CareQuality Commission

Cambridge University Hospitals NHS Foundation Trust

Quality Report

Addenbrooke's Hospital
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This report describes our judgement of the quality of care at this trust. 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 trust	Inadequate	🔴
Are services at this trust safe?	Inadequate	🔴
Are services at this trust effective?	Requires improvement	🟠
Are services at this trust caring?	Outstanding	☆
Are services at this trust responsive?	Inadequate	🔴
Are services at this trust well-led?	Inadequate	🔴

Summary of findings

Letter from the Chief Inspector of Hospitals

The Care Quality Commission (CQC) carried out a comprehensive inspection between the 21 and 24 April 2015. We carried out this comprehensive inspection as part of our regular inspection programme. Cambridge University Hospitals NHS Foundation Trust had been identified as having only two elevated risks and one risk on the Care Quality Commission's (CQC) Intelligent Monitoring system in December 2014. However in May 2015 the Intelligence Monitoring system showed that there were five elevated risks and four risks.

Cambridge University Hospitals NHS Foundation Trust is one of the largest hospitals in the United Kingdom with around 1096 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 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 due to the large student population of approximately 24,488.

All the clinical departments at CUH 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 were having to reassess bed capacity at least three times a day. This pressure on beds meant that a number of elective patients 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 within the hospital and that the critical care areas were not staffed in line with national guidance. We reported this to the hospital trust management and undertook enforcement action to apply a condition on the trusts registration to ensure that there were sufficient staff in place to care for critically ill patients. We have since been assured that there are systems in place to ensure that staffing levels are in accordance with national guidance and have removed this condition form the trusts registration.

We have rated Addenbrooke's and The Rosie Hospitals location as inadequate although we found that the staff were exceptionally caring and that they went the extra mile for their patients. However we have rated the overall trust as inadequate as there was a lack of management oversight and robust governance systems in place to highlight the concerns we found during this inspection.

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 staff were exceptionally caring.
- 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.

Summary of findings

- 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.

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".

Summary of findings

- 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 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

Background to Cambridge University Hospitals NHS Foundation Trust

Sites and locations: Cambridge University Hospitals (CUH) comprises of 12 locations registered with CQC. However there are two main sites Addenbrooke's and The Rosie hospitals which we inspected. The other 11 sites are satellite and outreach sites at other NHS locations.

Addenbrooke's Hospital and the Rosie Hospital (Woman's Hospital) in Cambridge provides 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 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.

Our inspection team

Our inspection team was led by:

Chair: Louise Stead, Director of Nursing, Royal County Hospital Surrey 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, 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.)

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.

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.

Summary of findings

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 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.

What people who use the trust's services say

The experience of patients using Addenbrookes and the Rosie Hospitals was mixed. The cancer patient's survey showed that patients were getting a service that was generally above average. Patients felt that the information they received from the trust and its staff was good and that they were given time to ask questions.

The NHS in patient survey showed that the trust performed in line with other trusts surveyed across all areas and in most areas there were improvements to scores year on year. The number of complaints received by the trust continued to fall. However, we heard from patients, who were not in receipt of a service at the time of inspection that the trust did not always respond to their complaints.

The cancer patient survey demonstrates that patients experience good care in most of the questions asked.

These relate to being given treatment options, being given information and explanations by staff and not being spoken about in front of them. In over a third of questions the trust were rated in the top 20% of English trusts.

The listening event we held on 21 April 2015 was well attended by approximately 30 people. We heard mixed accounts of the care provided at the trust. Most people were very loyal to their local hospital but felt that the introduction of the new IT system had had an impact upon the care they received. Some felt that systems were too complicated to access care and for other the lack of care experienced was due to the shortages of nursing staff.

