been given bad news and this service was established to support people with the preparations and journey towards the final moments. The service provided support, comfort and arranged any aspect of support required by patients and families.
- The service also provided support with the arrangement of undertakers, funeral services, body release, certificates and funeral arrangements. Six weeks after a person’s death the relatives were invited in for a follow up meeting to speak with the teams and for them to ask any questions they may have or to establish if any further support could be provided. This went above and beyond the call of duty to meet the needs and provide an outstanding level of care and support to those facing personal grief.
- Relatives of deceased patients had fed back to the chaplain that the system helped to alleviate a certain amount of stress being able to deal with all the documentation in one place. Relatives also fed back that it gave them a chance to ask questions at the six week follow up. This model of care for the bereaved and dying is being looked at and adopted by other hospitals who have been to visit to understand how this service is provided.

Are end of life care services responsive?

Requires improvement



End of life care services required improvement as whilst the local teams worked exceptionally hard to meet the needs of patients the end of a person’s life some improvements were required with the supporting systems. There were delays in discharges throughout the trust which affected the care provided to people at the end of their life with particular delays being noted in the fast track discharge processes which was not always quick and this impacted on patient care.

People had a choice in their care; they could make decisions where mental capacity allowed on their preferred place of death, resuscitation status and treatment options. The chaplaincy team provided an exceptional bereavement service with their model of bereavement provision being adopted in other NHS organisations as an example of good practice.

The mortuary team were responsive at managing capacity within their service and worked well with neighbouring trusts to manage capacity of mortuary space for Cambridgeshire. There were concerns noted around the longevity of being able to maintain the capacity of the service when a local mortuary merges with the one at Addenbrooke’s in future and the plans for managing this had not been determined.

Service planning and delivery to meet the needs of local people

- The SPCT took referrals from the whole of East Anglia with an estimated population of 752,900 people.
- The SPCT were acting and responding to new referrals in a timely fashion with 95% of new referrals being seen within 24 hours.
- The chaplaincy service was on-call 24 hours a day and recognised all denominations.
- Due to the ongoing concerns with information access on the EPIC system there has been lack of development enabling the palliative care department to extract patient data to monitor and improve patient care as the data they require is not accurate or accessible.

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- “Fast track” discharge planning could take anywhere up to three weeks to arrange due to lack of community resources.
- A consultant from the specialist palliative care team told us that they had close working relationships with community teams across East Anglia and aimed for seamless care for patients transferring between services. The specialist palliative care team had redesigned the service, cutting consultant hours to pay for two band six nurses to review patients without complex needs and to support the ward staff in their care and fast track discharge planning.
- One negative comment we received was that there were not enough quiet rooms for breaking bad news on some wards especially for bed bound people. Where this was the case staff told us “We are doing our level best to promote privacy and dignity wherever we can.”
- Translation services were available 24 hours per day through a telephone service.
- Staff and families had access to specialist services and nurses trained in caring for people living with dementia and people with learning disabilities, when a patient nears the end of their life.
- The needs of people who required end of life care were prioritised within the hospital wherever possible. However we were told that side rooms were not always available for end of life patients but staff would do their best to make them available wherever possible.
- The environment on the older wards was variable. For example the elderly medical assessment unit had little natural light due to the prefabrication design of the building. This ward environment was not suitable for people receiving end of life care due to the very poor natural lighting and little space for equipment.

Meeting people’s individual needs

- National research on bereavement had led the Lead Chaplain to devise a “One stop appointment” for bereaved families to alleviate further distress. One appointment was made for family members to, collect the death certificate, register the death, discussed any concerns around the death and view the deceased if required all at one appointment. Research had shown that at around six weeks after death loved ones started asking questions. Due to this the chaplaincy sent out letters six weeks after death offering relatives the opportunity of an appointment to come in and discuss any concerns around the person’s treatment or death. 23% of relatives responded to the letters and 13% asked for a meeting. The system was set up nine years ago at Addenbrooke’s and has proven to be effective in reducing both anxieties and complaints. The system has been rolled out to other hospitals as an example of good practice.
- Multi-cultural faiths were catered for within the chaplaincy with the chapel closing every Friday between 13:15 and 14:15 to facilitate Muslim prayer.
- There were prayer mats and multi faith books available such as the Quran and an ablution area for Muslims to wash themselves in prior to prayer.
- We saw evidence of poor discharge summaries with very little information on them.
- Information for people, their families and carers was available. We saw leaflets and booklets explaining symptoms and treatment options. The chaplaincy and bereavement service carried many books on for example “What happens next”. Information was also available for people with different ethnicity via “language line” or information staff accessed for them via the internet.

Access and flow

- There was an identifiable flagging system on EPIC for “End of life care.” However there was no way to identify these people if they were re-admitted to hospital. We spoke with one relative who told us that their loved one had been readmitted and put on the elderly assessment unit. She felt this was inappropriate for an end of life care patient due to its cramped conditions and extremely poor natural lighting. The trust has recently begun work to ensure that patients at the end of life are flagged on the system.
- We were informed that discharges were often delayed which placed additional pressures on hospital beds. We did not see any recorded evidence around delayed discharges for end of life care but we were told by staff they believed it was linked to poor discharge planning and delays in discharge letters being received by GP’s.
- The SPCT informed us that due to resource constraints in the community that fast track discharges for patients requiring end of life care were often delayed, we were told for up to six days, though there was no data routinely collected on this.
- We were provided with an example of one patient who was delayed for three weeks in receiving a fast track

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discharge which was linked to limited resource availability in the community. Their relative had been responsible for collecting equipment which they had found hard due to their own disability.

- The current mortuary capacity is continually around 80% with links to local funeral directors to support them with storage of the deceased during times of increased activity in the hospital. The service has good links with other hospital and services to maintain their capacity at a stable level. They also have an additional storage spaced they can use if demand requires it.
- The mortuary is due to be merged with another mortuary when a hospital in Cambridgeshire moves on site. The current mortuary will not be moved as part of the new development and there is no room to expand the space in the mortuary further. There is a concern that the capacity for the mortuary will not cope with increased demand on the service when the two mortuaries merge.

Are end of life care services well-led?

