

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

Good 

Urgent and emergency services

Good 

Medical care (including older people's care)

Good 

Surgery

Good 

Critical care

Good 

Maternity and gynaecology

Good 

Services for children and young people

Good 

End of life care

Good 

Outpatients and diagnostic imaging

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out a full follow up inspection between 20th and 22nd September with an unannounced inspection on 29th September 2016. This inspection was to follow up our comprehensive inspection in April 2015 where the concerns identified by the inspection team had resulted in my recommending the trust for special measures. A smaller focussed inspection in February 2016 followed up our most serious concerns and those areas rated Inadequate.

At this inspection we saw significant improvement across most of the areas we inspected. This included outstanding effectiveness in the critical care units and improvements in safety and leadership in maternity services and outpatients which we have now rated as good. These had been rated inadequate in 2015. There were similar improvements in medical care, surgery and urgent and emergency services with all services now rated as good overall. The improvement was in line with the trusts improvement plan and was assisted by constructive challenge from stakeholders at regular meetings.

Cambridge University Hospitals NHS Foundation Trust is one of the largest in the UK with around 1400 beds. The trust provides a major trauma centre for the east of England and specialist services in immunology, fetal medicine, IVF, neurosurgery, ophthalmology, genetics and metabolic diseases, specialised paediatric, cancer and transplant services.

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

During this inspection we inspected all key questions in all of the eight core services. The organisation had been through a significant change in senior leadership in the preceding 12 months which had resulted in a number of governance changes within the organisation. The trust was continuing progress against an overarching improvement plan in response to concerns found at our previous inspections.

Our key findings were as follows:

- The trust had received support from NHS Improvement since it was placed in special measures in September 2015 and had undertaken a review of governance structures across the organisation. This had included the implementation of the improvement plan and regular oversight of its implementation from regulators, commissioners and stakeholders.
- There was improvement in the quality and safety of all services with the exception of children and young people's services which found the demand on the service challenging. This improvement was in line with the trusts improvement plan.
- There was improved learning from incidents across the divisions. Most staff we spoke with had a good understanding of the duty of candour.
- There had been an increase in permanent staffing levels resulting in very low levels of agency nurse usage across the trust. There remained use of bank staff and some locum consultants.

Summary of findings

- The trust had developed a system of monitoring patient acuity on several occasions each day. This allowed senior managers and clinical staff to flex staffing levels to meet patient need.
- There were ongoing capacity issues within the trust resulting in cancelled and delayed surgeries. Children's services were also under pressure though the imminent opening of additional beds should alleviate some of this pressure.
- Internal capacity issues were also seen in delayed discharges from the critical care units. There were also delays in transferring some patients from recovery post operatively to a ward for post-operative care.
- There were ongoing capacity issues within maternity services meaning the unit diverted high risk deliveries on 17 occasions between December 2015 and July 2016.
- Significant improvement had been made into reducing the numbers of patients waiting for outpatient appointments. However, further work was required to further reduce the waiting lists for appointments and some investigations.
- The trust failed to achieve the national target for treating, admitting or discharging 95% of patients within four hours. In December 2015, the trust met the target, however performance began to fall in January 2016 and fell to 83% in May 2016
- The revised governance systems were sufficient to ensure that the senior team had robust information on which to make decisions.
- There was a large audit programme. However, we saw results in medicine were below the England average and the stroke national audit scored 'D' – the second lowest score. There was very limited audit in end of life care though the trust had identified this and were developing an audit plan.
- The electronic patient record (Epic) had now been in place for some 2 years. Many of the concerns we had identified at previous inspections had been addressed and staff were more familiar with the system though care planning was not always individualised and personalised.
- Staff were very caring and on some occasions went to great lengths to support and care for patients.
- There was an open culture. Staff reported incidents and there was increased evidence of learning from incidents.
- Staff spoke positively of local (divisional) management. Managers in all areas were well sighted on risks as well as developing new pathways and delivering care.
- Patients spoke highly of the care they received. Friends and Family Test results were generally positive across the trust however, there were very poor response rates in some areas.

Importantly, the trust must:

- Ensure medicines including controlled medicines are securely stored at all times.
- Ensure that end of life care is properly audited (such as preferred place of death and DNACPR) and actions taken in response to those audits.
- Ensure that complaints are responded to in a timely way wherever possible.
- Ensure resuscitation decisions are always documented legibly and completed fully in accordance with the trusts own policy and the legal framework of the Mental Capacity Act 2005.

In addition the trust should:

- Ensure it improves the environment for children in the ED to ensure children's safety at all times.
- Review staffing in the emergency department with respect registered nurses (child branch) to ensure children's needs and national guidance are met.
- Review staffing of the specialist palliative care team against national guidance.
- The trust should ensure that all staff complete mandatory training and safeguarding training to ensure it complies with the 90% compliance target.
- Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am in the critical care and intensive care units.
- The trust should ensure the actions from the safeguarding review they have conducted for level three training for staff in adult areas caring for patients under the age of 18 years are implemented.

Summary of findings

- The trust should review the level of children's safeguarding training healthcare assistants undertake to ensure it is in line with the Intercollegiate Role Framework for Looked After Children and the trusts own Safeguarding Children's Policy.
- Review consultant hours in maternity in line with national guidance.
- Continue to improve referral to treatment time performance including for cancer services and reduce the number of cancelled operations.
- Consider improvements to the response rate for the Friends and Family Test which are poor across the trust.
- Ensure that systems are in place to reduce the risk of confidential information leaks.
- Work to reduce the number of diversions of high risk deliveries in maternity services.
- Continue to reduce the time for end of life patients to be discharged to their preferred place of care.
- Ensure that all equipment is appropriately checked and safety tested where required.

We saw areas of outstanding practice including:

- Ward J2 ran weekly 'music and movement' classes to help meet the holistic needs of patients during their long-term recovery. A volunteer specialising in music and movement ran the classes and staff encouraged patients and their relatives to attend. This had received excellent feedback from patients and relatives.
- The teenage cancer unit provided outstanding facilities for young people diagnosed with cancer and receiving treatment for cancer. The teenage cancer unit provided a welcoming, age appropriate environment for young people to receive treatment, but also meet other young people and relax and socialise.
- The ED team had developed a mobile phone application called "Choose Well." The application offered guidance on waiting times and hospital services across Cambridge in order to improve the patient experience and offer choices in health care.
- The emergency department had secured £100,000 of funding from the Small Business Research Initiative (SBRI) to support the development of a crowd prediction modelling tool to enable the trust to understand and map patient flow through the department.
- The charitable trust was in the process of setting up a trauma ICU centre in Burma in which a number of the ICU/ NCCU staff were involved, as well as the Burma nurse specialist visiting later on in the year.
- The initiative for 'Family Facetime' proposed the purchase of two technology tablets to enable mums on the Obstetric Close Observation Area (OCoA) who are too unwell to visit their baby on the neonatal intensive care unit to receive a video link via Facetime with their baby.
- The bereavement follow up scheme saw a reduction in complaints of approximately 50%.

On the basis of this inspection I am recommending that Cambridge University Hospitals NHS Foundation Trust is removed from 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

Rating

Good



Why have we given this rating?

Urgent and emergency care services were rated as good overall. The safe domain has been rated as requires improvement.

- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- Staff knew how to report incidents and deal with complaints and there was a learning culture within the emergency department (ED).
- Between May 2015 and April 2016, the median time to initial assessment ranged between one and two minutes. This was consistently better than the England average, which ranged between five and seven minutes for the same period.
- Medical and nursing staff achieved 100% compliance with their appraisals during 2015/2016, and staff had access to appropriate information and guidance to carry out their roles competently. There were good examples of multidisciplinary team working with internal staff and external agencies for example admission avoidance and safeguarding.
- The patient escalation procedure and processes were robust and staff used the patient electronic record system effectively to identify and escalate concerns regarding deteriorating patients. We observed staff routinely offering patients pain relief and assessing the level of pain on initial assessment.
- The percentage of patients in the Friends and Family Test who would recommend the service was consistently above the England average from June 2015 to May 2016. Throughout our inspection, we observed patients treated with compassion, dignity, and respect. Patients we spoke with told us they were well informed regarding their care and treatment. The trust had access to a range of clinical nurse specialists within the department that could provide support to a wide range of staff.

Summary of findings

- The ED had access to translation services for patients whose first language is not English and provided leaflets in a number of formats to support patients who may need further guidance on their condition.
- No patients waited over four to 12 hours, from the decision to admit until admission, between June 2015 and May 2016. The number of patients leaving the ED without being seen between in May 2015 was 1.8%, rising to 2.4% in July 2015, steadily falling to 2% in December 2015. The percentage rose again to 2% in February 2016 before falling to 1.5% in April 2016. This was consistently better than the England average, which ranged between 2.5% and 3.5% for the same period.
- The median time to treatment was approximately 20 minutes below the England standard of 60 minutes, between May 2015 and April 2016. The trust performed consistently better than the 60-minute standard between June 2015 and April 2016.
- The ED used a number of alternative care pathways to alleviate pressure on the department and reduce admissions into hospital flow and employed a full time flow navigator to support patient flow. The trust had a dedicated relatives' room used by staff at times of bad news or as a rest area for relatives waiting for news of patients.
- There was good leadership within the ED, staff were clear on roles and responsibilities and understood the departmental development plan and the part they played in achieving its goals. Staff had been involved in planning future service configuration. Departmental risks were identified, mitigated and accountability clearly allocated to staff to ensure risks were monitored and updates shared within the governance structure.
- Staff we spoke with said that senior staff were approachable and willing to share their knowledge and expertise. Junior doctors told us that the ED was a good place to work, they felt valued by their colleagues, and that they had opportunities to learn and grow in professional confidence.
- The trust utilised patient focus groups in the community to gain feedback on its provision and plans for the future, for example the development of the ED and redesign of the building. There was a

Summary of findings

strong focus on innovation and future developments for the department, often with the engagement of departmental staff and external stakeholders in order to improve services for patients.

However:

- The dedicated paediatrics area was not secure and had no controlled access or staff reception area. Children arriving at the department had to pass through the main ambulance bay or the main adult waiting areas to access the paediatrics waiting area. Children were not visible from the main paediatrics area meaning that there was no opportunity for staff to monitor or see a child that may deteriorate. Due to staff vacancies, the paediatrics department did not have a registered children's nurse on duty at all times, which was not in line with the Royal College of Nursing guidance (2003).
- In August 2016, the department achieved a 64% compliance rate with the sepsis-six bundle, which was worse than the trust target of 95%. Seventy-six percent of patients received antibiotics within an hour, which was worse than the Royal College of Emergency Medicine standard of 100%.
- Between June 2015 and November 2015, the trust failed to achieve the national target for seeing, treating, admitting or discharging 95% of patients within four hours. In December 2015, the trust met the target; however, performance began to fall in January 2016 and fell to 83% in May 2016.
- Between May 2015 and December 2015, the average time spent by a patient in the ED ranged between three hours 20 minutes and two hours 20 minutes, which was higher than the England average (two hours and 20 minutes) for the same period.

Medical care (including older people's care)

Good



We rated medical care as good for safe, caring, responsive, and well led. We rated effective as requires improvement.

- Staff knew how to report incidents using the trust electronic reporting system. Learning from incidents was consistently shared with staff across the division and formal mortality and morbidity meetings were had been implemented across the service.

Summary of findings

- Staff had a good understanding of safeguarding principles and knew how to make safeguarding referrals.
- Staff knowledge and understanding of the Duty of candour was good across medical and nursing staff.
- Equipment was well maintained and regularly checked by staff to ensure it was within its service date.
- Clinical areas were visibly clean, uncluttered and well organised.
- Staff provided kind compassionate care to patients and their relatives in all areas we visited.
- We saw good examples of multidisciplinary team working, especially on the acute stroke and stroke rehabilitation wards.
- The risk of readmission for non-elective procedures were lower than the England average.
- The average length of stay for elective patients is lower than the England average.
- Staff were friendly and approachable and we observed staff treating patients with compassion, dignity and respect on all wards throughout the inspection.
- Feedback from people who use the service and those close to them was consistently positive about the way staff treated patients.
- The trust was either in line with or above the England average for referral to treatment times (RTT)
- There was a learning disabilities specialist nurse who supported staff on the ward in caring for people with additional needs.
- The trust's Specialist Advice for the Frail Elderly (SAFE) team saw all patients who were over the age of 75. This multidisciplinary team provided a seven-day service and provided advice to staff at ward level that supported patients over the age of 75 years.
- The average length of stay at the hospital between March 2015 and February 2016 for elective patients was 2.3 days, which was lower than the England average of 3.9 days.
- Staff felt well supported by local leaders, peers and by senior management and there was good communication between all staff grades and senior management.
- The culture within the hospital was friendly and the trust values were being upheld.

Summary of findings

However:

- Mandatory training levels were significantly below the trust target and we were not assured that staff had the required skills and competencies within their respective roles.
- There remained significant vacancies in medical and nurse staffing with a reliance on locum and bank staff in some specialties.
- Storage of medicines was not always satisfactory.
- Patient outcomes were mixed and not always in line with the national averages, for example the trust scored below the England average for all in-hospital care indicators in the National Heart Failure Audit in 2014
- The overall Sentinel Stroke National Audit Programme (SSNAP) score decreased from C to D between January and March 2016 (where band A is the highest and band E the lowest).
- Participation in the National Diabetes Inpatient Audit (NaDIA) 2015 showed that the trust performed worse than expected on 7 out of 21 questions however it was better than the England average for ten indicators.
- The risk of readmission at Addenbrooke's Hospital for all elective procedures is higher than the England average
- The average length of stay for non-elective patients is higher than the England average.
- The average response rate for the Friends and Family Test between June 2015 and May 2016 was 10% lower than the England average of 26%. In May 2016, only 83% of patients would recommend ward D10, which was significantly worse than the trust average.
- We identified concerns from staff that sufficient action was not being taken regarding the movement of staff between wards

Surgery

Good



Overall we rated surgery at Addenbrooke's Hospital as good. The safe, effective, caring and well-led domains were all rated as good, with the responsive domain rated as requires improvement.