Facts and data about this trust

1. **Size and throughput**

- Number of beds 1096

- Number of staff: Total: 7626 (whole time equivalent)

- Number of locations: 2 principle locations

- A+E attendances: 105,804 in 2014/15

- Inpatient admissions 2014/15 :Elective 12,361

Emergency 41,322

Total 61,400

- Surplus/deficit in previous year £8.4 million in 13/14

1. **Safety (trust wide)**

- Never events in previous 12 months: 4 from April 2014 to April 2015

- Serious incidents (STEIS): 92 April 2014 to March 2015

- C Diff: 54

- MRSA: 0

Summary of findings

1. **Effective (trust wide)**

HSMR Weekday 81.4 Weekend 90.9 Overall 83.5

SHMI Overall 84.5

1. **Caring (trust wide)**

CQC inpatient survey:

No. of items in top 20%: 2

No. of items 'average': 46

No. of items bottom 20%: 1

1. **Responsive (trust wide)**

Number of complaints in 12 months: 523 in 14/15

RTT non admitted (12 months): 94.6%

RTT admitted (12 months): 85.0%

Cancer 2 week wait: 86%

Cancer 31 day wait: 94%

Cancer 62 day wait: 81%

1. **Well led (trust wide)**

Staff numbers

Nurses: 2513

Doctors: 1142

Other: 3971

Total: 7626

Staff sickness: 3.00%

Staff turnover: 13.0%

Staff survey

- Overall response rate: 25%
- No. of items in top 20%: 0
- No. of items average: 12
- No. of items bottom 20%: 16

KF18 Staff experiencing harassment, bullying or abuse from patients or relatives

Overall: 25%

White staff: 24%

BME staff: 23%

KF19 Staff experiencing harassment, bullying or abuse from other staff

Overall: 26%

White staff: 25%

BME staff: 28%

Q23 Staff job satisfaction

Overall: 3.52

White staff: 3.53

BME staff: 3.51

Q27 Staff believing the trust provides equal opportunities for career progression or promotion

Overall: 85%

White staff: 88%

BME staff: 70%

The number of staff who would recommend the trust was higher than the national average.

White staff: 3.73%

BME staff: 3.98%

1. **CQC Intelligent Monitoring**

Risk

Elevated risk

Composite of Central Alerting System (CAS): Dealing with (CAS) safety alerts in a timely way (01-Apr-04 to 31-Jan-15): 2

Proportion of patients risk assessed for Venous Thromboembolism (VTE) (01-Oct-14 to 31-Dec-14): 2

Composite indicator: A&E waiting times more than 4 hours (01-Oct-14 to 31-Dec-14): 2

Snapshot of whistleblowing alerts (case status as at 04-Mar-15):2

GMC - Enhanced monitoring (case status as at 23-Mar-15): 2

Risk

SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Jul-14 to 30-Sep-14): 1

Summary of findings

Diagnostics waiting times: patients waiting over 6 weeks for a diagnostic test (01-Dec-14 to 31-Dec-14): 1

The number of patients not treated within 28 days of last minute cancellation due to non-clinical reason (01-Oct-14 to 31-Dec-14): 1

Monitor - Continuity of service rating (02-Mar-15 to 02-Mar-15): 1

- Total IM score 14

- Proportional IM score 7.29%

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe?	Inadequate 🔴

Are services at this trust safe?

We rated this key question as inadequate as the shortages of staff impacted upon the care being delivered to patients. The critical care areas were not staffed in line with national guidance nor had the trust systems in place to ensure that patients were not placed at risk of potential harm. The lack of staffing extended to a medical ward which cared for patients who were receiving non-invasive ventilation but did not have the required numbers of staff to care for them. Due to the pressures on capacity a number of wards were caring for patients with conditions for which the staff had little experience. This posed a risk to their safety. Staff were frequently moved to other wards to cover for the shortfall in nursing teams. The equipment in the maternity unit was old and we witnessed the unacceptable practice of a member of staff supporting a birthing mother's leg as the lithotomy pole was broken.

Duty of Candour

- All staff were aware of the Duty of Candour regulations. The Trust had ensured wide awareness of this through staff leaflets and team briefings.
- 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 evidenced 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.
- Training sessions were organised across the service to provide staff an understanding of the new legislation

Safeguarding

- The trust had safeguarding leads for adult and children's safeguarding teams. A network of link nurses were employed to ensure that concerns were acted upon.
- Whilst training databases demonstrated that staff received mandatory training in this area we noted that some services where training in safeguarding was low. The safeguarding team deliver face to face training.

Summary of findings

- The adults safeguarding policy was currently under review and is updated to reflect current national policy.