Requires improvement



Services for patients at the end of their lives required improvement in respect of being well led. Whilst the local teams were working hard to deliver a quality service there was a lack of vision for the service. There was no end of life care strategy for the service from the trust divisional leadership and senior management team who had not recognised the need raised by staff on expanding or improving the service. The mortuary team had not been involved in consultations regarding the merging of two hospitals and the merging of two mortuaries facilities and teams without extra space available which created a risk to the future of the service. There was a clear disconnect with the values of the board and the values of the staff working to provide the end of life care provision

Vision and strategy for this service

- We did not see any evidence that the trust had an “End of life care strategy”. Staff knew about “last days of life” guidance but this was not embedded in the hospital yet.
- There was no clear vision or trust consultation with the mortuary staff regarding the merger of two hospitals merging of two hospital mortuaries would affect the workload and the physical capacity and constraints of

the existing mortuary facility at Addenbrooke’s hospital. There is no way of extending the existing facility due to its location and the hospital which has expanded around the facility. There is also no plan or vision to relocate or build another mortuary.

- The trust has a vision, values and strategy for the focus and delivery of front line care however this was heavily focused towards research, academia and specialist service provision. There was a disconnect between the values of the board and the values of the staff working in the wards and departments. Business cases to build their service to support additional work, support and seven day provision had been submitted. However these business cases had been rejected by the trust for five years. There was a clear lack of investment in the provision of end of life care through palliative care and the mortuary by the trust.

Governance, risk management and quality measurement

- There were risk registers for the mortuary and for the palliative care service, the risk of not providing seven day services was evident on the risk register however the environment and equipment within the mortuary not being sufficient was not on the risk register.
- There is an end of life care steering group that looks at the provision of end of life care for the trust. This is chaired by the chief nurse.

Leadership of service

- We found that local leadership of the palliative care, bereavement, chaplaincy and the mortuary service to be extremely good with support from the SPCT Consultants down. However we saw little support for the service at divisional or trust senior management level. There was a disconnect between the local leadership and the divisional management level who did not act on requests by the service to drive improvement.
- We saw no trust leadership or support from the divisional management level for the mortuary service which was running at 80% capacity during the summer months and 100% of capacity during the winter. There was no engagement or inclusion by the leaders in the future of the mortuary service when it was agreed to merge two services.

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- Out of the 47 staff we spoke only five knew who the trust board members were or how to contact them or would recognise them if they were to visit their department.
- The Chief Nurse for the trust was the executive director responsible for representing end of life care at the board and was raising the profile of this service at a board level. The palliative care team informed us that this had been positive and that end of life care had been raised in profile on the board's radar.

Culture within the service

- There was a positive culture amongst the teams providing the services of end of life care. All staff spoken to told us they felt valued and supported as part of the team and their line managers who had an open door policy.
- Locally the passion and dedication towards delivering good care at the end of a patient's life was clear to see throughout the inspection. The palliative care, bereavement, chaplaincy and mortuary team dedicated a lot of hours to delivering the best service possible within their available resources. However much of this was provided on the good will of staff due to limited resources and there was limited input and oversight from the trust executive management and divisional management team.
- The staff within the mortuary, chaplaincy service and palliative care team were very open and were happy to raise concerns and believed the culture was open and learning could take place.


Public and staff engagement

- There was a lack of effective engagement with the staff in the trust on decisions about end of life care although the new chief nurse with end of life interest now sits on the board. The specialist palliative care team told us they hoped this appointment would help raise the profile of the service at trust level.
- Although staff knew how to refer to the specialist palliative care team there was a lack of knowledge amongst staff about to whom and when they should refer. However we saw a clear policy with guidance on who and how to refer.

Innovation, improvement and sustainability

- The external specialist counselling service for the specialist palliative care team staff is an innovation because it offers a level of support to staff who have difficult days to provide them with the support they require.
- The oncology team have devised, out of need, the wedding box for patients who want to get married in their last days of life. They engaged an external department store to agree to fund this which was innovative.
- Locally the specialist palliative care team were trying to improve and change but were not supported in doing so by senior management.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient's services at Addenbrooke's Hospital covered many specialities including dermatology, orthopaedic, ophthalmology, respiratory, and oncology. The diagnostic and imaging department carried out routine x-rays as well as more complex tests such as magnetic-resonance imaging (MRI) and computerised tomography (CT) scans. We inspected services that were solely provided from the hospital site. Services at the hospital saw adults and children and there was a separate children's outpatient's department.

Outpatient and diagnostic imaging services were available Monday to Friday. Some clinics and CT and MRI scanning were available at weekends and in the evenings. However there was an on-site radiologist available 24 hours a day seven days a week as well as specialist on call cover. Patients were referred by their GP, consultant's private practice or as self-referrals. The trust had 642,499 appointments during 2013-14.

In April 2014, the service began a redesign project called 'centralisation', to combine all outpatient clinics under one management structure. However, at our inspection, the project was incomplete, as it had been adversely affected by rolling out the trust's electronic patient record system, EPIC. EPIC had caused significant disruption to outpatient services at Addenbrooke's Hospital over the previous six months.

We:

- inspected the main outpatients department and radiology

- visited 12 clinic areas,
- spoke to 65 members of staff including diagnostic and imaging staff, consultants, nurses, and support staff
- observed care,
- looked at two patient records and
- spoke to 25 patients and those close to them.

Outpatients and diagnostic imaging

Summary of findings

These two services were very different: the diagnostic imaging services were good across all our five key questions, but the outpatients' services required improvements to be made. Outpatient services were not working efficiently to protect patients from avoidable harm, with a weak incident and learning system. Staff could not describe incident reporting requirements and were confused about reporting requirements of serious incidents. They could not describe or provide evidence of incidents that had led to improvement.

Staff did not always properly assess patient risk, with excessive backlogs of patients waiting for follow up or routine appointments in some clinics. One serious incident had determined avoidable harm to a patient with 21 more patients feared to be at risk. We asked to review a copy of this risk assessment. However, the review was currently underway.

While introducing EPIC, processes to deal with remaining paper records were unclear. For example, staff documented follow-up appointment requests on notepads. Paper records which were not stored in EPIC were inconsistently stored within the outpatients department. Inaccurate discharge summaries led to a risk that patients would not receive appropriate follow up care.

The service was not responding to people's needs for appropriate and timely care and treatment. There was a significant backlog of follow-up appointments in ophthalmology and dermatology and some patients reported waiting for an appointment for up to two years. The trust was not meeting a significant amount of its performance targets. The trust provided information that demonstrated that no new patients were waiting more than one year for an appointment.