- There was a strong incident reporting culture and staff received feedback from incidents to minimise the risk of similar incidents reoccurring.

Summary of findings

- Hand hygiene practices were consistently good in order to minimise the spread of infection. Equipment was in date and stored securely.
- Medicines were stored appropriately with one exception in plastic surgery, and staff carried out regular checks according to policy.
- Risk assessment of patients was consistently robust and there was evidence of appropriate escalation by staff in the event of a patient's condition deteriorating.
- There was good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, to reduce the risks of mistakes in surgery.
- Nurse and surgical staffing at the time of inspection was sufficient to safely meet patient acuity and needs.
- Surgery had a clinical audit programme which assessed compliance with National Institute for Health and Care Excellence (NICE) guidelines and local policy.
- Staff had the required skills and competencies to care for patients effectively and received robust training and induction to support them with this.
- There was good evidence of multidisciplinary team (MDT) working in all surgical areas to help maximise patient outcomes. Patient outcomes were monitored and reviewed through formal national and local audits.
- Staff were familiar with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) and there was evidence of obtaining appropriate consent.
- All observations of interactions between staff and patients and relatives were compassionate.
- Patients and relatives spoke highly of the care received and Friends and Family Test (FFT) results for surgery were consistently high.
- Clinical, divisional and ward leads showed good awareness of the risks within their service and had robust action plans to address them.
- Leads engaged with staff at all levels and responded to their concerns. The service was focused on continuous improvement to address the issues around responsiveness.
- Clinical governance was robust, and risks were highlighted on the risk register and appropriately mitigated as far as possible.

Summary of findings

- There was a positive working culture amongst all levels of staff in all the areas we inspected, and staff took great pride in their work. Surgical services had several ongoing innovative initiatives to develop services and maximise patients' experience.

However:

- There were issues with access to surgery and flow through the hospital. The service was performing worse than the national average for cancellation rates and the number of patients not treated within 28 days of last minute elective cancellation.
- Data provided by the trust prior to inspection showed that the service was performing significantly worse than the national average on meeting targets for referral to treatment times (RTT).
- Recovery was regularly used to accommodate patients; from July to September 2016 there were 68 occasions where patients remained in recovery for non-clinical reasons.
- Between June and August 2016, there were 1,176 patients recorded as outliers on surgical wards. However, cancellations, out-of-hours discharges and RTT were showing gradual improvement since our previous comprehensive inspection and there was evidence of actions to address the main areas of concern.

Critical care

Good



We rated the critical care services provided at Addenbrooke's hospital as good overall, with caring and effective as outstanding.

- There was a good reporting and learning ethos throughout the unit. Staff told us that there was a "no blame culture". Duty of candour was understood and discharged appropriately by staff. Morbidity and Mortality meetings were open to all staff which contributed to a positive learning and open culture across all disciplines of staff.
- Since the previous inspection in 2014, there had been significant improvements made in relation to nurse staffing levels, meaning that nurse staffing levels were sufficient to meet with the Faculty of Intensive Medicine Standards.

Summary of findings

- There had been a dedicated supervisor introduced. Staffing levels, as well as patient acuity and dependency were reviewed five times per day to ensure that staffing levels remained safe and that patients were receiving high quality care.
- The previous inspection in 2014 had identified that data collection and upload to the Intensive Care National Audit and Research Centre (ICNARC) had been stopped, meaning that data had not been submitted for two years.
- However we found on this inspection that there was a dedicated team for ICNARC data collection, consultant engagement for review and accuracy check, mid-month review of any trends and themes, and training provided to staff, which included other staff being able to input data. Data had been submitted since quarter four 2015.
- There were numerous examples of outstanding team work across medical, nursing and allied health professionals. Staff worked collaboratively to provide the highest possible care for patients. Feedback from patients and relatives during our inspection was very positive. We saw examples of innovations from the focus groups, which were recorded and logged onto an action plan.
- The critical care Rapid Response Team (RRT), provided outreach services into wards, proactively identifying patients who would benefit from closer monitoring. The team also ran bed side teaching as well as delivered on a number of internal courses, providing support and education to ward teams.
- There was a strong culture of service improvements and research. There were a number of research studies ran by the National Institute of Health Research (NIHR) studies, which the critical care unit were involved in. We saw poster presentation that had been presented at National conferences in 2016.

However:

- Data from the East of England critical care network showed that between April 2015 and March 2016 there were 776 delayed discharges (discharges delayed between 4-24 hours). It was recognized that the critical care unit was working hard to improve this

Summary of findings

by early identification of patients that could be discharged and escalating to the control and command centre. Bed capacity throughout the hospital contributed to these delays.

- The result of these delays meant that 32 patients in September 2015 across critical care, were transferred between 10pm and 7am. However, it was noted that numbers had been declining since the early months of 2015 to the latter months. This was due to actions, such as early identification of patients ready for discharge in the day and escalation to the control room.
- During August 2016, seven patients had been identified as requiring level one care, but remained on the unit. We were not assured that mixed sex breaches were being robustly reported, as we were told that only those delayed “overnight” were reported internally but not declared externally.

Maternity and gynaecology

Good



We rated this service overall as good with findings in the following:

- The service had robust systems in place to report incidents and the number of serious incidents reported was 16, with no never events reported between January and September 2016.
- Throughout maternity and gynaecology services we saw the “NHS Safety Thermometer” displayed in public areas. We saw completed essential patient risk assessments including venous thromboembolism (VTE) and early warning score (EWS) assessment outcomes.
- Staff confirmed to us that the maternity record system was improved with smart text filters in place but there was still a combination of electronic and paper records in place. Smart text is similar to a predictive text with the most used status or treatment descriptors featuring first on the system.
- All equipment checked was safety tested and was on the pre-planned maintenance programme.
- Staffing shortages within the delivery suite were seen each day but we were informed of clear plans to fill those vacancies with staff already recruited to start in October 2016.

Summary of findings

- Policies and procedures in place were based on up-to-date evidence-based guidance which had been followed: for example; fetal heart monitoring (FHR) monitoring, vascular thromboembolism (VTE) and early warning score guidelines.
- All staff were competent and understood the guidelines they were required to follow.
- Outcomes of women's care and treatment were robustly collected and monitored. For example, a maternity dashboard was available.
- Staff also confirmed that electronic hospital (Epic) coordination between electronic and paper-based systems had developed and they were able to show a thorough history for patients including risk factors. Although day case risks were not all completed on our initial review.
- We observed good practice in terms of audit, effective multidisciplinary team working and that staff consistently had the right skills, qualifications and knowledge for their role.
- All staff observed were extremely caring and we found that people were treated with dignity, kindness and respect throughout the directorate. There were also exceptionally good support systems in place to meet people's emotional needs, which included support following bereavement.
- The service consistently received more compliments than complaints.
- Women undergoing termination of pregnancy were cared for in a dedicated area that was accessed through a double door into soundproofed side rooms within labour ward but well away from labouring women or crying babies.
- Information had been provided in ways that the women could understand and which promoted women in being involved in making informed decisions about their own care and the delivery arrangements. Overall maternity and gynaecology services feedback received indicated that staff had a caring and compassionate approach. Women reported being treated with respect and dignity and having their privacy respected and dealt with in a sensitive manner across this service.
- Women could access and be discharged from the service in a timely way.

Summary of findings

- The gynaecology referral to treatment time (RTT) had maintained at 95% (trust target 92%) from the previous inspection in February 2016. There had been no national standard for RTT since October 2015.
- Service planning across the directorate was seen with workforce planning addressed. The demand on the service was addressed when patient acuity or staffing could not meet the needs of the women. The maternity unit had 17 diversions between Dec 2015 and July 2016 mainly due to a lack of capacity or insufficient staffing numbers.
- Senior managers had responded appropriately since the last inspection.
- Risk registers were up-to-date with clear ownership and actions completed or in progress.
- Key performance data was collected and analysed which meant that responsibilities were clear and that quality, performance and risk were fully understood and managed.
- The introduction of electronic hospital (Epic) caused problems with not meeting the needs of the service; for example, with data collection. Four out of six staff confirmed that improvements with the system had been a priority. "We are still on the journey but have moved forward since last year".
- There was an improvement with the completion of the neonatal early warning scores.
- All staff told us that senior managers were approachable and encouraged them to be open and transparent. Senior managers and staff confirmed their commitment and spoke about "the honour in being able to provide the best care possible to women and their families". Staff dedication and passion for delivering high-quality care was inspiring and there were numerous examples of outstanding practice in relation to innovation, improvement and sustainability.

Services for children and young people

Good



We rated this service as good because:

- The service managed safety well. Staff knew how to report patient safety incidents and what should be reported as an incident. Managers investigated when things went wrong and shared lessons to be learnt with all staff to help prevent further similar incidents.

Summary of findings

- Medical and nursing staff knew that when things went wrong with care and treatment they needed to inform patients honestly, give them support and apologise to them verbally and in writing. This process is known as duty of candour.
- Duty of candour training and knowledge was good across medical and nursing staff.
- Equipment servicing was up to date and equipment checked was safety tested.
- Clinical areas were visibly clean.
- The service had enough staff to keep patients safe and to provide the care they needed. Staffing levels for senior doctors, nurses and healthcare assistants consistently met demand.
- We found good transitional care services at Addenbrooke's Hospital for patients transferring from children's services to adult services.
- The hospital had good systems in place to continually improve the quality of their services and protect high standards of care.
- The divisional leadership team were knowledgeable about the service and understood the constraints within which the service was working.
- There was a strong culture of openness and transparency within children and young people's services.
- Staff provided kind compassionate care to patients and families in all areas we visited.
- Patients and relatives felt informed and included in the decisions being made about their care.

However:

- Staff on adult wards caring for young people aged 16 and 17 did not undertake children's safeguarding level three training in line with the Intercollegiate Role Framework.
- Staff management of controlled drugs in children's intensive care was a concern. Staff left controlled drugs keys unattended and hung on portable workstations.
- Senior management raised concerns about the lack of acute paediatric beds available across children's services.

Summary of findings

- The children's divisional management team told us that 250 scheduled admissions were cancelled between January 2016 and August 2016 due to a lack of beds.
- Between September 2015 and August 2016, the trust cancelled 132 procedures for children and young people. Of these 121 were rebooked within 28 days of the procedure being cancelled and 11 patients waited longer than 28 days to be rebooked.
- Staff did not receive training in how to take patient's consent for treatment. Staff delegated the task of consent should have completed a consent competency package according to the trust consent to examination, treatment and post mortem policy. However, the trust provided no detail on completion of this.

End of life care

Good



We rated end of life services as good because:

- Patients were well cared for and kept safe from avoidable harm. Staff worked to clear guidelines and policies, and were all up to date with mandatory training, including on how to manage risk and safeguard patients from abuse.
- Staff used good infection control techniques, such as use of personal protective equipment and disposal of waste.
- Staff provided care personalised to each patient and in line with national guidance. , That was reflected in care records that were well organised and accessible.
- The service was responsive to patients' needs. Patients referred to the service were seen promptly and the team was responsive to their individual needs throughout their care, including managing their pain and symptoms with anticipatory medication. The team tried hard to improve discharge times so that patients at the end of their lives could be in the place of their choice.
- Staff were exceptionally caring and compassionate. They treated patients with dignity and respect, and were responsive to the needs of patients and visitors. We saw outstanding examples of how staff had fulfilled patients' dying wishes, including by arranging a wedding in the hospital, moving a patient's wife of 65 years into the bed next to him so they could hold hands, and tracking down a patient's daughter so she could be with him before he died.

Summary of findings

- The service had good governance arrangements for continually improving the quality of their services and safeguarding high standards of care.

However:

- There were inconsistencies in the types of care plan used, with no specific replacement of the Liverpool care pathway, a care pathway covering palliative care options for patients in the final days or hours of life.
- The hospital did not meet the staffing levels within the palliative care team, as recommended by the Association for Palliative Medicine in Great Britain and Ireland, and the National Council of Palliative Care.
- Half of DNACPR forms reviewed were completed incorrectly.
- Patient wishing to die at home could go on a fast track discharge. The average time for this was 3.84 days. Although there had been recent improvements this did not meet the recommended time of 2 days.

Outpatients and diagnostic imaging

Good



Overall, we rated the outpatient and diagnostic imaging service as good. We rated outpatient and diagnostic imaging as good for safe, caring and well led. We rated responsiveness as requires improvement and although effectiveness of the service was inspected, we did not rate it. We found:

- The trust had taken action to ensure that patients awaiting appointments were being risk assessed to enable appointments to be booked in order of clinical priority.
- There had been improvements with appointment slot issues (ASIs) and did not attend (DNA) rates since our inspection in February 2016.
- Staff received feedback about incidents that happened in their area and there was evidence of learning.
- Staff received appraisals and there was effective multidisciplinary working within the department.
- Staff were caring and patients and carers spoke positively about the care and compassion shown by all clinic staff. Friends and family test (FFT) data showed 93.8% of patients would recommend the service although this was based on a low response rate.