Incidents

- There have been three never events reported as surgical errors two within operating theatres (May 2014 and April 2015) and other two within outpatients operating theatres (May 2014 and December 2014).
- Of all the serious incidents requiring investigation 30% related to confidential information leaks and 20% to slips/ trips and falls.
- 98% of NRLS incidents are reported with No or Low harm.
- They are also reporting slightly more incidents per 100 admissions than the England average. Our analysis indicates that this is not statistically different.
- Learning from incidents was cascaded throughout the hospital via team meetings. However some staff were unable to identify lessons learnt when interviewed.

Staffing

- The trust has a higher number than national average of consultants and middle grade doctors.
- The trust has a problem recruiting nurses and currently has a high number of nursing vacancies. This shortfall is mitigated through the use of bank and agency staff and whilst this is below the national average at 4.9% as opposed to 6.1% there remain some shifts which are not filled.
- The trust was not adhering to the national guidance in respect of patients requiring complex care and whilst the trust supplied some evidence of the extent of this issue the CQC utilised its powers under section 31 of the Health and Social care Act 2010 to impose a condition on the registration of the trust to ensure that systems were in place to regularly assess and monitor the quality of service provision in these areas. Following further information and assurance from the trust the CQC removed this condition from the trusts registration.

Are services at this trust effective?

The trust was rated as requiring improvement because 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. Where agency staff were used, they were not always able to access information about patients they were supporting. Whilst there were up-to-date evidence-based guidelines in place, we were concerned that these were not always being followed. Outcomes of audits were not always positive with

Requires improvement ●

some measures significantly less than 50% in audits such as sepsis. Staff were competent and understood the guidelines they were required to follow, however, lack of staffing and problems with the computer system (EPIC) made this difficult. In addition, staff 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.

Evidence based care and treatment

- Most specialities 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.
- However in Maternity services we found that these guidelines were not always being followed. This included Fetal Heart Rate monitoring, Venous thromboembolism and early warning score guidelines. Staff were competent and understood the guidelines they were required to follow but outcomes of people's care and treatment was not robustly collected or monitored. For example, there was no complete maternity dashboard available for the last four months.

Patient outcomes

- The trust had problems with the completeness of ICNARC data which had been not been submitted for two years. Locally there was some mitigation in the collection of local data sets.This meant that the trust could not highlight trends or how they benchmarked themselves against other services.
- The Bowel cancer audit and the hip fracture audits showed that the trust was around the national average but the diabetes audit, the stroke (SNAPP) and the heart attack (MINAP) audit showed that the trust was not performing at the national average.
- The trust participated in most audits but results were patchy. Data collection had been made more difficult by the implementation of the EPIC system.

Multidisciplinary working

- We saw some good examples of multidisciplinary working across the trust and into the community.
- Wards teams had access to the full range of allied health professionals and team members described good,

Summary of findings

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.

- There were outstanding examples of MDT working given by the infectious diseases clinic. We heard how a social worker was assigned to work with the clinic in order to support patients who were newly diagnosed with HIV and their families.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Mental capacity was not always assessed for patients who may lack capacity. Knowledge of staff was patchy about the assessment and recording of mental capacity assessments. The IT system did not always have a robust plan of care for patients who lacked capacity.
- Deprivation of Liberty Safeguards were not always understood or recorded appropriately by staff on the hospital IT system or on paper records.

Are services at this trust caring?

Whilst the trust rated themselves as requiring improvement in the area of caring this was due to not having sufficient staff which we rate under safety. We found that whilst staff were busy they did show patients compassion, dignity and respect. We rated this domain as outstanding as in three areas, critical care, children and young people's services and in end of life care staff went above and beyond their duties to ensure that patients received a high quality of care. The wedding box and the ACTIVE Children's and Young People's Board are two examples where staff put the patients first and demonstrated outstanding caring to patients.

Outstanding ☆

Compassionate care

- Feedback was mostly positive about the way staff treated patients receiving care throughout the wards.
- The most recent survey results returned by patients to the ED for January to February 2015 show that over 90% (1619 out of 1764) would recommend the service to friends or family.
- 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.

Summary of findings

- 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.

Understanding and involvement of patients and those close to them

- 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. Response rates varied across the surveys undertaken with 32.5% of in patients responding, 16.2% of patients in the emergency department and 24.2% of patients responding in the maternity survey. Over 92% of all patients stated that they would recommend the trust.

- Across the trust 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".

- Staff in the children's service had set up an ACTIVE Children's 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's 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.