However, diagnostic imaging services were providing appropriate and safe care. Staff within this department understood incident reporting processes and used effective infection control systems. They maintained equipment in line with appropriate legislation and guidance. The diagnostic and imaging department was part of the imaging service accreditation scheme (ISAS) which identified that the trust was performing well.

There were excellent examples of multidisciplinary working, particularly in the infectious diseases clinic, and staff reported good internal relationships. There was excellent practice within the allergy clinic. The trust had implemented a one-stop allergy service to diagnose and manage many allergic disorders, this clinic was dynamic to the needs of patients and provided a comprehensive service.

Services generally met people's needs and staff understood how to support people with physical, mental health and cultural needs. Staff were friendly, approachable and caring. Patients said they were happy with their care and staff were kind and caring within outpatients and diagnostic imaging. Patients felt included in decision making and care planning for their conditions.

Overall, the service lacked robust management and governance system in the outpatients department. We could not be assured that staff were assessing and monitoring issues within the outpatients' department to ensure improvement.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Inadequate



These two services were very different: – the diagnostic imaging services protected patients from avoidable harm whereas the outpatients' services did not. Outpatient services were not working efficiently to protect patients from avoidable harm, with a weak incident and learning system. Patient risk was not always appropriately assessed with regard to excessive backlogs of patients waiting for follow up or routine appointments in some clinic settings. In ophthalmology and dermatology it was documented that some patients had been waiting for an appointment for up to two years. One serious incident had determined avoidable harm to a patient with 21 more patients feared to be at risk. We asked to review a copy of this risk assessment however; this was not provided to us. Staff could not describe incident reporting requirements and there was significant confusion about the reporting requirements of serious incidents. Staff could not describe incidents, or give evidence of making improvements from incidents.

Due to the implementation of EPIC, whilst processes were in place to deal with remaining paper records these were unclear. For example, staff documented follow-up appointment requests on notepads and there was an inconsistent approach to ensuring the appropriate storage and other diagnostic records which could not be stored to EPIC. EPIC had also been producing inaccurate discharge information leading to a risk that patients would not receive appropriate follow up care.

Some equipment had not been adequately maintained by the estates team and one clinic was not working to appropriate infection prevention and control guidance.

However, diagnostic imaging services were providing appropriate and safe care. Staff within this department understood incident reporting processes and there were effective infection control systems in place. Equipment was also well maintained in line with appropriate legislation and guidance.

Systems for ensuring staff had appropriate training were generally well embedded except for the medical outpatient team where significant improvement was required to ensure staff were up to date with their mandatory training.

Incidents

- Seven members of staff we spoke with out of 65 were unclear about the requirement to report patient safety incidents or near misses. A few staff we spoke with could not describe the incident reporting system or find it on the trust's internal systems when asked.
- Four other staff said they had not reported incidents that they had witnessed due to the working pressures within the department generally.
- Four other staff said they had not reported incidents that they had witnessed due to the working pressures within the department generally.
- We reviewed a quarterly analysis of themes and trends of incidents within the outpatients department; however found that senior staff we spoke with were unaware of this data or how it was being used to inform learning. This meant that the service could not demonstrate it was acting and responding to actual or potential incidents of patient harm or ensuring that learning and improvement took place.
- Information the trust provided to us demonstrated that there had been 12 serious incidents within the department in the previous year. However when we asked staff to describe how an incident had led to service improvement or learning they were unable to provide an answer.
- There was significant confusion within the department of what constituted a serious incident and how these should be managed. The ophthalmology clinic told us that they had reported 21 serious incidents but no record of these could be found. Therefore the department was not assessing and responding to the risk of harm to these patients.
- We looked at the root cause analysis investigation reports for three serious incidents and saw that appropriate investigation took place. However the processes for follow up and ensuring lessons were learnt and embedded were not followed.
- There was however a good incident reporting culture in diagnostic imaging services. Staff were aware of how to record and report incidents on the electronic reporting

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system. Staff demonstrated an awareness of what types of incidents needed to be recorded and who they needed to be reported to for example, the Radiation Protection Advisor (RPA) or CQC as appropriate.

- Learning from incidents in radiology could be evidenced through radiation safety committee minutes.

Cleanliness, infection control and hygiene

- All the outpatient and diagnostic imaging areas we visited were found to be generally clean.
- The infectious diseases clinic was exceptionally clean and well organised.
- We noted that the majority of staff in clinical areas observed 'bare below the elbow' guidance and adhered to the hospital's infection control guidance. We observed staff adopting hand hygiene techniques in the majority of areas we visited.
- There was a good supply of alcohol hand gel dispensers.
- Infection prevention and control policies were accessible to all staff on the intranet, and staff we spoke with knew how to find them.
- Waste management systems were in place for the disposals of clinical and non-clinical waste.
- The trust gave us a number of audits for February 2015 which demonstrated regular cleaning checks took place and that actions for improvement were highlighted and action taken.
- The environment within the maxillofacial and oral clinic was not working to best practice. There were no separate clean or dirty areas for contaminated dental equipment. We asked to review a risk assessment and noted that the risk was being managed with use of colour coded boxes to separate dirty and clean equipment. This risk had however been ongoing for five years, with no plans to find a permanent solution.

Environment and equipment

- There was an inconsistent approach to the maintenance of equipment within the clinic settings that we visited. However, equipment such as blood pressure monitors and defibrillators in other clinics had been regularly serviced tested and appropriately cleaned.
- Where electrical testing was completed, we saw labelling on equipment to demonstrate that testing had been completed and on which date.
- We looked at a sample of resuscitation equipment across the departments. We found that checks were not being carried out regularly. For example, an adult

resuscitation trolley had not been checked for three days (should be daily) prior to our inspection. We also found that an oxygen cylinder on the paediatric resuscitation trolley had passed its expiry date by six weeks. We informed the trust about this during our inspection.

- There were radiation warning signs outside any areas that were used for diagnostic imaging. The preparation of radioactive materials was carried out behind keypad coded locked doors to ensure safety.
- Policies and procedures were in place for all scope equipment including separate guidance for the cleaning of radiographic equipment.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protect patients against unnecessary exposure to harmful radiation.
- Specialised personal protective equipment such as lead aprons for staff and lead shields for patients were available in the radiology department and it was confirmed these were checked on a daily basis and screened annually for damage.
- The radiology manager kept an inventory of equipment and we saw that this was kept up to date with the addition of new equipment as necessary.