Summary of findings

- Medical staff planned and delivered patient care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- The board and other levels of governance within the trust worked effectively together and interacted with each other regularly. Structures, processes and systems of accountability were clearly set out, understood and effective.
- Staff gave us numerous examples of innovations and improvements which had been introduced across OPD and DI as well as plans to improve sustainability.

However, we found:

- There were still appointment backlogs in some specialties.
 - The trust was failing to meet referral to treatment time in six of the 18 specialties. However, this was an improving performance since our last inspection.
 - There were waits of longer than six weeks for some diagnostic tests.
 - FFT response rates were low.
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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 1486 beds covering a wide range of specialties.

Population served:

Patients predominantly come from Cambridgeshire, Essex, Suffolk and Hertfordshire. The demographics vary 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:

Inspection Chair: Jane Barrett, Chair Thames Valley Clinical Senate

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

The team included The team included two CQC inspection managers, twelve CQC inspectors, two CQC pharmacy inspectors, an assistant inspector and a variety

of specialists including, a pharmacist, two medical consultants, a consultant in emergency medicine, a consultant obstetrician, a consultant surgeon, an intensive care consultant, a consultant paediatrician, a junior doctor, 14 nurses at a variety of levels across the core service specialities, a midwife and an 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 20th and 22nd September 2016 with an unannounced inspection on 29th September 2016. Before visiting, we reviewed a range of information we held, and asked other

organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); NHS Improvement; NHS England and the local Healthwatch.

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 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.

Facts and data about Addenbrooke's and the Rosie Hospitals

Key figures

• **Beds:** 1486

– 1394 General and acute inpatient and day case

– 92 Maternity

• **Staff:** 8930

– 1238 Medical

– 2978 Nursing

– 4714 Other

• **Revenue:** £890,810,000

• **Full Cost:** £1,004,137,000

• **Surplus (deficit):** £(113,327,000)

Activity type

Outpatient (total attendances; July 2014 to June 2015)
1,336,900

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.
2. We rated effective as good overall due to there being an outstanding rating in critical care.
3. We rated end of life care as good overall due to there being an outstanding rating in caring.

Urgent and emergency services

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

Information about the service

The urgent and emergency services at Addenbrooke's Hospital comprised the emergency department (ED), major and minor trauma areas, resuscitation area, paediatrics area, and clinical decisions unit (CDU). The ED is 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 (TNCS). Patients arrived at the department by walk in, ambulance and by the East of England Air Ambulance Service.

Between April 2015 and May 2016, the urgent and emergency services at Addenbrooke's hospital saw 127,686 patients, of which around 21% were children.

In the year 2015 to 2016, 27.5% of attendances resulted in admission, which was above the England average of 21.6%.

The service was divided into several areas including minors, majors, resuscitation area, paediatrics, assessment areas B and C and dedicated ambulance bays, providing care for patients with minor injuries to major trauma. The ED had an integrated system of working, with general practitioner admissions cared for through the department. The clinical decisions unit (CDU) operated 24 hours a day seven days per week for adult patients requiring less than 24 hours admission for ongoing observation or treatment. The unit consisted of two bays of four beds, separate male and female toilets

and a single room, often used to support patients with specific needs, for example a mental health crisis. The unit had a clear operational policy including patient exclusion and admission criteria

There was a paediatric area with separate waiting and treatment facilities. The minor injury area had four 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.

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 64 members of staff from various roles within the ED and 13 patients and relatives. We also spoke with four ambulance staff from the East of England Ambulance Service and two police officers from the Cambridgeshire Constabulary. We also examined 17 patient records including records in relation to patient medication 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 hospital 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

Urgent and emergency care services were rated as good overall. The safe domain has been rated as requires improvement.

- There were clear procedures for managing and referring safeguarding concerns in relation to children and adults who may be at risk of abuse. Staff we spoke with knew how to make a referral and who to refer their concerns to within the trust.
- Staff knew how to report incidents and deal with complaints and there was a learning culture within the emergency department (ED).
- Between May 2015 and April 2016, the median time to initial assessment ranged between one and two minutes. This was consistently better than the England average, which ranged between five and seven minutes for the same period.
- Medical and nursing staff achieved 100% compliance with their appraisals during 2015/2016, and staff had access to appropriate information and guidance to carry out their roles competently. There were good examples of multidisciplinary team working with internal staff and external agencies for example admission avoidance and safeguarding.
- The patient escalation procedure and processes were robust and staff used the patient electronic record system effectively to identify and escalate concerns regarding deteriorating patients. We observed staff routinely offering patients pain relief and assessing the level of pain on initial assessment.
- The percentage of patients in the Friends and Family Test who would recommend the service was consistently above the England average from June 2015 to May 2016. Throughout our inspection, we observed patients treated with compassion, dignity, and respect. Patients we spoke with told us they were well informed regarding their care and treatment. The trust had access to a range of clinical nurse specialists within the department that could provide support to a wide range of staff.
- The ED had access to translation services for patients whose first language is not English and provided leaflets in a number of formats to support patients who may need further guidance on their condition.
- No patients waited over four to 12 hours, from the decision to admit until admission, between June 2015 and May 2016. The number of patients leaving the ED without being seen between in May 2015 was 1.8%, rising to 2.4% in July 2015, steadily falling to 2% in December 2015. The percentage rose again to 2% in February 2016 before falling to 1.5% in April 2016. This was consistently better than the England average, which ranged between 2.5% and 3.5% for the same period.
- The median time to treatment was approximately 20 minutes below the England standard of 60 minutes, between May 2015 and April 2016. The trust performed consistently better than the 60-minute standard between June 2015 and April 2016.
- The ED used a number of alternative care pathways to alleviate pressure on the department and reduce admissions into hospital flow and employed a full time flow navigator to support patient flow. The trust had a dedicated relatives' room used by staff at times of bad news or as a rest area for relatives waiting for news of patients.
- There was good leadership within the ED, staff were clear on roles and responsibilities and understood the departmental development plan and the part they played in achieving its goals. Staff had been involved in planning future service configuration. Departmental risks were identified, mitigated and accountability clearly allocated to staff to ensure risks were monitored and updates shared within the governance structure.
- Staff we spoke with said that senior staff were approachable and willing to share their knowledge and expertise. Junior doctors told us that the ED was a good place to work, they felt valued by their colleagues, and that they had opportunities to learn and grow in professional confidence.
- The trust utilised patient focus groups in the community to gain feedback on its provision and plans for the future, for example the development of the ED and redesign of the building. There was a strong focus on innovation and future developments for the department, often with the engagement of departmental staff and external stakeholders in order to improve services for patients.

However:

Urgent and emergency services

- The dedicated paediatrics area was not secure and had no controlled access or staff reception area. Children arriving at the department had to pass through the main ambulance bay or the main adult waiting areas to access the paediatrics waiting area. Children were not visible from the main paediatrics area meaning that there was no opportunity for staff to monitor or see a child that may deteriorate. Due to staff vacancies, the paediatrics department did not have a registered children's nurse on duty at all times, which was not in line with the Royal College of Nursing guidance (2003).
- In August 2016, the department achieved a 64% compliance rate with the sepsis-six bundle, which was worse than the trust target of 95%. Seventy-six percent of patients received antibiotics within an hour, which was worse than the Royal College of Emergency Medicine standard of 100%.
- Between June 2015 and November 2015, the trust failed to achieve the national target for seeing, treating, admitting or discharging 95% of patients within four hours. In December 2015, the trust met the target; however, performance began to fall in January 2016 and fell to 83% in May 2016.
- Between May 2015 and December 2015, the average time spent by a patient in the ED ranged between three hours 20 minutes and two hours 20 minutes, which was higher than the England average (two hours and 20 minutes) for the same period.

Are urgent and emergency services safe?

Requires improvement



We rated Safe as Requires Improvement because:

- The dedicated paediatrics area was not secure and had no controlled access or staff reception area. Children arriving at the department had to pass through the main ambulance bay or the main adult waiting areas to access the paediatrics waiting area. Children were not visible from the main paediatrics area meaning that there was no opportunity for staff to monitor or see a child that may deteriorate.
- We found some equipment not reviewed in line with its service or stock-checking schedule and one out of date piece of equipment on an emergency airway trolley.
- Due to staff vacancies, the paediatrics department did not have a registered children's nurse on duty at all times, which was not in line with the Royal College of Nursing guidance (2003).
- Compliance against the use of the sepsis six bundle was below trust target.
- The department monitored compliance with the sepsis-six bundle and in August 2016 achieved a 64% compliance rate, which was worse than the trust target of 95%. Seventy-six percent of patients received antibiotics within an hour, which was worse than the Royal College of Emergency Medicine standard of 100%.

However:

- Incident reporting was embedded within the staff team practice and there was a learning culture within the department.
- Methicillin-Resistant Staphylococcus Aureus (MRSA) screening performance between May 2016 and August 2016 was routinely 90% or above.
- The emergency team worked proactively with the police, social services, and healthcare services to reduce individual cases of domestic violence within the Cambridgeshire region.
- Between May 2015 and April 2016, the median time to initial assessment ranged between one and two minutes. This was consistently better than the England average, which ranged between five and seven minutes for the same period.

Urgent and emergency services

- The median time to treatment was approximately 20 minutes below the England standard of 60 minutes, between May 15 and April 16. The trust performed consistently better than the 60 minute standard between June 2015 and April 2016.

Incidents

- The service followed the trust's incident reporting policy; incidents were reported, investigated; and lessons were learnt. The service submitted incident reports for 567 incidents between March 2016 and June 2016 for the emergency department (ED). Of these, 449 incidents caused no harm, 65 incidents caused low to minor harm, 17 caused moderate harm, and 34 incidents caused severe or major harm; a further two incidents were not categorised. Appropriate action was taken by the trust in relation to all the incidents that we reviewed including investigation, root cause analysis and change in practice.
- The trust reported one serious incident in relation to the ED. This involved a confidential information and governance breach. The trust fully investigated the event and reported this appropriately in line with the NHS serious incident reporting framework.
- The staff we spoke with knew how to report incidents on the trust electronic reporting system and stated that they received feedback from any incidents via email or from their line manager. One member of staff gave an example of using the system to report concerns regarding staffing levels; another gave an example of reporting a faulty piece of equipment.
- Mortality and morbidity meetings were held specifically for adults, trauma, paediatrics, and mental health. Staff stated that they were advised of learning from such analysis through team briefings, team meetings, board rounds, and emails to all staff. We saw minutes of meetings were detailed and included learning points for each case presented and individual performance actions were allocated to staff for review at the next meeting.
- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the Duty of Candour was and that it was

about being open and transparent when things go wrong. We reviewed the serious incident in relation to information governance and saw that this was dealt with in line with the Duty of Candour.

- The trust reported no pressure ulcers, falls or catheter acquired urinary tract infections between July 2015 and June 2016 via the patient safety thermometer. The safety thermometer is an improvement tool for measuring, monitoring, and analysing patient harm free care on a set day each month, and reported monthly.

Cleanliness, infection control and hygiene

- The trust infection control team carried out an unannounced visit to the ED in June 2016, the visit was organised in response to low hand hygiene compliance in May 2016. The visit included a hand hygiene audit, which showed staff compliance with hand hygiene was only 75% against the trust target of 100%. The hand hygiene audit for the ED in August 2016 was 79.8%, which showed improvement over time but was still below the trust target. The clinical decisions unit achieved 100% compliance with hand hygiene audits from April-August 2016.
- The trust provided infection control training to all staff within the ED and set a 90% compliance rate. Within the last twelve months, all staff achieved a 98% or above compliance rate.
- Staff we observed adhered to the trust hand hygiene and 'bare below the elbow' policy, and wore personal protective equipment during care. Staff washed their hands in line with the World Health Organisation's "Five Moments of Hand Hygiene" guidance between personal care activities with patients and utilising the hand sanitizer where appropriate.
- Staff could explain the protocol for patients with possible infectious disease and demonstrated they had good understanding of infection, prevention and control. The staff also asked patients key questions on arrival at the department to establish if they posed an infection risk to other patients and staff.
- Hand sanitizer was available at the entrance to each area of the ED and clear signage was in place asking all staff and visitors to wash their hands. The ED had a stock of cleaning and sanitising equipment and key guidance for staff and patients on infection prevention, protection, and control was available at all hand washing areas.

Urgent and emergency services

- There was appropriate provision of cleaning materials and housekeeping staff were visible throughout our inspection and continually engaged in cleaning activities. Staff frequently emptied waste bins during the course of the day and the environment was visibly clean.
- Patient trolleys, equipment, and curtains providing privacy appeared visibly clean throughout the department. Curtains were also labelled with an expiry check date and we found all curtains to be within service date and in good condition.
- We spoke with three members of the cleaning team and one housekeeper, and observed their daily work regime. This included updating signage in patient bays to say they were clean and safe to use. We also saw red paper bands applied to equipment across the department stating that the equipment was clean and was safe to use. All departmental records in relation to the cleaning of areas were up to date at the time of our inspection.
- Data supplied by the trust showed that Methicillin-resistant Staphylococcus Aureus (MRSA) screening performance in the ED between May 2016 and August 2016, was routinely 90% or above.