- 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.

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.

Summary of findings

- 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 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
- 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.

Are services at this trust responsive?

Inadequate 🔴

We rated this domain as inadequate as there were significant numbers of operations cancelled by the trust due to bed capacity issues. We also found that there was a significant back log of patients waiting for initial and follow up appointments with in the outpatients service. 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. Governance systems in outpatients were not in place to address the responsiveness of the department. There were no records of patients who did not attend appointments and no reasons as to why this may have occurred. There were significant numbers of patients awaiting care in their own homes who could not be discharged by the hospital until this was available and funded.

Service planning and delivery to meet the needs of local people

- The service was working with key stakeholders to ensure that health and social services met the changing needs of the local area. 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.
- The hospital's challenge of being a regional centre for many specialties 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.

Summary of findings

- There was a lack of service planning across the women's 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.

Meeting people's individual needs

- All units 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 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.

Dementia

- 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.
- 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.

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 were consistently high.
- The trust held bed meetings several times a day to assess the flow through the hospital. This enabled early identification of issues and action could be taken to ensure capacity for non-elective admissions. This often meant that elective patients operations were deferred until a bed was available. Referral to treatment times saw a significant drop from October 2014 and this has continued.

Summary of findings

- Short stay areas were available within the trust but these were often used as extra capacity and meant that patients on these wards stayed outside of the intended time limits.
- The trust had a ward which was used as a decanting facility in order to deep clean wards. This had been used to meet extra demands for capacity.

Learning from complaints and concerns

- The chief nurse was responsible for clinical 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).
- We observed display boards on ward areas reading, "You said, we did" which demonstrated that the service learnt from complaints and concerns where possible.
- Literature and posters were displayed within the wards, advising patients and their relatives how they could raise a concern or complaint, both formally and informally.
- 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.

Are services at this trust well-led?   **Inadequate** 🔴

Well led at trust level has been rated as inadequate. Whilst the vision and values are well developed and are well known to members of staff the arrangements for governance and performance management do not always operate effectively. An example of this is the lack of consideration of good practice guidance in relation to staffing in areas such as critical or complex care. Whilst the trust was aware that grouping of patients occurred a risk assessment and rationale for the practice was not undertaken nor were the risk monitored. There was a disconnect between what was happening on the front line and the senior management team. This was evident at divisional and senior level. Frontline staff could evidence business cases which had been presented at a divisional level but had not been accepted that the senior leadership team were not aware of. The divisional structure meant that services were split across different divisions which led to a lack of ownership for the service and stifled improvements across the trust.

Staff satisfaction was poor. The plans to improve the culture or staff satisfaction were not robust. Whilst there was recognition of the

pressures of work for staff there were no action plans for ensuring that staff were supported and able to deliver high quality care which was rewarding. Staff on the wards did not always feel actively engaged or empowered. There were teams working in silos and there was a disconnect between the senior clinical division management and the senior managers of the trust.

The approach to service delivery and improvement was reactive and focused on short term issues. Improvements were identified by local teams but raising of these at a senior level did not always occur.

Vision and strategy

- The trust has a vision and strategy which included being the best at everything they chose to do, being a health system not just a hospital and to focus on compassion and care alongside clinical excellence.
- 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. The Chief Executive stated that this was a tertiary specialist hospital and not a district general hospital however the staff working in the hospital believed that they were a district hospital with specialist services. This meant that there was a disconnect between the values of the board and the values of the staff working in the wards and departments. Cases to build their service to support additional work, and seven day provision had been submitted. However these business cases had been rejected by the trust for five years in some services. There was a clear lack of investment in the provision of end of life care through palliative care and the mortuary by the trust.
- There was no clear vision or trust consultation with the mortuary staff regarding the merging of two hospital mortuaries. This 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. However, the trust stated that preliminary discussions were being held in relation to the services following the building of a new hospital for Papworth in 2018.
- The values of the hospital were driven from the staff working within it. These were safe, kind and excellent. Most staff we spoke with were able to articulate these values and we saw staff providing a kind and compassionate service to people.

Summary of findings

- The trust board monitor the strategy for achieving the trust's priorities through the quality committee and its report to the board of directors.

Governance, risk management and quality measurement

- Monthly performance and quality meetings are held between the executive team or their delegates and each divisional team. These review quality, workforce, operational performance and finance as well as performance measures under the CQUIN programme.