Medicines

- We checked the storage and management of medicines and found effective systems in place. We found that refrigerator temperatures were monitored with the exception of one fridge in clinic 9, which we found did not have any records to confirm that appropriate temperature checks had taken place.
- Drugs and lotions were stored safely with all medicine cupboards we checked being locked. All medicines we checked were within their expiry date.
- Staff were aware of the trust's medicines management policy and it was available in departments for staff to refer to.

Records

- An electronic records management system called EPIC had been introduced into the service in October 2014 and the department was aiming to be paper free by October 2015.

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- However during this inspection we noted that there were inconsistencies in how paper records were being managed although records were available for patients attending the outpatients departments.
- In one clinic we saw that a room storing confidential patient records was unattended and had been wedged open by a door stop in a publically accessible area.
- In the orthodontic and maxillofacial clinics administrative staff had developed their own local way of storing hard copy diagnostic records. However, there is a risk that without a consistent approach to the storage and maintenance of records such as x-rays and diagnostic records may become lost or disregarded.
- In the fracture clinic, we noted that requests for follow up appointments were being written on notepads. There is a risk that these requests for follow up appointments could become lost; meaning that patients could be placed at risk because of delays or appointments. The trust stated that all patients' records are signed off before the patient leaves the clinic this would include any follow up arrangements.
- We spoke with stakeholders prior to our inspection who told us that there had been ineffective discharge letters sent out by the trust. These included a lack of information about treatments or diagnoses people had received or missing information in relation to medications. This meant that there was a risk of people receiving inappropriate follow up or after care due to inaccurate records produced by the trust. The trust confirmed that they had experienced some issues with sending out letters but recovery plans were now in place.
- The standard of record keeping in the outpatient neuropsychology assessment service was good.

Safeguarding

- There was a safeguarding lead at the hospital and staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff knew who the trust's safeguarding lead was and how to contact them.
- Staff working in the outpatients department were provided with mandatory safeguarding training to level 2. Data we received demonstrated that the majority of staff were up to date with this training however

improvement was needed in relation to administrative and clerical staff in trauma and orthopaedics clinic where uptake of level 1 training where only 75% against a target of 90% was being achieved.

- Staff were able to talk to us about the insight and knowledge they had gained from this training.

Mandatory training

- Staff mandatory training was evidenced by a paper based table indicating that the majority of staff of clinic staff were up-to-date with mandatory training with figures of above the trusts 90% target being reported.
- This was not however the case in a small number of outpatient areas for example dermatology department was not up to date with training in conflict resolution, fire and manual handling.
- Medical outpatients training required significant improvement with only 40% of nursing staff being up to date with resuscitation training, fire training and manual handling training.

Assessing and responding to patient risk

- There was a significant backlog of patients waiting for ophthalmology appointments. At the time of our inspection the total number of patients waiting for a follow up appointment was 6,911 and 2,500 new patients were waiting for a first appointment. We asked on numerous occasions to be provided with a risk assessment or evidence which demonstrated that the service had assessed and prioritised patients at risk of harm. This is important because in spite of the backlog, the service could have seen patients with the most serious eye problems first. We were not provided with evidence that any such patient assessment had been undertaken.
- We found that a serious incident reported in July 2014 had determined avoidable harm had come to an ophthalmology patient whose follow up appointment had been delayed by 6 weeks. As part of the investigation we saw that a further 21 patients had been identified as at potential risk with even more serious incidents envisaged. We asked to review a copy of this risk assessment however; this was not provided to us. The trust provided a summary of actions taken of the 21 patients. 2 had come to harm and one was awaiting medical treatment prior to ophthalmology treatment.

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- We found this also be the case within dermatology where a backlog of 2,500 patients was reported. Again no patient risk assessment could be provided to us to demonstrate that patients would be prioritised based on clinical need.
- We escalated these concerns immediately following our inspection. The trust had recovery plans in place but had not successfully covered medical staffing to reduce the waiting times in the ophthalmology service. Within the dermatology service a new template had been designed and a Fellow had been recruited to cover some appointments however most actions were on hold, delayed or in progress. We were not assured that patients were being protected from avoidable harm in these services.
- If a patient deteriorated, systems were in place to contact an emergency response team. There were also a number of resuscitation trolleys across outpatients which were available.

Nursing staffing

- Staffing was low within the Ophthalmology department. Staff told us, and we saw from records, that they were being asked to cover extra shifts and sometimes were required to cover two clinics when there should be one member of staff present at each.

Medical staffing

- There was a shortage of consultants employed by the trust with outpatient commitments. Data provided by the trust showed that across outpatients there were 21 vacancies for consultants who had direct outpatient commitments. The trust provided evidence which showed that they were recruiting to fill these vacancies. At the time of our inspection, 8 posts had been filled and start dates confirmed.
- We heard that locum cover was being provided where necessary. However, managers and clinicians acknowledged that due to the implementation of EPIC it was difficult to use new locums who were not familiar with the trusts systems.
- We spoke with consultants who told us that clinics often overran or were over booked. For example, morning clinics often exceeded their allotted time. This meant that they had less time for ward rounds and other commitments as morning clinics exceeded the allotted time.

- We heard that on occasion clinics had had to be cancelled due to a lack of consultant cover or the need for a clinician to attend accident and emergency. The trust could not provide data which confirmed how often this had happened. However staff reported this to be a rarity happening once or twice per year with little effect on patient care.
- The associate director of operations recognised that lost medical capacity in both ophthalmology and dermatology had impacted on service delivery.

Major incident awareness and training

- There was an internal major incident policy in place which contained plans to assist staff in dealing with circumstances such as loss of staff, loss of information technology or data, loss of utilities, denial of access to property or parts of, supply chain failure, or acute pressures in capacity.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patient care, treatment and support was based on national guidance and legislation. Staff were trained and competent to carry out their roles effectively and in line with best practice. Staff were supported to maintain and develop their professional skills and experience and appraisals took place annually and these were generally completed on time.

The diagnostic and imaging department was part of the imaging service accreditation scheme which ensured that patients received a consistently high quality service. However we found a lack of patient outcome measures in place across the outpatient department. The trust performed worse than the England average in relation to its new to follow up rate. There were excellent examples of multidisciplinary working, particularly from the infectious diseases clinic, and staff report good internal relationships. There had however been some problems with timely access to information to provide patients and other healthcare professionals with up to date patient information due to the implementation of EPIC.