Environment and equipment

- The March 2016 Patient Led Assessment of the Care Environment (PLACE) of the ED paediatric area identified the environment was clean and clear. However, some scuffs on the walls and floors, and a deep scuff in floor near vending machines, were identified and these were reported to the estates team for refurbishment.
- The dedicated paediatrics area was not secure and had no controlled access or staff reception area. Children arriving at the department had to pass through the main ambulance bay or the main adult waiting areas to access the paediatrics waiting area. The area was therefore accessible by anyone who entered the ED, unless challenged by a member of staff and directly accessible from the minors and majors areas. We saw this was on the ED risk register. Staff we spoke with were concerned due to the lack of individual treatment and assessment rooms available for paediatrics.
- The paediatric waiting area had a gated entrance; however, the gate was permanently kept open during our inspection. We saw an occasion when a child wandered into the main corridor where staff were pushing large equipment and patients to and from various corridor areas, placing the child at risk of harm.

Staff could also not see the paediatrics waiting area from within the main paediatrics area. This meant that that children could not be observed in case of deterioration and that anyone could enter this area unchallenged.

- Data supplied by the trust showed between April 2016 and June 2016, the medical engineering team serviced 100% of high-risk medical devices within the emergency department. This was in line with the trust target of 98% compliance with high-risk medical device servicing schedules.
- We examined equipment check labels to establish if equipment was checked appropriately. On four pieces of equipment that were beyond their respective service dates. We brought this to the attention of the staff on duty and these were immediately taken out of service or replaced.
- The ED had two rooms specifically designed for patients who may have mental health needs. The rooms were well decorated, had two door entrance and exit routes, panic alarms, heavy weight non-moveable furniture, slip free handles, and no areas where a ligature may be used. (A ligature can be used by a person to hang or cause themselves harm).
- The emergency airways trolleys in the ED were all sealed and daily checks of equipment were completed. We checked eight adult and two children's emergency airways trolleys in total. The seal on one piece of adult equipment was broken and one item in the paediatrics trolley was out of date. The staff on duty that also checked the remaining stock for renewal dates immediately replaced both items.
- We checked three adult resuscitation trolleys and one paediatric trolley. All of the equipment was in date and had been tested by hospital engineering staff.

Medicines

- We reviewed the medication records of eight patients on the trust electronic patient management system. All records were accurate and included allergies likely to affect the patients. All staff we spoke with found the new electronic system useful as it raised electronic alerts and reminders to guide staff regarding the dose, administration, and timings.
- The medication storage area in major areas A and B, resuscitation and paediatrics rooms were visibly clean.

Urgent and emergency services

Medicine cupboards were locked and medicines found to be in date and in a well maintained condition. All areas were key pad restricted and the security code changed on a regular basis.

- Controlled drugs (CDs) were stored securely in locked controlled drugs cabinets and we checked the records in major areas A and B, resuscitation and paediatrics. Twice daily checks had been completed between June 2016 and September 2016 in all areas to ensure records were accurate and up to date.
- The pharmacy department operated a five day (8am to 8pm) clinical service within the ED. The ED team informed the pharmacist about any medicine issues and patients who should be seen as a priority. A pilot study (March 2015) of the clinical pharmacy service showed it led to a reduction in direct admissions to hospital and saved 30 minutes of doctor time per patient.
- Commonly prescribed medicines such as pain relief or antibiotics were labelled and available for patients to take home. This helped to ensure patients did not have to wait for medicines to be dispensed from the pharmacy.
- Staff knew how to report a medicine incident. Medicine incidents were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff with e-mails and staff meetings.
- Checks to ensure that any known allergies or sensitivities to medicines were recorded accurately on patients' prescription charts within 24 hours of admission.
- We found that overall medicines were stored securely. Controlled Drugs were stored following safe and good guidance procedures. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators and records showed that they were kept at the correct temperature.

Records

- The trust introduced a paperless patient record system called Epic, prior to our last comprehensive inspection in April 2015. We examined 17 clinical records for patients in the ED contained within Epic and discussed these details with the staff using the system. Patients arriving by ambulance had their initial notes transferred onto Epic by administration staff. Clinical staff then used

this to begin the assessment process, whilst entering further details onto Epic following discussions with ambulance staff or other professionals, e.g. the police during patient handover.

- Patients walking into the department or entering by wheelchair had their initial details transferred onto Epic by clinical staff at the entrance of the department.
- All nursing and medical staff we spoke with were confident using Epic and commented on how much quicker and reliable it was than a paper based system, often stating that due to it being available across the hospital, they could access patient records from any work station on wheels or share Epic records with colleagues to promote patient outcomes.
- We observed staff using this system to call a specialist stroke nurse, a doctor to treat sepsis and an ENT specialist to support individual patients, all of whom arrived within a few minutes of being called.

Safeguarding

- The trust chief nurse was executive lead for safeguarding. There was a named nurse for safeguarding children and a named nurse for safeguarding adults as well as an organisational lead for child sex exploitation.
- Training compliance in relation to safeguarding was good within the ED. Nursing staff within the paediatric team achieved 100% compliance at level 1 and 2 safeguarding children, and 92.3% at level 3. The nursing staff within the paediatric team achieved 100% compliance with safeguarding adult's level 1 and level 2 respectively. The team were therefore above the 90% training target for both safeguarding children and adults.
- Other clinical staff within the paediatric team achieved 100% compliance at level 1 and 2 safeguarding children, which was better than the 90% target. Compliance with safeguarding adult's level 1 and level 2 training were both 100%.
- Nursing staff and other clinical staff within the ED achieved compliance with safeguarding children training levels 1 and 2, both better than the trust 90% though they were below trust target at 74.1% for level 3 training. The team achieved 100% compliance with safeguarding adult's level 1 and 94.6% with level 2 training, both were above the 90% compliance target for both safeguarding adults.

Urgent and emergency services

- Additional clinical service staff within the CDU achieved 100% compliance at level 1 and level 2 safeguarding children above the 90% compliance target and 72.7% compliance at level 3, which is below the 90% compliance target. The team achieved 100% compliance with safeguarding adults training, better than the trust 90% compliance target.
- Nursing staff within the CDU achieved 100% compliance at level 1 safeguarding children training, 95.7% at level 2, both better than the trust 90% compliance target and 74.1% at level 3, which was below the 90% compliance target. The team achieved 100% compliance with safeguarding adult's level 1 and 94.6% with level 2, both were above the 90% compliance target for safeguarding adults.
- There were clear processes and procedures in place for safeguarding adults and children in the ED. There were policies in place for the trust which were available to staff access through the trust's intranet system. Staff we spoke with knew how to recognise abuse and make a referral to the safeguarding leads for adults and children. Safeguarding referral guidance was available next to workstations and in staff information folders.
- We saw guidance for staff on recognising and reporting domestic violence and female genital mutilation displayed in the department. We saw this displayed in the staff changing areas.
- Staff from the ED participated in multiagency meetings in relation to safeguarding. We saw minutes from a safeguarding matters meeting August 2016, that showed joint participation and attendance by the ED staff.

Mandatory training

- The department had a full time practice development nurse responsible for leading and developing training to support staff skills, knowledge, and competencies.
- The trust set a target of 90% completion for all staff groups for mandatory training.
- Compliance rates for mandatory training within the paediatric, ED and CDU teams were generally greater than 90% for example conflict resolution, life support and fire training. There was some variability in health and safety training rates with some groups of staff such as additional clinical staff where 75% of staff had completed the training.
- Compliance rates for moving and handling varied across the teams, additional clinical services staff within the paediatrics team achieved 66.7% compliance, within the

ED 75% compliance and CDU 80% compliance, all below the trust 90% target. Nursing staff within the CDU achieved 90.9% compliance, within the ED 82.4% compliance and within the paediatrics team 100% compliance.

- Within the ED nursing and medical team 100% of staff had completed basic and advanced life support training. Additional clinical staff within the ED team had all completed basic life support training.
- Staff we spoke with said the trust was proactive in offering training, but sometimes due to staffing levels or shift patterns, they could not always attend face-to-face training. One member of staff showed us their own direct online training, referred to by staff as DOT. This gave staff instant online access to their own individual training record from any computer or workstation on wheels. The record gave percentage completion against the trust training target, offered time scales for training updates and other training available to staff.
- Online training was one of the key methods of training used by the trust for its staff team. Staff we spoke with liked the opportunity to access this training and felt that online learning enabled them to learn at their own pace and access training to suit their needs.
- Induction training was mandatory for all new staff, and an ED orientation programme was in place to guide staff through their initial days in the department, this included patient flow, patient pathways, observation, and other key subjects. We spoke to four student nurses who confirmed their induction to the department had been comprehensive and that staff had been supportive to their learning needs.

Assessing and responding to patient risk

- We reviewed 17 patient records, the Epic system prompts staff to complete data and when to escalate a concern over a patient's condition. All risk assessments were completed, allergies, modified early warning scores (MEWS) and paediatric early warning scores (PEWS) were all clearly documented.
- Epic used data entered by staff from their initial patient assessment to generate risk scores, for example sepsis and mental health, and set patient observation time scales with visual alerts to prompt staff to call doctor. We observed staff using this system to quickly call a specialist stroke nurse, a doctor to treat sepsis and an ENT specialist to support individual patients.

Urgent and emergency services

- Between May 2015 and April 2016, the median time to initial assessment ranged between one and two minutes. This was consistently better than the England average, which ranged between five and seven minutes for the same period.
- The median time to treatment was approximately 20 minutes below the England standard of 60 minutes, between May 2015 and April 2016. The trust performed consistently better than the 60 minute standard between June 2015 and April 2016.
- Rapid assessment of patients' conditions was undertaken on patients admitted by ambulance and other patients as required. Patient treatment bays were close to the ambulance entrance and staffed by senior nurses and medical staff to undertake the patient assessment and ensure diagnostic tests were done quickly as required.
- Over the last 18 months, the trust declared 128 black breaches. Black breaches are occasions where handovers from ambulance arrival to the patient being offloaded to A&E or ED took longer than 60 minutes. Between July 2015 and June 2016, 69% of black breaches were attributed to capacity within the hospital. The trust recorded and analysed all black breaches, and implemented a command and control system to respond to any issues, for example extended waits on ambulances, to reduce risks to patients.
- Between June 2015 and April 2016, the trust reported 1440 ambulance handover delays of over 30 minutes, which was similar to the England average for the same period.
- Between June 2015 and May 2016, only 4% of ambulance turnaround times were over 60 minutes. The other 96% were between 30 and 60 minutes, with 50% under 30 minutes.
- The trust had a rapid assessment triage (RAT) within its ambulance bay area in accordance with the Royal College of Emergency Medicine guidance. The RAT is an assessment of patients that should occur within 15 minutes of arrival at the ED. The RAT operated 24 hours a day, seven days a week. Staffing in this area was dependent on need but always included a nurse in charge and mix of nursing and health care assistant staff. The team could also direct patients directly to specialist teams within the hospital, for example surgery.
- In August 2016, the ED achieved a 64% compliance rate with the sepsis-six bundle, which was worse than the trust target of 95%. Seventy-six percent of patients received antibiotics within an hour, which was worse than the Royal College of Emergency Medicine standard of 100%.
- The trust electronic record system Epic flagged any patients likely to be at risk of sepsis and gave staff an alert to follow the trust escalation process for a patient at risk of sepsis. We examined the records of two patients arriving at the ambulance bay likely to be at risk of sepsis. The initial staff assessment had triggered the sepsis alert and appropriate action was taken in both cases to call a doctor and follow the sepsis pathway.
- The department utilised the "sepsis six-bundle" interventions to treat patients and identify those at high risk. Sepsis-six is the name given to a bundle of therapies designed to reduce the mortality of patients with sepsis. The department monitored compliance with the sepsis-six bundle and in August 2016 achieved a 64% compliance rate, which was worse than the trust target of 95%. Seventy-six percent of patients received antibiotics within an hour, which was worse than the Royal College of Emergency Medicine standard of 100%. The department had a sepsis-action plan in place displayed on staff notice boards, clearly showing staff responsibilities and the actions taken and planned interventions by the department to improve performance.
- We observed 16 patients arriving by ambulance on trolleys to the ambulance bay; all of them were seen and assessed by a nurse in less than fifteen minutes. We observed one patient have their initial and secondary assessment completed on arrival, be seen by a doctor, and prescribed antibiotics in less than 25 minutes.
- 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 Care Quality Commission national accident and emergency survey (A&E) 2014, showed the trust scored 'about the same' as other trusts for four questions. These were for how long did the patient wait with the ambulance crew before care was handed over to the A&E staff. Also for the questions how long patients waited before being examined by a doctor or nurse, how clean was the A&E department; and did patients feel threatened by other patients or visitors?

Urgent and emergency services

- We spoke with four staff from the East of England Ambulance Service who told us that staff in the ED were very responsive to patient risk. One member of staff told us if ambulances were delayed in the ambulance bay due to flow through the hospital, a senior nurse or doctor would triage a patient on the ambulance if the patient's condition had worsened.
- The trust had implemented a new flow chart and procedure for supporting patients attending the ED with mental health issues in order to reduce the risk of harm to themselves or others. This procedure was clearly displayed on workstations around the department and staff were aware of the procedure and how to escalate concerns for a patient's welfare to the psychiatric liaison service.
- The emergency care intensive support team (ECIST) noted the patient escalation procedures as a model of best practice with clear guidance available for staff on when to escalate a delay and to whom. (ECIST is a national team set up to provide support to health and social care communities in reviewing their system for urgent and emergency care.)