- The integrated report is produced monthly and feeds into all Board assurance committees and to the Board of Directors. This meeting is attended by executives and three non-executives. The purpose of the committee is to provide assurance to the board regarding the delivery of high quality care to patients.

- The integrated performance report provides highlights of the meetings with the clinical divisions, the quality scorecard, harm and delay free care, person centred care, effective care, financial performance and the staff as partners. We reviewed a number of these integrated reports and found that the main issues for the trust were highlighted in the report. The divisions reported under three main headings, operational performance, financial performance and priorities. However there was little narrative regarding action taken to resolve issues in either the board minutes or the integrated performance report.

- Staff within the clinical divisions were clear about their responsibilities for highlighting concerns and improvements to services through the divisional structure. However they reported that they felt that the senior team was not always aware of the issues they raised as they received little feedback from the senior team.

- The trust's quality strategy includes clear goals and measurements for success. However there was a lack of learning shared across the divisions. The quality strategy highlights the trust's desire and recognition that to resolve some of the issues facing the trust system wide action is necessary.

- The governance system within the trust which functions well at clinical divisional level was less well evidenced at a senior level in that the performance report was the only method of uplift of information from the divisions to the board level to a senior manager level. We noted that there was a noticeable disconnect between the clinical divisional level and the senior team. We were informed that executives were attending divisional meetings on an ad hoc basis to ensure that they were

aware of issues highlighted at divisional level. Staff felt that the senior managers were unaware of the issues they faced. Several teams explained that they had repeatedly taken business cases for improvements to services to their clinical divisional meetings which were rejected year on year. In one instance a post was approved but no further action taken. However senior staff were unaware of these business cases and the drive to improve services in these areas.

- The integrated performance report and the quality committee minutes reviewed did not highlight action taken to address performance issues highlighted with in the report. An example of this includes; the discussion of the suspension of the deep cleaning programme (January 2015 Quality Committee minutes) which highlights the pressures on the trust to open extra capacity and how they will staff this. This means that the ward used as a decant ward so that others can be deep cleaned is no longer available. The report highlights how this will be achieved without reviewing the impact of doing this or how it will be measured or monitored.

- The senior management team were unaware that staffing levels for patients with complex conditions did not meet national guidance. Once alerted to the issue we were assured that the outcomes for patients were not affected by the grouping of patients in this area. However the trust had problems with the completeness of ICNARC data which had been not been submitted for two years. Locally there was some mitigation in the collection of local data sets. This demonstrated that governance and risk management systems were not as robust as they could have been.

- The trust senior management recognised the risks of an ageing estate, increased demand and capacity, the impact of the introduction of the ehospital (EPIC) system, delays in the transformational programme and the lack of nurse staffing. These risks were rated extremely high at 25 on the risk register despite mitigating actions being taken to reduce the risk. The risk register demonstrated assurances taken to measure the effectiveness of the mitigating factors but these were not time bound nor did they have an executive action owner. The register also identified what further actions could be taken to mitigate the risks. However these were not time bound nor assigned to action owners. It was difficult to see from the evidence produced whether actions taken were timely and/or had an effect to reduce the risks identified.

- We were concerned that the corporate risk register highlighted that five risks were rated as major risks as this means that they

were likely to occur and no mitigation had been put in place. When we explored this with the executives and chair we were assured that mitigation had taken place however the risks remained major on the risk register.

Leadership of the trust

- The executive team had changed significantly in the year leading up to the inspection. Three members of the executive team (of five) had joined the trust in 2014/15. In the 12 months prior to the inspection the trust had undertaken a fundamental leadership restructure forming five new clinically lead divisions supported by five formed divisional teams. The non-executives had a strong background in health care or in related areas of experience relevant to the trust.
- Staff felt well supported by their local manager but reported that they did not see the senior management team, apart from the chief nurse, in ward areas. The chair of the trust undertook ward visits with the Chief Nurse.
- Before our inspection the trust was asked to assess itself against CQC key questions using the ratings used within CQC. The trust undertook this activity through discussion and negotiation with the leaders of the clinical directorates. The trust submitted their self-assessment without board sign off. We explored the rationale for the ratings the trust had placed upon themselves and found that the senior team had misaligned the key lines of enquiry within the key questions. An example of this was that the trust assessed itself as requiring improvement in caring due to the pressures on staff, however we found that staff were extremely caring in their interactions with patients. Having a shortage of staff relates to safety of patients or responsiveness of staff, rather than the caring experience for patients.