Evidence-based care and treatment

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- Waste management procedures were in place for the disposal of radioactive waste which complied with the Environment Agency's Environmental Permitting Regulations 2010.
- Diagnostics and imaging conducted patient dose assessments and audits to ensure that patients received the correct level of radiation dose when receiving x-rays. Part of this work used national guidelines to inform their practice.
- We saw reviews against IR(ME)R regulations were undertaken and that learning was disseminated to staff through team meetings and trainings. This included auditing radiotherapy services and diagnostic x-ray services. Learning and investigation had taken place where improvements had been identified regular follow up took place through the radiation safety or medical exposures committees.
- The trust had recently developed radiation safety policies and procedures in accordance with national guidance and legislation. The purpose of the policies was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had a radiation protection supervisor to lead on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations.

Patient outcomes

- The diagnostic imaging was part of the Imaging Services Accreditation Scheme (ISAS) and was into year two of three of accreditation. ISAS is a patient-focused assessment and accreditation Programme that is designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- There was lack of local initiatives within the outpatient department generally to monitor and report on patient outcomes. For example, there was a lack of local audits identified on the department's audit plan which demonstrated all specialities were using audit as a way to monitor and improve outcomes for patients.
- The trusts follow up to new rate was consistently worse than the England average for the period July 2013 and June 2014.

Competent staff

- There was a mixed response from staff with regards to appraisals. Some staff told us that they had not received an appraisal in the last year. When we asked managers about appraisal rates we were told on numerous occasions that appraisals were being booked to be completed by July 2015. The trust data we received showed us that the majority of staff within the directorate had received an appraisal within the last year.
- Junior medical staff had good support from consultants and told us they always responded or came in when they were on call to provide support in complex cases.
- Staff had good access to learning and development courses to help support them in their roles.
- An up to date equipment competency log was kept for all staff working within the radiology department.

Multidisciplinary working

- Good internal team working was reported between services for example, between clinics and diagnostic imaging services and the pathology department.
- There were outstanding examples of MDT working given by the infectious diseases clinic. A social worker was assigned to work with the clinic in order to support patients who were newly diagnosed with HIV and their families.
- Virtual meetings were held as part of the Regional HIV Network in order to share learning and provide professional development across professionals in the region caring for patients both as inpatients and outpatient.
- The booking centre managers were working to develop external relationships with the CCGs in order to improve quality and consistency of the service.

Seven-day services

- Outpatient services were not available seven days a week. In order to deal with appointment backlogs some outpatient services were being made available in the evenings and some clinics were available Saturdays between 9:00am and 5:00pm.
- Although CT and MRI scanning are available on a Saturday there is an on-site radiologist 24 hours a day, seven days a week. There are three consultant radiologists providing specialist on-call cover who also provide reporting services on Saturday and Sunday

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Access to information

- A selection of administrative and clerical staff told us of the impact of EPIC on the work that they undertook.
- We saw that letters were prepared in an unformatted way and were told that information such as laboratory results, took a long time to appear on the system. This sometimes meant healthcare professionals did not have access to the most up to date and accurate information for their patients.
- Prior to the inspection we spoke with the Local Medical Committee and been contacted by numerous GP's concerned at the lack of information provided following discharge since October 2014. Concerns included insufficient information on patients' diagnoses and care and long delays in discharge and clinic letters being received by GP's.

Are outpatient and diagnostic imaging services caring?

Good



We observed staff being friendly, approachable and caring. Patients told us they were happy with the care they received and were treated by kind and caring staff within outpatients and diagnostic imaging. They told us that in general they felt included in decision making and care planning in relation to their conditions. Some patients however reported that they had had to wait long period of time for their appointment.

Compassionate Care

- Throughout our inspection we observed care being provided by nursing, medical and other clinical staff. We saw examples of staff being friendly, approachable and professional. For example, when people became lost staff would accompany people to the area in which they should be. We witnessed people being spoken to with respect at all times.
- Patients in general reported a positive experience. For example, one patient told us "My treatment here has been excellent" and another patient who had attended for multiple appointments told us that the staff made them feel "special".
- The only consistent complaint we received was of long waiting times in some clinics.

- In February and March 2015 it was reported that 89% of people would recommend the service to their friends or family.
- Whilst staff we spoke with were aware of their responsibilities to ensure privacy and dignity was maintained for people.

Understanding and involvement of patients and those close to them

- Most patients we spoke with felt well informed and included in the entire decision making process in relation to their care and treatment. For example, one patient told us "I have been very well informed and kept up to date during my treatment here."
- We spent time in the reception area of the outpatient departments observing patients being greeted and booked into the department. We saw patients were greeted in a warm and welcoming manner and given clear instructions by the receptionist regarding which waiting area to sit in and any delays there were in the clinics.
- Patients said they felt listened too and that their concerns regarding their health had been taken seriously and their anxieties alleviated.
- We observed staff interactions with patients and saw that they explained what was happening and ensured that the person and their relative, where appropriate, understood the care or treatment being provided to them.

Emotional support

- Patients we spoke with told us staff were kind and considerate to them during their visit to the outpatients department. For example, one patient stated that the staff had all been "considerate and effective".
- The staff at the neuropsychology assessment service were highly praised for the emotional support they gave patients using the service.

Are outpatient and diagnostic imaging services responsive?

Inadequate



We rated this key question as inadequate as the trust was not meeting a significant amount of its performance targets. For example, 14 out of 18 specialities were not

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seeing patients within the 18 week referral to treatment target time. Performance in relation to the cancer two week wait target and 62 day to first definitive treatment target had seen a significant decline in the two months prior to our inspection.

The implementation of EPIC meant that the trust had been unable to produce accurate data in order to ensure patients were being followed up appropriately when they did not attend their appointments and diagnostic imaging services had been unable to differentiate between urgent and routine referrals.

In contrast, there was excellent practice within the allergy clinic. A one stop allergy service had been implemented which provided a service for the diagnosis and management of a wide range of allergic disorders, this clinic was dynamic and comprehensive.

In general services were set up to meet people's individual needs and there was an understanding from staff about how they could support people with physical, mental and cultural needs.