Nursing staffing

- A band seven nurse was in charge of the department, who also carried the departmental bleep (mobile pager), in case of escalation or emergency issues. The department normally had two band seven registered nurses (RN) on duty at any one time, but at the time of our inspection, the department was short of one band seven, whilst recruitment for band seven posts continued.
- The ED nurse team shifts were arranged so that more staff were working in periods of anticipated higher demand for services, for example there was an additional twilight shift to support the team working from the evening and through the night.
- At the time of our inspection the department had five whole time equivalent (WTE) vacancies for band five RN and six WTE for band seven RN. There was an active rolling recruitment process in place to attract new staff to work in the department.
- The department had a sickness absence rate of 3% in September 2016; this was lower than the average NHS sickness absence rate of 4.5% reported in January 2016. At the time of our inspection, a number of staff had called in sick; this meant in the majors area the staffing ratio had fallen from one RN to four patients, to one RN to six patients. However, the nurse in charge of the department took effective steps to support patient welfare and ensure their individual needs were met. The staff team worked effectively in order to promote team working and ensure patient care was maintained during busy periods or short-term staff absence.
- There were registered nurses, child branch who provided support to the ED paediatric area covering long days. The planned staffing establishment meant that for the majority of each day a paediatric nurse was on duty. However, between 07.45am and 10am there was gap when no paediatric nurse was on duty. The department had recently appointed two band six children's nurses that were due to start in the department shortly after our inspection and had one band five post out to advert. Staff who covered this gap had received paediatric life support and other training to ensure they had the correct skills. This meant that department did not have a registered nurse, child branch on duty at all times, which was not in line with the Royal College of Nursing guidance (2003).
- The CDU had two RN and one HCA on duty from 7.30am to 8.30 pm and again between 8.15pm and 7.45am seven days per week. The short-term rehabilitation team (START) were also based within the CDU and consisted of one WTE RN and two part time RN.
- We observed the nursing handover; this was comprehensive and focused on key issues in relation to the safe management of patients and the department. Issues covered included patient care and treatment, staffing levels, patient flow and any safety issues likely to be of concern.
- The team used a social media platform to contact other staff to cover any nursing staff shortfalls within the department. Staff we spoke with preferred this as a method of contact and felt it enhanced the opportunities for staff to cover at short notice due to the instant access the social media platform provided.
- The department had an appropriate skills mix within the staff team. The rotation of staff on a daily basis combined with the six weekly staff rotation across the department encouraged teamwork and increased the skills and competencies of staff.
- Agency/bank staff use varied across the department, in July 2016 the CDU used 13.3% agency/bank staff, and in August 2016, this increased to 16.3%. The ED used 14.6% agency/bank staff in July 2016, this increased to 15.1% in August 2016. The paediatrics emergency department

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used 23.2% agency/bank staff in July 2016, this increased to 25% in August 2016. The department mainly utilised its own bank staff team to cover shift patterns where possible and the fill rates reflect the current departmental vacancy levels, particularly in the paediatrics department. The small number of agency nurses used worked regularly in the department. They had received an induction and their competencies checked before they commenced work.

Medical staffing

- The department provided 18-hour consultant cover, from 8am until 2am. After 2am, the department had consultants on an on-call basis. The hospital is the trauma centre for East of England and the emergency medicine consultants coordinated transfer of traumas from across the region on a 24-hour basis, seven days a week.
- The percentage of consultants in the ED was 35%, which was higher than the England average of 26%; middle grade staffing was 2%, which was lower than the England average of 13%. The percentage of registrars within the department was 58%, which was higher than the England average of 39% and junior medical staffing was 5%, which was considerably lower than the England average of 23%.
- The consultant shift patterns on weekdays ensured that there was at least one consultant in the emergency department and the clinical decisions as well as a consultant coordinating the trauma network coordination service (TNCS). The consultant shift pattern at the weekend ensured consultant cover across the department until 2am when an on-call consultant was available.
- Consultants were supported by junior doctors ranging from foundation year to specialty registrars. Specialty registrars managed the department between 2am and 8am supported by the on-call consultant.
- The department had three acute emergency medicine consultants with specific paediatric training. They worked across the wards and covered from 8am to 5pm seven days per week.
- We observed handovers between medical staff. They were comprehensive, and covered patients at risk, flow through the department and staffing levels amongst other key areas.
- The ED preferred not to use locum staff but instead use their own medical team to cover any areas as required.

However, data supplied by the trust showed locum use in July 2016 was 21.2% and 4.3% in August 2016. The department had a business case in place to support the recruitment of further consultants. At the time of our inspection, there were 17.2 whole time equivalents (WTE) available and the team were aiming to increase this to 24.2 WTE within the next twelve months.

Major incident awareness and training

- The trust had a major incident plan (often referred to as MAJAX) and business continuity plan in place. Staff we spoke with were aware of the plan and when this was likely to be implemented.
- The ED had a lead member for staff responsible for managing major incidents and coordinating staff development on decontamination, chemical, biological, radiological, nuclear, or explosive events (CBRNe) or an industrial event (HAzMat).
- The decontamination room and storerooms for MAJAX equipment were of a very high standard, visibly clean and well organised. Equipment labels showed that equipment was routinely checked that it was in date and ready for deployment in a major incident.
- The team had developed strategies to specifically deal with a failure in radio communication and when using specialist breathing apparatus that included the use of flash cards. The flash cards were clear and stored appropriately, clear signage was in place to guide staff through any emergency process including decontamination, dressing and undressing processes.
- The trust had developed an area outside of the ambulance bay, where patients likely to cause a risk to other patients due to an infectious disease or HAZMAT episode could be isolated and directed safely to the decontamination and safe areas. Signage in these areas was clear and well maintained.
- The trust had six staff specifically trained to deliver MAJAX training to staff and a further two staff were undergoing the training at the time of our inspection and data supplied by the trust showed 58 nursing staff within the ED had attended major incident training.

Are urgent and emergency services effective?

(for example, treatment is effective)

Urgent and emergency services

Good



We rated effective as Good because:

- Staff followed national guidance and local policies when caring for patients.
- There was a comprehensive audit programme of national and local audit within the emergency department.
- We observed staff routinely offering patients pain relief and assessing the level of pain on initial assessment.
- There were good examples of multidisciplinary team working with internal staff and external agencies for example admission avoidance and safeguarding.
- Staff had access to appropriate information and guidance to carry out their roles competently.
- Medical and nursing staff achieved 100% compliance with their appraisals during 2015/2016.

Evidence-based care and treatment

- The emergency department (ED) had a dedicated audit plan that clearly showed achievement against audit time scales, identified the accountable individual and gave reference to National Institute for Health and Care Excellence (NICE) guidance and Healthcare Quality Improvement Partnership (HQIP) amongst others.
- A wide range of local audits were undertaken by the ED including understanding patient flows through the ED, mental health in the department and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) particularly around sepsis.
- There were named audit leads within the audit plan. There was good engagement in audits from staff we spoke with on inspection and completion rates for audits were either achieved or ongoing with identified actions for individual staff members.
- Initial assessment of patients with different conditions were undertaken against protocols 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 on assessment and standards for the care of these patients.
- 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.

- The trust had a hyper acute stroke service, a clear pathway was in place for when a patient suspected of having a stroke arrived at the ED, and specialist stroke nurses were available. The acute stroke service was available 24 hours a day seven days a week and had an on-call system for out-of-hours services.
- Policies within the department had been developed based on local and national guidance. Staff could access a wide range of policies and procedures and hard copies were filed on workstations in all areas of the department for staff to quickly access.
- The trust carried out a fractured neck of femur re-audit in line with Royal College of Emergency Medicine (RCEM) standards in June 2015. Ten consecutive patients with a primary diagnosis of fractured neck of femur were reviewed over a 3-week period between May-June 2015. The RCEM standard for patients receiving an X-ray states that 75% of patients should have an X-ray within 60 minutes of arrival at hospital. Data supplied by the trust showed 20% of patients received an x-ray within 30 min, 60% received an x-ray within one hour, and 80% received an x-ray within two hours, the trust therefore met this standard.

Pain relief

- The RCEM standard for patients in severe pain (pain score 7 to 10) is that patients should receive appropriate analgesia. The standard states that 50% of patients should receive analgesia within 20 minutes of arrival, 75% within 30 minutes of arrival and 98% within 60 minutes of arrival. The trust audit showed that no patients received pain relief within 20/30/60 minutes, 50% of patients received this within two hours, and 70% of patients received this within four hours, the trust therefore failed to meet this standard.
- The trust scored better than other trusts in the national 2014 Care Quality Commission accident and emergency (A&E) survey relating to how many minutes after patients requested pain relief medication did it take before they got it (7.73 out of 10).

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- We observed staff routinely offering patients pain relief and assessing the level of pain on initial assessment. Pain scores were recorded and we saw in the paediatrics area that visual pain descriptors were used with children to help them express their pain levels.
- We spoke with three patients who told us their pain had been assessed on arrival and that they were satisfied with the pain relief and guidance they had received from staff.

Nutrition and hydration

- The trust scored higher than other trusts in the question within the national 2014 Care Quality Commission accident and emergency survey relating to access to suitable food or drinks when patients were in the accident and ED (8.23 out of 10).
- We observed patients being offered food and hydration where it was clinically safe to do so.
- We spoke with a housekeeper who explained that patients could access drinks and food but usually the food was in the form of sandwiches, as patients would receive plated meals on the ward if admitted. Staff used kitchen areas to support preparing patients' food and drinks, kitchens were visibly clean, and rotas of cleaning activity and fridge temperature were in place.
- For patients who were unable to eat and drink or were being assessed, supportive fluids intravenously or subcutaneously were prescribed and available.

Patient outcomes

- The department undertook national Royal College of Emergency Medicine (RCEM) audits to benchmark performance. Audits included pain in children, asthma in children, mental health in children and adolescents, paracetamol overdose, antibiotic prescribing in respiratory tract infections, venous thromboembolism (VTE) risk in lower immobilisation, vital signs in children and procedural sedation.
- TARN (Trauma Audit and Research Network) patient comparative outcome analysis at 30 days for East of England Trauma Network hospitals from 01 April 2013 to 31 March 2015 shows the hospital has 1% more survivors, which is in the middle of the national range of performance for the same period.
- TARN data entry completeness between April 2014 and March 2015 was 84%, which is the second highest completion rate in the network during that period.

- The trust participated in the Royal College of Emergency Medicine (RCEM) Fitting Child Audit 2014-15, showing 100% compliance with standard one (managing children against an algorithm. There was 92% with standard two (eye witness and history taking) and 75% with standard three (blood glucose monitoring). However, only 27% met standard four (patient information leaflets being available). A full action plan had been implemented improve performance.
- The trust participated in the RCEM Audit, Assessing for Cognitive Impairment in Older People Clinical Audit 2014-15. The trust fell below the RCEM 100% standard for documenting an early warning score with 86% compliance, carrying out a cognitive assessment 35% compliance, and using a structured cognitive assessment tool 97% compliance. A recommendation was made to improve patient assessment documentation, and we observed staff utilising the Epic system to record detailed initial assessments due to changes made following the audit.
- The trust participated in the RCEM Mental Health in the Emergency Department Audit 2014-15. The trust achieved 42% compliance against the RCEM 100% standard for making a risk assessment and recording in the patient's clinical record. The trust achieved a 68% compliance with the history of a patient's previous mental health issues being taken and recorded, 20% compliance with a mental state examination being taken and recorded and 22% compliance with the patient being asked about their alcohol & illicit substance consumption within the last 24 hours. However, the trust achieved 84% compliance for a provisional diagnosis being documented and 74% compliance with the patient being assessed by a mental health practitioner from the organisations specified acute psychiatric service.
- The following patient groups should be reviewed by a consultant (or senior trainee) prior to discharge from the ED, adults (over 17 years) with non-traumatic chest pain, febrile children less than one year old, and patients making an unscheduled return to the ED with the same condition within 72 hours of discharge from the ED. In June 2015, the trust reviewed 20 cases and found the number of adults (over 17 years) with non-traumatic chest pain signed off by a consultant was four (20%), signed off by senior specialist registrar six (30%), not signed off ten (50%). The number of febrile children less than one year old signed off by consultant was eight

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(40%), signed off by senior specialist registrar six (30%), not signed off six (30%). The number of unscheduled patient returns to the ED within 72 hours of discharge signed off by a consultant was five (25%), signed off by senior specialist registrar 15 (75%), and no patients not being signed off.

- Between May 2015 and September 2016, the unplanned re-attendance rate within seven days for the ED ranged between 6% and 7.2%. This was higher than the England standard of 5% but below the England average of 7.2%.

Competent staff

- All nursing staff and health care assistants had the opportunity to rotate across areas within the ED every six weeks. This enabled staff to gain experience and skills in the various areas of practice.
- The nurse in charge of the ED deployed staff to a different work area daily when arriving for duty. The nurse in charge kept a detailed record of where staff had previously worked in order to try to rotate staff into a new work area. Staff felt the rotation was a good idea as it increased their individual skills, gave them new experiences and offered opportunity to work with a wider range of staff within the department.
- All new staff entering the department went through a detailed induction process and dedicated orientation process to ensure they were familiar with the department layout and key issues they were likely to come across, for example, patient flow, staff roles and responsibilities, and escalation of patients at risk, amongst others.
- Staff we spoke with told us they received supervision on a four to six weekly basis. This was an opportunity for them to discuss their individual and team performance and seek guidance and training within their role. All staff we spoke with were positive about supervision and stated this made a genuine difference to their professional roles and made them feel valued by their manager.
- Medical and nursing staff achieved 100% compliance with their appraisals during 2015/2016.
- The department had a nominated member of staff that supported staff with revalidation in order to help them collate evidence and ask questions in relation to the revalidation process.
- Staff could access direct online training (DOT) from any workstation; this instantly gave them access to key data

in relation to their training and development including training completion and training required. The system was easy to navigate and gave staff instant access to establish their individual training and competency needs at any time.