Culture within the trust

- The latest staff survey results, 2014, show that the trust has a below average score for staff engagement than trusts of a similar size, 3.69 v 3.74. This showed a reduction year on year. Scores for staff motivation and feeling that they make a difference meant that they were in the bottom 20% of trusts. However a significantly higher than average number of staff felt that they would recommend the hospital as a place to work. However this was a deterioration on the results from 2013. The trust performed worse than average for 62% (18/29) of the key findings in 2014. This is three times as many as the 21% (6/29) of key findings where the trust performed better than average for all trusts. The staff survey uses three measures to rate staff

engagement and the trust performed worse in comparison with the figures in 2013. Whilst staff felt less bullied and harassed by members of the public the experience of bullying and harassment from internal staff was above the national average.

- 79% of staff (compared with a national figure of 71%) were working extra hours and this is reflective of the capacity issues within the hospital and the shortages of nursing staff. On average more than 500 shifts per month go unfilled by bank or agency staff. Bank staff fill the majority of gaps in staffing. Bank staff are made up of those choosing to work at certain times and those permanent members of staff working extra hours. (December integrated performance report).

- The chief nurse was in the process of implementing supervisory practice for senior sisters and charge nurses. However currently many did not have an allocated day to be supernumerary due to the pressures on shortages of staff and bed capacity.

- There was a lack of ward to board and board to ward information flow. The integrated performance report had only a high level summary of what was happening in the clinical divisions. Middle grade staff reported that they did not feel that their contributions were valued by senior trust board members.

Fit and Proper Persons

- The trust had discussed the trusts response to the fit and proper person test at a board meeting in February 2015.

- The trust has a system in place for senior staff to make a declaration of fitness. Where there are gaps in recruitment files the HR department contact the person for an explanation or to provide the appropriate documentation. The trust had not employed a director since this regulation had come into force.

Public and staff engagement

- The trust was actively seeking to increase the number of responses to the friends and family test.

- Some divisions within the trust had held patient focus groups to better understand the issues of poor patient experience. There was no evidence of how this was used to inform further service planning or delivery.

- The trust participated in the NHS Friends and Family test and had electronic data collection devices around the trust. A recent dementia care survey undertaken in October 2014 had received only 2 responses from the 10 surveys given out.

- Formal complaints to the trust rose between July and October 2014. The chief executive signs a covering letter to all complaints received. The chief nurse reviews all complaints regarding nursing care. The complaints team were refining

Summary of findings

processes to ensure a timely conclusion to complaints and to sharing lessons learnt. At present actions are at clinical divisional level and sharing of these does not always occur between divisions. The team are also trying to initiate a single point of contact for complainants.

- The latest NHS Staff survey in 2014 showed that staff were receiving appraisals, felt less bullied and harassed by those using the hospital and would recommend it as a place to work. However questions around staff working extra hours, feeling that their role made a difference or being satisfied with the quality of care they could give and working effectively as a team were in the worse 20 of trusts nationally. Staff feeling stressed and having poor job satisfaction were amongst the questions where the trust saw most deterioration in scores.

Innovation, improvement and sustainability

- The integrated performance report provides high level feedback on the performance of the clinical divisions. In November only two of the five divisions reported improvements that could or were being made to services. A number of staff across services informed us that business plans submitted to division were rejected year on year. We were unable to corroborate how information on suggestions from teams within the trust are fed into the Quality Committee for review and discussion.
- The trust had highlighted risks which were key to its sustainability such as aging stock, capacity and shortages of nursing staff. In the day to day activities of the trust this was evident through the suitability of the ward environment, the constant moving of equipment and the tardiness of maintenance leading to poor patient experience.

Overview of ratings

Our ratings for Addenbrooke's and The Rosie Hospitals

	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

Our ratings for Cambridge University Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Inadequate	Requires improvement	☆ Outstanding	Inadequate	Inadequate	Inadequate

Notes

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 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.

Outstanding practice and areas for improvement

Areas for improvement

Action the trust 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 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.