Service planning and delivery to meet the needs of local people

- Staff working within the outpatient department told us patients could use the 'choose and book' system to enable them to choose an appointment in a hospital location close to their home. A booking team was available to assist patients with the provision of letters to inform them of their appointment date and time.
- Rapid access clinics were available in cardiology, breast and rheumatology.
- Virtual clinics had been set up in a number of areas. We heard about this in detail from the fracture clinic who had recently developed this service. The virtual clinic consisted of a multidisciplinary team of staff including nursing and consultant grade staff. The purpose of the clinic was to review patient x-rays and notes to make treatment decisions without the need for the patient to attend an appointment. Patients were then called and explained treatment options over the phone.
- Whilst we noted patients had access to water in many of the clinic areas, hot beverages were not accessible in many of the areas we visited. The main outpatients department was situated next to a reception area where there were facilities to purchase food and drinks. However patients risked missing being called for their

appointment in some areas if they wished to visit the shops for food and drink, as some clinic were situated quite a distance from these facilities. We spoke with one patient who told us they had been waiting in excess of an hour for their appointment and had not been offered a hot drink.

- Extra clinics were being provided at weekends to meet demand. For example, ophthalmology clinics were being provided on a Saturday due to increased numbers of patients.
- Television screens were present in the majority of clinic areas we visited which kept patients up to date on waiting times in clinics.
- In clinics that also saw children, there were designated areas for children to play and wait for appointments. We observed that they were well used by families. There was however a lack of facilities to cater for adolescents such as age appropriate magazines.

Access and flow

- The entrance to the outpatients department was very confusing. There was a reception desk which dealt with transport and travel and we heard that many people reported to this desk believing it was an outpatient's reception desk.
- Signage was also not clear. We observed many patients becoming confused or lost and having to ask people in corridors for help way finding. We spoke with a volunteer of the hospital who told us that many of the people they assisted were those requiring direction.
- Many managers and staff we spoke with were not aware of an access policy in place for the service. Whilst the trust provided us with a copy of a policy dated July 2014, the copy that was provided to us during the inspection as being worked to by a senior member of staff was dated 2009. This meant we could not be assured the most up to guidance was embedded and being utilised.
- There was a significant backlog of patients waiting for ophthalmology appointments. The longest wait for a first appointment was 51 weeks and on an 18 week referral pathway 516 patients were waiting beyond this standard. The longest wait was for one patient being 51 weeks with another 20 patients having been identified as waiting 41 weeks.
- Some clinic managers we spoke with were unclear about the numbers of patients that had been waiting for excessive amounts of time for appointments. For

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example, in general surgery we heard that people again could have been waiting for between 18 months and two years for an appointment. We are therefore not assured effective systems are in place to ensure patients have timely access to the service.

- Managers we spoke with were also unable to provide us with data which demonstrated that people who did not attend for their appointments were being managed and appropriately followed up. This is because the majority of specialities did not know how many patients had not attended we were told this was because EPIC was not producing accurate data.
- There was a significant problem with the choose and book appointment slots issues (ASIs). It was also noted patients had not been being called back where appointments had been booked through choose and book as the trust does not use the national call centre. For example, there was a backlog of 227 ophthalmology and 233 dermatology patients waiting a call back at the time of our inspection and a total of 605 across all specialities.
- All bookings made to the designated appointment centre were to the next available slot. This meant that at the time of booking patients were not being booked into slots which enabled them to be seen in line with their referral criteria for example within two or 18 weeks. However the trust confirmed that all referrals are clinically triaged and appointment priorities changed accordingly.
- At the time of our inspection the trust had seen a fall in performance against the two week wait for cancer diagnoses. In December 2014 and January 2015 the trust saw a small percentage fall to 92% against a projected target of 92% but a more significant dip to only 89% during February 2015. The figures for March were not available however we were told that the trust was forecasting a further performance dip to only 60%.
- We asked to review a recovery plan but this was not provided to us, therefore we could not be assured appropriate action was being taken in order to improve services. However we were told that the trust had made a commitment to the local CCG to be meeting performance targets by July 2015.
- The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was worse than the England average. The percentage figures had significantly fallen in the first part of 2015, meaning that patients were waiting longer for urgent treatment. Latest figures in February 2015 showed that the trust had achieved 72.5% against this target, as opposed to the desired target of 85%. Further work needs to be done to achieve the target; however the trust had forecast an improvement to 80% for April 2015.
- Since the implementation of EPIC the trust had seen a serious decline in its 18 week referral to treatment performance. At the time of our inspection, 14 out of 18 specialities were not meeting the required target of 92% of patients waiting no more than 18 weeks from referral. Whilst recovery plans were in place for each speciality, sustainable improvement monitoring systems were not evident.
- Managers told us that some clinics were putting on additional services during the evenings and weekends to try and meet the service demand and see those patients who had been waiting a long time.
- A recent audit had identified that only 50% of calls being made to the outpatient department were being answered. We noted that there were plans to recruit 20 staff to the booking centre to improve this.
- In the radiology and diagnostic imaging service we found that following the implementation of EPIC, patients being referred for routine or urgent diagnostic tests were being placed on one list. We heard that this meant that once on the waiting list it was not possible to distinguish which patients needed an urgent appointment or a routine referral. We asked the trust to provide evidence to demonstrate that it was risk assessing and taking action to address the problem. None could be provided to us.
- The trust was also not meeting its 6 week diagnostic performance target with over 1000 breaches being reported between January and March 2015. Again a recovery plan was in place and it was noted that the figures reported in March 2015 were significantly lower than those in the preceding two months.
- The access to the outpatient neuropsychology assessment service has improved significantly over the last four years and currently runs more efficiently seeing double the amount of patients more quickly that compared to 2009. Evidence for this is provided via statistics regarding number of contacts etc. per year and interviews with referring neurologists, who all reported

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that the service is now more responsive and fit for purpose than it was in 2009. Currently the volume of patients seen per week and waiting times are in line with other regional neuropsychology services.