- Nursing staff were trained to order X-rays within the ED. Staff were deemed competent following specific training in Ionising Radiation (Medical Exposure) Regulations (2000, IRMER) and dedicated training from one of the trust's own radiographers. This enabled staff to quickly support patients and recommend treatment to reduce patient waiting times.
- The ED offered the pre-hospital emergency medicine training (PHEM), the first training programme to be validated by the UK General Medical Council.

Multidisciplinary working

- The ED teams had access to a range of allied health professionals and team members described excellent collaborative working practices between the teams. There was a joined-up and thorough approach to assessing the range of people's needs and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- Consultants we spoke with told us they found the input of other clinical teams and specialist nurses to be very good and that it was patient focused.
- We attended a bed availability meeting, held to determine priorities, capacity, and demand for all specialities. Staff told us these meetings would reduce or increase based on patient flow throughout the hospital.
- We spoke with therapy staff who told us that they felt part of a multidisciplinary team (MDT) and colleagues valued their views and opinions. All staff described teams working well together and sharing best practice to improve patient outcomes.
- We observed numerous interactions between members of the MDT. All were positive and clearly showed mutual respect for each other's roles.
- The ED had good working relationships with local ambulance and police staff. We observed numerous positive interactions between hospital and external staff to ensure patients' needs were met.
- We spoke with the chaplaincy team who attended staff meetings to support staff who may be working with patients and families facing a sudden bereavement or

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difficult diagnosis. The team gave an example of how they had developed follow-on appointments with medical staff for relatives of patients who had died in the ED. This process enabled relatives to discuss issues they may not have had the opportunity to discuss at the time of the patient's death or deal with any ongoing complaints or bereavement issues.

Seven-day services

- The ED at Addenbrooke's was open seven days per week and 24 hours per day.
- The short-term assessment and rehabilitation team (START) were based within the clinical decisions unit adjacent to the ED and provided seven-day cover from 8am to 6pm. The team consisted of nurses, physiotherapists, and occupational therapists who worked collaboratively with the ED staff to help avoid hospital admissions by patients entering the ED. In July 2016, the team saw 199 patients, 82 of whom avoided admission to the hospital wards and were either treated or offered alternative care pathways.
- The hospital had a referral pathway for liaison psychiatry that was available Monday to Friday 8am to 12pm and 8am to 6pm at weekends. Out of hours, (between 8pm and 9pm) staff could utilise the hospital bleep system to call for advice and support from an out-of-hours consultant. After 9pm the duty officer at a nearby trust could be contacted for advice and guidance as part of the liaison psychiatry services.
- The ED had access to computerized tomography (CT) and magnetic resonance imaging (MRI) seven days per week and 24 hours per day. Staff we spoke with stated that the service was very responsive to the department's needs.
- The ED had developed a 'point of care' for the processing of patient blood tests on site, in an office area adjacent to the ambulance arrival bay. The service provided support to the staff team by processing blood tests seven days per week and 24 hours per day. We spoke with nursing and medical staff who stated the service had made a huge difference to how they support patients and that having access to blood results so quickly and close to them on site improved patient care and treatment.
- The chaplaincy services were available seven days per week and 24 hours per day to support the ED teams. The

service developed key relationships with other local religious groups and faiths to ensure that anyone who may suffer a sudden bereavement could access support appropriate to their individual needs and choices.

Access to information

- The ED department used the Epic electronic record system. This meant that records were available to staff immediately. Initial patient contacts were placed onto the system by administrative or clinical staff. The system also maintained a record of who had accessed medical records.
- Blood results and other investigations such as x-ray and scan results were available as soon as they were ready and on the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). All staff we spoke with were aware of their responsibilities in relation to the policy and that the policy was there to support patients who may lack capacity when entering the department.
- Mandatory training included MCA and DoLS as part of safeguarding level 2 training.
- In many cases patient consent was not immediately possible due to the condition of the patient on arrival and the urgency of the care they required. However in all other cases we observed staff routinely seeking consent from patients prior to treatment within the department.
- We spoke with four nurses who were able to differentiate between Gillick competency (a principal to judge capacity in children to consent to medical treatment) and Fraser guidelines and how these were applied in practice when caring for children. Staff also gave examples of when consent would be implied or when specific consent would be required to carry out care and treatment.
- The trust have confirmed that Mental Capacity Act training is an integral part of safeguarding adults level two training, compliance for all staff teams was therefore routinely better than the 90% compliance target set by the trust.

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- We specifically spoke to three nurses and two health care assistants to establish if they understood how to a patient was living with dementia or not to ensure they were employing the right communication and support to protect patients' wellbeing.

Are urgent and emergency services caring?

Good



We rated caring as Good because:

- The percentage of patients in the Friends and Family Test (FFT) who would recommend the service ranged between 92% and 95% from June 2015 to May 2016, consistently above the England average of 89% and 87% for the same period.
- Throughout our inspection, we observed patients treated with compassion, dignity, and respect.
- The trust had access to a range of clinical nurse specialists within the department that could provide support to staff.
- All patients we spoke with told us they were well informed regarding their care and treatment.

Compassionate care

- The percentage of patients in the Friends and Family Test (FFT) who would recommend the service ranged between 92% and 95% from June 2015 to May 2016, consistently above the England average of 89% and 87% for the same period.
- The emergency department (ED) scored 9.32 out of 10 in the Care Quality Commission national accident and emergency survey 2014 when asking patients, "Overall, did you feel you were treated with respect and dignity while you were in the accident and ED?"
- We saw staff respected and recognised patients' individual needs and choices at all times. We heard conversations between staff and patients who were receiving care. Staff were kind and gentle, offering reassurance and positive support to patients who were often uncomfortable and needing reassurance.
- Throughout our inspection, we observed patients treated with compassion, dignity, and respect. Curtains were drawn where practicable and privacy was respected when staff were supporting patients with

personal care. For example, we saw staff routinely reminded patients about privacy, and ensuring patients arriving by ambulance into the ambulance bay were covered and kept warm.

- Patients we spoke with told us they felt safe in the ED's care and with their treatment at all times.
- Relatives of an end of life patient were concerned regarding their parking on arrival and that they may be charged for overstaying when sitting with their family member. The nurse in charge immediately took the relatives' details and dealt with the estates team to reassure them that they could concentrate on looking after the family member and not worry about any parking tickets or issues.

Understanding and involvement of patients and those close to them

- We observed nurses, doctors, and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- The ED scored 9.02 out of 10 in the Care Quality Commission national accident and emergency survey 2014 when asking patients, "While you were in the A&E Department, how much information about your condition or treatment was given to you."
- All patients we spoke with told us they were kept informed regarding their care and treatment. One patient told us that he felt there had been some confusion regarding his care and treatment, but staff had listened carefully to his concerns, reassured him, and ensured he was referred to the correct service.
- We spoke with the relatives of a terminally ill patient, who told us they had been fully involved in decisions regarding the patient's care and treatment and that the staff had respected their views and given them lots of information regarding their relative's care.
- The chaplaincy team had developed strong links with the local Muslim community in order to support the death of patients who followed or practised the religion of Islam. This included specific support for dealing with the deceased, ensuring that Islamic practises were followed after death of the patient and local community representatives attending the hospital to support the family.

Emotional support

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- The trust had access to a range of clinical nurse specialists within the hospital that could provide support staff within the ED. These included a dementia specialist nurse, acute stroke nurse, learning disability nurse, psychiatric liaison and specialist play therapist.
- The trust had a chapel on site and a chaplaincy service that was available to patients, relatives, and staff 24 hours a day seven days a week. The service was a psychosocial model that sought to support people from a wide range of religions, beliefs, and cultures.
- Staff had access to counselling services if they had been affected by any cases they had dealt with, contact details were available on the trust intranet and various notice boards around the department.

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

Good



We rated responsive as Good because:

- No patients waited over four to 12 hours, from the decision to admit until admission, between June 2015 and May 2016.
- The department provided leaflets in a number of formats to support patients who may need further guidance on their condition.
- The ED had a full time flow navigator to encourage patient flow and access by following on discharge plans, transfers, and admissions.
- The number of patients leaving the ED without being seen between in May 2015 was 1.8%, rising to 2.4% in July 2015, steadily falling to 2% in December 2015. The percentage rose again to 2% in February 2016 before falling to 1.5% in April 2016. This was consistently better than the England average, which ranged between 2.5% and 3.5% for the same period.
- The ED used a number of alternative care pathways to alleviate pressure on the department and reduce admissions into hospital whilst supporting patient flow.
- The emergency department (ED) had access to translation services for patients whose first language was not English.

- The trust had a dedicated relatives' room used by staff at times of bad news or as a rest area for relatives waiting for news of patients.

However:

- Between June 2015 and November 2015, the trust failed to achieve the national target for seeing, treating, admitting or discharging 95% of patients within four hours. In December 2015, the trust met the target, however performance began to fall in January 2016 and fell to 83% in May 2016.
- Between May 2015 and December 2015, the average time spent by a patient in the ED ranged between three hours 20 minutes and two hours 20 minutes. The England average for the same period was two hours and 20 minutes.

Service planning and delivery to meet the needs of local people

- The emergency department (ED) had a business case to improve its services for paediatric patients due to concerns regarding the safety and access to the department. The team had engaged with a local primary school to seek their feedback on how to improve the department and create a safe child-friendly environment.
- The departmental leadership team were aware of changes in the local demography and the increase in demand placed on the department. The team were working closely with the senior leadership team to establish how the department would meet future demand. This included developing a crowd prediction-modelling tool to enable the trust to understand and map patient flow through the department.

Meeting people's individual needs

- The ED had access to translation services for patients whose first language was not English. During our inspection, we saw an interpreter that had been specifically brought into the department to support a patient with translation needs.
- The trust had a dedicated learning disability and dementia nurse available Monday to Friday 8am to 6pm. We spoke with three nurses and two health care assistants in the ambulance bay who told us that the nurses were responsive to their needs and would come to support them with specific patients as required.

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- The emergency ambulance bay had a set of dementia drawers stocked with equipment to support patients with dementia, for example books and a doll. Staff told us they would use these to help patient relax.
- The trust employed a part time play therapist to support the paediatrics team when caring for children.
- The department provided leaflets in a number of formats to support patients who may need further guidance on their condition; these were also available in the children's area aimed specifically at offering advice and guidance to parents or carers of children.
- There were signs specifically placed above patients beds in the ED. This enabled patients to orientate themselves with the department whilst lying on a trolley. The signage around the ED was very good, offering clear guidance on patient pathways and waiting times.
- The trust had a dedicated relatives' room used by staff at times of bad news or as a rest area for relatives waiting for news of patients. The chaplaincy team told us they often used this room to support patients and their families at times of need.
- The hospital had a referral pathway for liaison psychiatry that was available Monday to Friday 8am to 12pm and 8am to 6pm at weekends. Out of hours between 8pm and 9pm staff could utilise the hospital bleep system to call for advice and support from an out-of-hours consultant.
- The ED was preparing to install a mobile phone charging unit in its waiting area to enable patients to charge their mobile devices whilst they are waiting to be seen or waiting for a relative or friend and enable them to communicate with significant others outside the hospital. The costs were part of a winning bid to the patient amenities charity ACT.
- iPads were going to be installed in the paediatric area in October 2016, to support children who are waiting to act as part of distraction techniques for children who are nervous of the hospital environment and treatment. The costs were part of a winning bid for £2000 from the Royal Voluntary Service Fund.
- treatment area and was available from 11am to 11pm, seven days per week, enabling patients to be seen and either discharged with treatment or admitted to the wards for further diagnosis and treatment.
- The department senior nurse and the emergency physician in charge on each shift would troubleshoot delays or problems transferring patients to the relevant wards or other departments and monitor the flow of patients and activity levels. There were two-hourly checks by the senior clinician in each area of the department to ensure delays were dealt with. Representative of the ED attended each bed capacity meeting.
- The clinical decisions unit (CDU) operated 24 hours a day seven days per week for adult patients requiring less than 24 hours admission for ongoing observation or treatment. The unit consisted of two bays of four beds and a single room. The unit had a clear operational policy including patient exclusion and admission criteria.
- The ED had a full time flow navigator from 12.30pm to 3am Monday to Friday who specifically worked with all teams across the ED to encourage patient flow and access by following up patient discharge plans, transfers, and admissions.
- Between June 2015 and November 2015, the trust failed to achieve the national target for seeing, treating, admitting or discharging 95% of patients within four hours. In December 2015, the trust met the target, however performance began to fall in January 2016 and fell to 83% in May 2016.
- No patients waited over four to 12 hours, from the decision to admit until admission, between June 2015 and May 2016.
- Between May 2015 and December 2015, the average time spent by a patient in the ED ranged between three hours 20 minutes and two hours 20 minutes. The England average for the same period was two hours and 20 minutes.
- The number of patients leaving the ED without being seen between in May 2015 was 1.8%, rising to 2.4% in July 2015, steadily falling to 2% in December 2015. The percentage rose again to 2% in February 2016 before falling to 1.5% in April 2016. This was consistently better than the England average, which ranged between 2.5% and 3.5% for the same period.