Meeting people's individual needs

- In general the clinics we visited met people's individual needs. Most services were accessible via lifts and ramps were available where appropriate to assist with people's physical disabilities. The neuropsychology clinic room was appropriate and resources were available to the staff and patients using this service.
- We were however concerned with the cataract clinic location, this was not easily accessible via lifts and signage was not appropriate. For example, there was no contrast in colour and fonts were small.
- There was a chaperone policy in place. This information was clearly on display throughout the service.
- Translation services were available in outpatients and diagnostic imaging. Translators were available via the phone or could be booked for face to face appointments.
- We spoke in detail with staff working in the Infectious diseases clinic and found that there was ample accessible information available to people in order to provide advice and support. The clinic had links with various community support teams and counselling services.
- There were good links with to the local mental health teams and the internal referral processes were clear.
- There was excellent practice within the allergy clinic. This clinic was dynamic and comprehensive. A one stop allergy service had been implemented which provided a service for the diagnosis and management of a wide range of allergic disorders, including hay fever, perennial rhinitis; allergic or non-allergic, asthma, eczema, urticaria and angioedema, anaphylaxis, food allergies and drug allergies, including allergy to anaesthetic agents, NSAIDs, antibiotics and local anaesthetics.
- Information was available to patients regarding support groups they could contact for specific conditions. We saw information relating to support groups for visually impaired people and for infectious conditions.

Learning from complaints and concerns

- Information was accessible on the Trust web site including the complaints policy. We saw posters distributed at multiple locations across the departments.
- Staff we spoke with were familiar with the complaints process and were able to tell us that what they should do if a patient raised a concern.
- We were not be provided with evidence which demonstrated that complaints were used to inform learning and improvement locally.
- Staff we spoke with could not describe a complaint which had led to service improvement.
- Governance meeting minutes did not demonstrate that complaints were discussed to ensure learning took place.

Are outpatient and diagnostic imaging services well-led?

Inadequate



Overall, we found that the service lacked a robust management and governance system which meant that we could not be assured the issues within the outpatients' department were being effectively assessed and monitored to ensure improvement. Whilst the department was aware of significant backlogs of patients and action plans were in place actions were either ongoing, on hold or delayed and little action had been taken to ensure that patients were protected from the risk of avoidable harm. The diagnostic imaging service did have good governance systems and issues were identified and addressed.

In 2014 the outpatients department started on a project of 'centralisation' whereby all outpatient clinics were to be managed under one management structure. However, due to the implementation of EPIC this project had not been successfully finalised. As a result, many staff felt confused about how they and the service they worked for fitted within the overall structure of the trust. This meant that there was a lack of service planning and vision and a lack of management accountability to take issues forward.

A 'disconnect' within the service was referred to often as was "fragmentation". The service was divided with separate management structures for administrative and clinical

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functions. There were mixed views on the culture within the department with some staff telling us they felt there was an open and supportive culture and others reporting one of bullying and issues of innovation being stifled.

Vision and strategy for this service

- The majority of staff we spoke with told us they were unclear about a vision or strategy in taking this service forward.
- In 2014 the outpatients department started on a project of 'centralisation' to combine all outpatient clinics under one management structure. However, due to the implementation of EPIC the trust had not completed this project. This had left many staff feeling confused about how they and the service they worked for fitted within the overall structure of the trust.

Governance, risk management and quality measurement

- The trust had not fully developed or implemented governance processes. The staff in one clinic told us that they did not know the route to escalate clinical governance concerns so decisions were being made locally with lack of senior management engagement.
- We were provided with minutes of the outpatient's governance meeting which took place once a week. We asked to be provided with a copy of the minutes for each of the weeks in the meeting structure. We were only provided with weeks 2 and 4 (weeks 1 and 3 were not forthcoming). We were concerned about the level of governance scrutiny as only three members of the department attended this meeting. It was also apparent that the two sets of minutes we reviewed were the same with very limited details about updates or progress against actions having been added to the later set.
- There was an outpatient's board. However, this board had only met twice prior to our inspection and did not fully understand the problems being faced within this department. However, this was acknowledged and we noted a clear commitment from leaders to identify and take issues forward.
- Risk management systems were not robust. We were provided with a copy of the directorate's risk register but this did not reflect many of the risks which we heard

about during our inspection. Actions planned lacked consistency and robust actions to ensure patient safety. For example, the backlog of patients in ophthalmology or dermatology.

- Incident data was not used to inform learning and improvement and the trust could not provide us with evidence which demonstrated that feedback from patients led to quality improvements.
- Staff could not give us examples of how audits had led to changes in outpatients. Consequently, the service lacked a system for continuous improvement.
- However, there was an effective radiation safety committee in place with a wide selection of members and good attendance

Leadership of service

- There was a lack of leadership for the outpatients department. Most staff we spoke with felt unclear about who had overall responsibility for the service and where issues would be escalated to. Clinical staff told us that management did not listen and that they felt they were running the service outside of the trust's leadership structure.
- The associate director of operations recognised that there remained some level of confusion around the centralised outpatients service, but that in response to this the outpatients board had been set up to create a leadership structure to drive forward the centralised service with representation from across the divisions.
- The outpatient manager post was vacant at the time of our inspection and had been for a number of months as had a choose and book manager. This meant that there was a lack of oversight within the department.
- A "disconnect" within the service was referred to often as was "fragmentation". The service was divided with separate management structures for administrative and clinical functions. Whilst some clinics had embraced this and found ways of working together, others remained unclear about roles and accountabilities.
- Staff told us that the clinical leaders of the service were supportive and welcoming.
- The executive team were not visible to the staff working within the outpatient departments; some clinicians we spoke with told us that they had never met the CEO. This was in contrast with the way in which the diagnostic imaging department felt as they saw the executive team.

Culture within the service

Outpatients and diagnostic imaging

- There were mixed views on the culture of the service.
- Some staff told us that they felt the service was open, supportive and transparent and that they were proud to work for the trust. An example of a representative quote; “I feel proud to work for this trust we work together like a family”.
- However, others felt unsupported and that innovation within the service had been stifled. For example, one clinician stated “I would rather work in a unit which allows and encourages change” and a manager said “I do not feel particularly well supported beyond my immediate line manager, I just don’t feel concentrated on [as a department]”
- We heard from three members of staff who stated that they had felt bullied after raising concerns about patient safety following the implementation of EPIC.
- Two members of the administrative and clerical staff told us that they had been made to feel “incompetent” in their role and had feelings of being “ashamed” of the quality of work they were being enabled to produce through EPIC.