Access and flow

- The ED had an integrated system of managing emergency and general practitioner (GP) admissions to the hospital. The GP service was based in the ED minors

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- In the year 2015 to 2016, 27.5% of attendances resulted in admission, which was above the England average of 21.6%.
- The ED used a number of alternative care pathways to alleviate pressure on the department and reduce admissions into hospital whilst supporting patient flow. These included working with the local intermediate care team, community heart failure team, acute geriatric intervention service RADAR, clinical decisions unit, and the ear nose and throat on-call doctor.
- The trust used a traffic light system outside the department's ambulance door. This meant arriving ambulance staff saw either a red light meaning they must wait or a green light, meaning they were able to enter the department. Ambulance staff we spoke with liked the system and said if they waited long periods or a patient became critically unwell, they would automatically call a member of staff and bypass the red light system.
- The department had a clear policy on the criteria and assessment of patients that could use chairs rather than trolleys called the "Chair Centric Policy." This enabled staff to appropriately support patients arriving by different means into the department, maximise space, and trolley utilisation.
- The clinical decisions unit (CDU) admitted 1,626 between April 2015 and March 2016.

Learning from complaints and concerns

- The ED received 49 complaints in relation to its services between June 2015 and June 2016. Twenty-seven related to clinical treatment, four were in relation to staff behaviour and values, and three related to staff in general. Two complaints were in relation to admission, discharge, or transfer, one related to prescribing errors, and one related to transfers by ambulances. Data supplied by the trust showed eleven complaints that had not been categorised.
- The chaplaincy team had specifically worked with the medical team to develop a six-week follow on appointment for any relative whose family member had died in the ED. This was based on research carried out by the chaplaincy team, which identified that complaints made by family members were often following sudden death and the need for explanation of what happened and why.

- We saw evidence, in governance meeting minutes, and the "ED matters" communication, where complaints were discussed or shared with the wider staff team.
- The ED kept a record of compliments received, these included thank-you letters from relatives and patients for the quality of care and support provided.

Are urgent and emergency services well-led?

Good



We rated well-led as Good because:

- There was good leadership within the emergency department (ED). Staff were clear on roles and responsibilities and understood the departmental development plan and the part they played in achieving its goals.
- The ED staff had been involved in planning future service configuration.
- Risks were identified, mitigated and accountability clearly allocated to staff to ensure risks were monitored and updates shared within the governance structure.
- Staff we spoke with said that senior staff were approachable and willing to share their knowledge and expertise.
- Junior doctors told us that the ED was a good place to work, they felt valued by their colleagues, and that they had opportunities to learn and grow in professional confidence.
- The trust utilised patient focus groups in the community to gain feedback on its provision and plans for the future, for example the development of the ED and redesign of the building.
- There was a strong focus on innovation and future developments for the department, often with the engagement of departmental staff and external stakeholders in order to improve services for patients.

Leadership of service

- The ED had a clear management structure consisting of a service manager, clinical lead consultant, and senior clinical nurse.
- There was effective leadership of the ED. Senior staff were visible as clinical and managerial leads, with clear levels of accountability and control over operations.

Urgent and emergency services

Staff knew who was in charge at any time and how to escalate any concerns regarding the management of the department, for example staffing levels, safety, or security.

- Staff we spoke with said that senior staff were approachable and willing to share their knowledge and expertise. Staff spoke very highly of the clinical lead, told us they were approachable, and listened to their concerns.
- The department was following the five core behaviours of “CUH working together”. These were to choose to improve, make good and timely decisions, be trusted and accountable, pull together as a team, and be open and learn from mistakes. Staff we spoke with were aware of the trust strategy and the need to work together to improve patient care.

Vision and strategy for this service

- The emergency department (ED) and clinical decision unit had a localised service development plan, last updated in July 2015. The plan set out the departmental key goals for 2015/2016. These included reviewing systems and processes, maximising the use of ambulatory care pathways and improving the training and development of staff.
- The trust had developed its ED and clinical decision unit local strategy on key documents, for example, the Cambridge University Hospitals NHS Foundation Trust (2014), Quality Strategy 2013-2018; NHS England (2013), Transforming Urgent and Emergency Care Services in England – Urgent and Emergency Care Review, End of Phase 1 Report; and the NHS England (2014), Five-Year Forward View.
- Staff with were aware of the localised service plan and the department’s key goals.
- The ED staff had been involved in planning future service configuration. The department held strategic away days for various roles within the department, which included discussions and planning about short, medium, and long-term plans for the future of the department and its staff teams.

Governance, risk management and quality measurement

- There were several established systems to ensure good clinical governance and monitor performance, clinical governance and infection control committees were specific for the ED.
- The clinical governance meetings were held monthly with key staff and details of the meeting and minutes circulated to staff. Each meeting produced action points as required and we saw that these were passed onto the teams in flexible ways, by email and daily briefing meetings to ensure continual improvement to quality of the service.
- Details from governance meetings were reported to the acute services board, which occurred every six weeks, and into the trust board to enable oversight and learning across departments. We saw minutes of the meetings and noted that actions were clearly attached to individuals, including time scales for feedback. We noted that a number of actions from previous meetings had been completed, demonstrating that the department took action on any outstanding points.
- The department held a localised risk register which rated risks in the form of red, amber and green (RAG). The risk register was reviewed as part of the governance activities and risks were appropriately mitigated. All risks identified by the inspection team were on the existing risk register and staff we spoke to were aware of the risks appropriate to their departmental area. Key risks noted on the risk register were the capacity and flow through the department and the provision of appropriate care for mentally ill adults and children. Also included was the risk of un-authorised access by adult members of the public and adult patients to the ED paediatric assessment area.

Culture within the service

- Senior staff we spoke with were aware of their responsibilities in relation to the Duty of Candour.
- All patients we spoke with acknowledged a caring and positive culture within the ED and were happy with their experience of care and treatment despite the delays they may have experienced.
- All nursing staff and health care assistants we spoke with told us they felt the ED was a very supportive and interesting place to work. They said staff worked well together across the professional disciplines and shared skills and knowledge where possible. We saw staff

Urgent and emergency services

interacted in a supportive way to ensure safety and efficiency for patient care. There was a positive and calm feeling within the team, even during very busy periods.

- Staff particularly liked the culture of learning and the opportunity to rotate and change working areas. They felt this contributed significantly to team working and improving their skills and knowledge.
- Junior doctors told us that the ED was a good place to work, they felt valued by their colleagues, and that they had opportunities to learn and grow in professional confidence.

Public engagement

- The ED used the Cambridge Evening News and social media to share updates on the department, including waiting times, fund raising events and news from the department.
- The trust utilised patient focus groups in the community to gain feedback on its provision and plans for the future, for example the development of the ED and redesign of the building.
- The trust had an electronic newsletter that was emailed out to the patients who subscribed to the mailing list containing information regarding urgent and emergency services provided.
- A recent outcome from working with patient focus groups and the local community was the installation of cordless patient telephone lines in the ED to support patients' communication with families and friends. The costs were part of a winning bid to the Royal Voluntary Service Fund.
- The ED participated in local school work experience programmes for students who wished to pursue a career in nursing or medicine and a programme entitled "So you want to do medicine" for sixth form students.
- The paediatric team spent time working with a local primary school, raising money for the charity ACT and teaching them about the ED. Some of the children from the school came on a tour of the paediatric department and gave feedback on possible developments that could be made to improve the environment.
- In March 2016, the ED participated in a hospital open day and ran a small stall for visitors allowing them to have a go at plastering to see how it felt to support patients with broken or fractured limbs.

Staff engagement

- As part of the trust's 'frame and diagnose' stages of revisiting its strategy staff were asked for feedback on the development of the trust's vision and mission for the future. The trust held 15 workshops with 240 staff across all staff groups and levels to collect their views.
- The trust's most recent survey between April 2016 and June 2016 showed that 79% of staff enjoyed working at the trust. 83% were proud to work there, 93% felt they made a difference to patients and 90% said they willingly did more work than was required of them.
- The ED developed the 'listeners' support group'. The support group consisted of staff volunteers who took on the role of a listener within the department to support their peers in difficult times at work or in their personal life. The support group had a dedicated policy to guide them in this process.

Innovation, improvement and sustainability

- The ED team had developed a mobile phone application called "Choose Well." The application offered guidance on waiting times and hospital services across Cambridge in order to improve the patient experience and offer choices in health care.
- The ED had a dedicated social media page for staff. The page enabled staff to be aware of any news, updates to practice, good news stories, feedback from incidents or complaints and to seek staff cover if there were staff shortages.
- Hygiene Solutions, a specialist external cleaning company were working with the ED to develop and introduce an ultraviolet high performance cleaning process for patient cubicles.
- Funding had been agreed from the Design Council to further improve and introduce new patient signage into the ED that would give patient level information on what to expect in the area of the department during their stay.
- The department had secured £100,000 of funding from the Small Business Research Initiative (SBRI) to support the development of a crowd prediction modelling tool to enable the trust to understand and map patient flow through the department.

Medical care (including older people's care)

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

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 (DTC) 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. A divisional director and a divisional head of nursing and an associate director of operations supported each division.

There were 63,231 admissions to medical care services at Addenbrooke's between March 2015 and March 2016, of which 60% were emergency admissions, 10% were elective and 30% were day cases.

According to information provided by the trust, medical care services had a complement of inpatient beds across 27 wards, including the medical short stay emergency unit, stroke wards, and geriatric medicine wards. During our announced inspection, we visited all of the medical care areas and wards managed throughout the divisions. We also visited the discharge lounge.

We used a variety of methods to help us gather evidence in order to assess and judge the medical care services. We spoke with 18 patients and those important to them, four doctors, including junior doctors, middle grade doctors and consultants, 40 registered nurses, two health

care assistants, two student nurses, three 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, 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 trusts 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

We rated medical care as good for safe, caring, responsive, and well led. We rated effective as requires improvement.

- Staff knew how to report incidents using the trust electronic reporting system. Learning from incidents was consistently shared with staff across the division and formal mortality and morbidity meetings were held across the service.
- Staff had a good understanding of safeguarding principles and knew how to make safeguarding referrals.
- Staff knowledge and understanding of the Duty of candour was good across medical and nursing staff.
- Equipment was well maintained and regularly checked by staff to ensure it was within its service date.
- Clinical areas were visibly clean, uncluttered and well organised.
- Staff provided kind compassionate care to patients and their relatives in all areas we visited.
- We saw good examples of multidisciplinary team working, especially on the acute stroke and stroke rehabilitation wards.
- The risk of readmission for non-elective procedures were lower than the England average.
- The average length of stay for elective patients is lower than the England average.
- Staff were friendly and approachable and we observed staff treating patients with compassion, dignity and respect on all wards throughout the inspection.
- Feedback from people who use the service and those close to them was consistently positive about the way staff treated patients.
- The trust was either in line with or above the England average for referral to treatment times (RTT)
- The average length of stay at the hospital between March 2015 and February 2016 for elective patients was 2.3 days, which was lower than the England average of 3.9 days.
- There was a learning disabilities specialist nurse who supported staff on the ward in caring for people with additional needs.

- The trust's Specialist Advice for the Frail Elderly (SAFE) team saw all patients who were over the age of 75. This multidisciplinary team provided a seven-day service and provided advice to staff at ward level that supported patients over the age of 75 years.
- Staff felt well supported by local leaders, peers and by senior management and there was good communication between all staff grades and senior management.
- The culture within the hospital was friendly and the trust values were being upheld.

However:

- Mandatory training levels were significantly below the trust target and we were not assured that staff had the required skills and competencies within their respective roles.
- Patient outcomes were consistently not in line with the national averages.
- There remained significant vacancies in medical and nurse staffing with a reliance on locum and bank staff in some specialties.
- Storage of medicines on G3 did not always follow policy.
- Patient outcomes were mixed and not always in line with the national averages, for example the trust scored below the England average for all in-hospital care indicators in the National Heart Failure Audit in 2014
- The overall Sentinel Stroke National Audit Programme (SSNAP) score decreased from C to D between January and March 2016 (where band A is the highest and band E the lowest).
- Participation in the National Diabetes Inpatient Audit (NaDIA) 2015, showed that the trust performed worse than expected on 7 out of 21 questions though ten indicators were better than the England average.
- The risk of readmission at Addenbrooke's Hospital for all elective procedures is higher than the England average
- The average length of stay for non-elective patients is higher than the England average.

Medical care (including older people's care)

- The average response rate for the Friends and Family Test between June 2015 and May 2016, was 10% lower than the England average of 26%. In May 2016, only 83% of patients would recommend ward D10, which was significantly worse than the trust average.

Are medical care services safe?

Good



We rated safe as good because:

- Learning from incidents was consistently shared with staff across the division and formal mortality and morbidity meetings were had been implemented across the service.
- We observed staff washing their hands and using hand sanitiser at regular points throughout patient care. We saw staff using personal protective equipment when required.
- All patients had their allergies recorded on their records and medicines were administered and stored securely.
- Staff had a good understanding of safeguarding principles and how to make safeguarding referrals.
- Staff used modified early warning scores consistently and reviewed patients in a timely manner when required.

However:

- Mandatory training levels were below the trust target of 90%, at an average of 68% across the medical service.
- There remained vacancies in medical and nurse staffing with a reliance on locum and bank staff in some specialties. There was however no agency nurse usage in medicine.
- Storage of medicines was not always satisfactory.