Public and staff engagement

- No one that we interviewed working in the outpatient department including the senior manager responsible for the service was aware that the trust had taken part in the friends and family test for outpatients since November 2014. This was escalated during our inspection and we were provided with evidence which

demonstrated that this had been taking place. The results showed that in general the trust was the benchmark for patients who would recommend this service. In February and March 2015 it was reported that 89% of people would recommend the service to their friends or family.

- There was a lack of patient experience initiatives in place generally. However we noted that the service had completed an outpatient survey in February 2015. We noted that forms had been collated and analysed. However, we could not be provided with an action plan which demonstrated the feedback would be used to make service improvements.
- There were inconsistencies in staff engagement initiative between clinics and specialities. For example, some clinics undertook regular staff bulletins and others relied on team meetings to share localised information. However, we reviewed a sample of team meeting minutes and noted these varied in quality and in some cases provided little relevant information to staff about their service.

Innovation, improvement and sustainability

- Staff told us that some clinics were looking to implement self-check in stations.
- We heard about the virtual clinic initiative in the fracture clinic. We were told that learning would be shared so that other clinics could develop similar services.

Outstanding practice and areas for improvement

Outstanding practice

- The allergy clinic had a one-stop allergy service that provided diagnosis and management of a wide range of allergic disorders. This clinic was dynamic and comprehensive.
- Virtual clinics had been set up in a number of areas, each consisting of a multidisciplinary team of staff including nursing and consultant grade staff. The purpose of the clinic was to review patient diagnostic tests and notes to make treatment decisions without the need for the patient to attend an appointment. Patients were then called and treatment options explained over the phone.
- The chaplaincy and bereavement service offered a one-stop appointment where bereaved relatives could see all trust staff that they needed to see in one visit. Bereaved relatives were also invited back six weeks after the death to enable staff to provide emotional support and answer any questions. The six-week follow-up had been devised at Addenbrooke's and rolled out nationally.
- The specialist palliative care consultants at Addenbrooke's had won National and International recognition as an area of excellence in palliative care for their work in developing the "Breathlessness Intervention Service".
- The online educational resource – cambridgecriticalcare.net – developed by the neurological critical care team is a repository of educational resources aimed not only at local trainees, but trainees nationally and internationally.
- Patients previously treated within critical care were invited to a twice-yearly focus group to help drive service improvement. Through this focus group, real change had been implemented, including improving the transition of care from the critical care area to the ward, establishment of a quiet/interview room for doctors to speak to relatives on the critical care unit, and the re-design of the relatives' room.
- On the general critical care unit, a junior doctor jointly with the IT department developed an application for a mobile tablet called "My ICU Voice" to enable patients who had a tracheostomy to communicate with staff.
- Team working in the critical care unit was outstanding. Given the limited resources, all members of the multidisciplinary team worked collaboratively to ensure patients received kind and compassionate care. Nursing staff were observed doing everything they could to ensure patients' carers were well informed of their loved ones' condition.
- There was well-managed and coordinated medical handover and follow-up of patients following admission, with all specialties being represented for effective care management planning.
- The "supervisor of midwives" network at the trust was outstanding and was an important contact for patients and staff. The purpose of supervision of midwives is to protect women and babies by actively promoting safe standards of midwifery practice.
- The Birthing Unit in The Rosie Hospital had facilities that were outstanding and state of the art. They included 10 birthing rooms, all with en-suite bathrooms, mood lighting and music systems, a fold-down double bed, birthing balls, slings, birthing stools, floor mats and comfortable seating and access to a sensory garden.
- The neonatal intensive care service is at the forefront for provision of care for babies. The neonatal transfer team (ANTS) was the first such team to formally and consistently enable parents to travel with their sick babies.
- The ACTIVE Children and Young People's Board enabled current and former young patients, and any other children who were interested, to meet and share ideas. The club was involved in producing child-friendly information and in projects such as Teens in Hospital, which was looking at ways of improving the experience of young people, especially those on adult wards.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- All patients awaiting an outpatient's appointment are assessed for clinical risk and prioritised as to clinical need.
- Effective governance and management arrangements are put in place in outpatients.
- Systems or processes must be established and operated effectively to enable the outpatients department to assess, monitor and improve the quality and safety of services.
- Services around end of life are reviewed to allow for fast track or rapid discharges to be undertaken in a timely way.
- Patient dependency in the intensive care unit is reviewed and staffing monitored against this on a day to day basis to ensure compliance with the Faculty of Intensive Care Medicine / Intensive Care Society core standards for ICU (Ed1) 2013.
- There is adequate staffing to provide safe care for patients requiring non-invasive ventilation.
- Data collection for the ICNARC case mix programme is monitored and that data collected is reliable, accurate and representative of the functioning of both critical care units.
- Patients are discharged from critical care units to the wards in a timely manner and minimises the number of patients being discharged after 10pm.
- It encourages collaborative working and sharing of clinical governance data between the general critical care unit and the Neuro Critical Care Unit.
- Medicines are prescribed in line with national guidance and the law.
- All patients who may lack capacity have a mental capacity assessment and, if appropriate, a deprivation of liberty safeguards (DoLS) assessment and that patients' consent is properly sought before treatment.
- All emergency equipment is checked in line with policy.
- Risk assessments are completed and correctly recorded.

- All environments are safe and that high levels of nitrous oxide in delivery suites are addressed.
- Consistent foetal heart rate monitoring is provided in maternity services.

Action the hospital **SHOULD** take to improve

- The impact of high bed occupancy on the admission of emergency patients and the provision of emergency surgical services at Addenbrooke's Hospital is reviewed.
- Review the provision of end of life care to consider providing cover over seven days a week.
- Ensure that focus is given to drive improvement and delivery of the end of life care service, including community engagement and investment in the service.
- Ensure the estates department is staffed with enough appropriately trained people to facilitate a more timely response to maintenance requests to help improve the environment, infection control and health and safety for patients and staff.
- Improve the skill mix across critical care to ensure that 50% of staff complete their certificate in critical care in line with best practice standards.
- Ensure access to dedicated physiotherapy and pharmacy services seven days a week.
- Ensure that there are arrangements in place with clear management plans for the merging of two mortuaries in Cambridgeshire.
- Review the arrangements for patients undergoing termination of pregnancy for foetal anomalies on the labour ward.
- Ensure that medical and surgical patients are cared for in an appropriate ward.
- Reduce the number of cancelled surgery admissions.
- Consider the use of pain assessment tools for patients who require additional assistance in communicating their needs.