Incidents

- The trust reported 21 serious incidents (an incident where one or more patients, staff members, visitors, or member of the public experience serious or permanent harm) between July 2015 and June 2016.
- All staff had access to the trusts electronic reporting system, (QSIS) in order to record incidents. Staff described the reporting process to us.
- Staff said they reported incidents and received feedback about incident outcomes. Learning from incidents was passed onto staff at quarterly governance meetings or monthly team meetings.
- Mortality and morbidity were discussed within each medical speciality as part of the trusts clinical governance meetings on a bi-monthly basis. The trust provided us with meeting minutes prior to the

Medical care (including older people's care)

inspection for the following specialities: hepatology in June 2016, respiratory in March 2016, diabetes, and endocrinology in May 2016. The minutes demonstrated that data was monitored, reported appropriately and learning was identified.

- Nursing and medical staff we spoke with had a good understanding of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw two examples where the Duty of Candour had been used and had been logged on the electronic record system.

Safety thermometer

- The NHS safety thermometer is a national initiative and local improvement tool for measuring, monitoring, and analysing harm free care. Staff reported the number of pressure ulcers (PU), falls, urinary tract infections (UTI) and venous thromboembolism (VTE) on a monthly basis.
- Ward areas clearly displayed data from the safety thermometer for staff and the public to view.
- Between June 2015 and June 2016, the trust reported 17 pressure ulcers, 31 patient falls and 16 UTI's. The prevalence rate during this period fluctuated for all three of these categories.

Cleanliness, infection control and hygiene

- The medical care wards at the hospital were visibly clean and uncluttered, protecting patients from risks of infection.
- Staff adhered to the trust hand hygiene and 'Bare below the Elbow' policy, and wore personal protective equipment such as gloves and aprons during personal care.
- All wards had antibacterial gel dispensers at their entrances, at the entrance to bays and near patient bedsides.
- Appropriate signage regarding hand washing was visible at the entrance to all wards in line with World Health Organisation (WHO) guidance.
- Every ward had a monthly hand hygiene audit, which demonstrated good hand hygiene. The hospitals target

for hand hygiene compliance was 95% or above. The average monthly audit results across the trust between April 2015 and March 2016 showed hand hygiene compliance was always above 99%.

- The trust reported one case of Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia between June 2015 and May 2016 across the trust. There were 20 cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) between June 2015 and May 2016 across the trust. There were 44 cases of Clostridium Difficile (C. Diff) at the hospital in the same period. C. Diff is an infection that can infect the bowel and cause diarrhoea. Each ward area had cleaning schedules in place to ensure all equipment was cleaned between use.
- Waste was appropriately segregated across all wards with separate colour coded arrangements for general waste, clinical waste, and sharps (needles). Bins were clearly marked with foot pedal operation and were within safe fill limits.

Environment and equipment

- The clinical areas we visited were bright and well organised and mostly free from clutter.
- We inspected 11 resuscitation trolleys. Staff checked resuscitation trolleys daily for an intact seal and weekly for a fully equipment check. We saw evidence of that checks had been completed in July, August, and September 2016 (up to the inspection date) for trolleys we inspected.
- Systems were in place to maintain and service equipment. We checked four hoists on Lewin Ward, all had been serviced in June 2016, with the next service due date for December 2016.
- Electrical appliances had been tested to ensure that they were safe for use.
- 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 allowed access the ward. Staff used swipe cards to open doors.
- We observed the management of sharps complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. However, on ward D6 we saw a sharps container that was not dated and signed on assembling and on ward F6 temporary closures were not always used when sharps containers were not being used.

Medicines

Medical care (including older people's care)

- All medicine trolleys we inspected were found to be locked and secured to the wall in accordance with trust policy.
- Controlled drugs (medicines that are required to be stored and recorded separately) were stored and recorded appropriately.
- Each patient wore a wristband that had a unique bar code to identify the patient that was scanned by staff prior to the administration of medication. In addition, we heard nurses ask the patient their name and date of birth. This helped staff to ensure they were giving prescribed medicines to the correct patient.
- Staff kept medicine refrigerators locked and we saw daily temperature records for each refrigerator, which showed medicines, were stored within the correct temperatures range.
- Patients we spoke with told us that they received their medicines on time.
- We reviewed three prescription charts on ward D9, four prescription charts were reviewed on ward K3, four were reviewed on ward R2, and one was reviewed on Lewin ward. All showed that medications administered and allergies were recorded appropriately.
- However, on ward G3 medicines were not always stored safely. Medicines were locked in a medicine storeroom; however, we found disorganised medicine storage in two medicine cupboards. This included loose strips, boxes, and bottles of medicines left on a tray placed on top of other medicines inside two cupboards. We highlighted our concerns to the nurse in charge who told us this should not happen. On returning to the ward, the following day we found both cupboards had been tidied.
- Staff told us there was no pharmacy led replenishment service to ward G3, which meant that the nurses had full responsibility for ordering and storing medicines. The trust Chief Pharmacist explained that a business case had been approved to ensure a full replenishment service would be available.
- There was no secure method of transporting medicines around the ward G3. We observed the lunchtime medicine administration round where medicines were taken onto the ward on top of an open tray. There was no risk assessment to ensure the security and safety of medicines.
- On ward G3, we identified that one patient had not been given an antibiotic at lunchtime on the day we visited. The reason for not giving the medicine was 'medication

unavailable and ordered'. The antibiotic was a stock medicine on the ward and was available. On investigation by the nurse in charge, we were told that a nurse had documented the code on the patient's drug chart before they went on a break and had then forgotten to give the antibiotic. The electronic medication system did not alert staff to the fact that an antibiotic had been omitted. This was reported to a senior member of staff at the time of the inspection and was recorded as a medicine incident.

- Staff we spoke with knew how to report a medicine incident. We were also told how the team learnt and shared information from regular ward meetings. Staff knew how to report a medicine incident. Medicine incidents were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff via e-mails and staff meetings. We were told about an incident, which led to an improvement in organising the discharge letters to be sent out with patients.
- 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.

Records

- The trust introduced a paperless electronic patient record system called Epic, prior to our inspection in April 2015. We examined 14 clinical records for patients across medical services contained within Epic and discussed these details with the staff using the system.
- All staff we spoke with were confident using Epic. However, staff told us that the system was not consistent when it came to care planning for patients. At the time of our inspection, the trust was reviewing the system for care planning on Epic with the intention of integrating a consistent approach to care planning across the hospital.
- All patient risk assessments were completed; modified early warning scores (MEWS), falls assessments, nutritional risk assessments, and VTE risk assessments were all clearly documented. Epic used data entered by staff from their initial patient assessment to generate risk scores, for example for sepsis or pressure ulcers and set patient observation time scales with visual alerts to

Medical care (including older people's care)

prompt staff to call a doctor if a patient's risk had escalated. Due to the nature of the online system, all additions or amendments to the records were traceable to the individual member of staff responsible.

Safeguarding

- The adult safeguarding policy had been updated since our last inspection of the medical service in April 2015 to reflect current national policy. The policy included the trust named nurse and named doctor that have specific responsibility for safeguarding children and adults across the trust. The named nurse acts as the trust's nominated lead for safeguarding and assists the chief nurse in developing the safeguarding strategy, taking appropriate action concerning concerns and compiling and coordinating the trust's response in safeguarding investigations.
- All the staff we spoke with were aware of the trust's safeguarding procedures for adults and children, what constituted abuse, and how to report it.
- All staff undertook safeguarding training as part of their mandatory training units. Completion rates for safeguarding training were provided separately to the rest of mandatory training by the trust. Safeguarding training level 1 gives staff the skills and knowledge required to identify and respond to concerns, disclosures, and allegations of abuse and substandard practice. Safeguarding level 2 trained staff to make appropriate decisions concerning the sharing of information when acting to investigate and prevent significant harm occurring to adults at risk. The trust target for completion of safeguarding training was 90%.
- The completion rate for adult safeguarding training amongst medical staff was 82% for level 1 and 77% for level 2. The average completion rate amongst medical staff for safeguarding adults across all specialities was 80% for level 1 and 70% for level 2, all were below the trust target of 90% compliance.
- Nursing staff compliance with children's safeguarding level 1 was 95% and 92% for level 2. Medical staff compliance with children's safeguarding level 1 was 83% and 74% for level 2, both of which were below the trust 90% compliance target.
- Mandatory training included the following modules; Conflict Resolution, Equality & Diversity, Fire Safety, Health & Safety, Information Governance, Infection Control, Moving & Handling and Resuscitation.
- Training was provided by e-learning or face-to-face classroom sessions. All the staff we spoke with on the wards told us they had completed their mandatory training.
- Mandatory training was monitored throughout the divisions and information received from the trust indicated the overall target rate for mandatory staff training was 90%.
- Conflict resolution, infection control and information governance had the highest average training completion rate of 89%, which was closest to the trust target of 90%. Equality and diversity training and health and safety had a training completion rate of only 18% and moving and handling had an average completion rate of 84%, both of which were below the trust 90% compliance target.
- The average completion rate of resuscitation training across the service was 57%. Eighty-five percent of nursing staff and 60% of medical staff had completed resuscitation training. Only 11% of additional professional scientific and technical staff had completed the training, all staff were below the 90% compliance target.
- No staff group had an average mandatory total training completion rate equal to or exceeding the trust target of 90%. Medical staff compliance with mandatory training was on average 65%. Nursing staff compliance with mandatory training was on average 70% which meant we could not be assured that staff had the skills and competencies to carry out their roles effectively.
- The average level of mandatory training completed in the medicine service was 68%, which is below the trust 90% compliance target.

Assessing and responding to patient risk

- The trust had an up to date operational policy on the prevention and management of deteriorating patients for staff to follow.
- The trust used the national early warning score (NEWS) system to identify deteriorating patients. A score was calculated following each physiological observation carried out by staff and this determined the level of risk of deterioration for each patient.

Mandatory training

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- If a patient's NEWS was greater than three, health care assistants had a responsibility to report this to the nurse who was assigned to look 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.
 - We saw three examples where NEWS observations had been escalated in line with trust policy.
 - The trust provided a rapid response team (RRT) who would review patients who ward staff had identified as deteriorating and would assist with initial stabilisation and condition management along with the patient's own medical team. The team is led by a consultant and is staffed by nurses and doctors. The RRT is available 24 hours a day, seven days a week, to attend any medical emergency or an unwell patient in the hospital.
 - We observed two nursing handovers during the inspection, these occurred at every shift change. During handovers, staff communicated any changes in patient's conditions 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 reviewed at the required frequency. Risk assessments identified required actions to minimise any potential risk to patients.
 - Patient acuity was reported three times per day by the wards to the operations centre./ Senior managers could then place staffing to match the acuity of patients. Two ward managers we spoke with told us that managers responded to changing acuity and additional staff were added to shifts if the acuity changed. On ward N3 we saw this in operation during the inspection.
- Nursing staffing**

- All the medical wards had undergone a review of their nurse staffing levels in December 2015, using the verified nurse-staffing tool 'Safer Nursing Care Tool', which took the acuity and dependency of patients into account.
- Each ward reported the acuity of their patients several times a day. This enabled managers and senior clinical staff to identify high acuity areas and manage the staff accordingly. This included increasing the number of staff working if the patient's acuity required this. We saw this happen on one respiratory ward during our inspection.

- Most wards providing medical care had nursing vacancies. Ward K2 had vacancy rates of 38%. Six wards had more than five whole time equivalent (WTE) vacancies. The average vacancy rate across medical wards in the trust was 12%.
- Between April 2015 and March 2016, ward G3, which was medical care ward for the elderly and discharge lounge, used an average of 29% bank staff and ward M4, the gastroenterology ward, used an average of 24% bank staff. Overall, nine medical wards used above the trusts average amount of 16% for bank staff during the reporting period.
- The average staff sickness absence rate in ward G3 was 40% and 10% in nuclear medicine, which were the worst performing areas for staff sickness absence at Addenbrooke's. The average rate of staff sickness absence across all medical wards in the trust was 3%, which was in line with the trust average.
- Wards displayed nurse staffing levels on whiteboards for patients and visitors to see when entering the ward areas.
- Nursing and medical staff raised concerns to us during inspection regarding staffing levels across the directorates. Staff told us that they were moved around on a regular basis to fill staff shortages on other wards.
- The trust did not currently utilise agency staff, but covered shortfalls in staffing through an internal bank staff system. Bank staff were required to undertake an induction process and orientation of the relevant ward. Orientation included a tour of the ward and facilities, fire procedure, bleep system, and risk event reporting. However, the inductions paperwork did not include hygiene and infection prevention. The induction and orientation paperwork was signed by the agency/bank worker and inducing member of staff.

Medical staffing

- The trust had a higher number of consultants (39%) and middle grade doctors (46%) than the national average, which was 37% and 42% respectively. Junior grades were 15%, which is than the national average, of 21%.
- The junior doctors provided daytime cover across all of the medical speciality wards.
- At the time of our inspection, there were 25.92 whole time equivalent (WTE) medical vacancies across the medical service. The highest percentage rate of vacancies was in rehabilitation medical staffing (60%),

Medical care (including older people's care)

which equated to three WTE vacancies. The average rate of vacancy across the service was 5.5%, which is slightly higher than the average vacancy rate across the whole trust (3.8%).

- The average rate of medical staff sickness across the service between April 2015 and March 2016 was 0.5%, which was lower than the trust average of 0.9%.
- Between April 2015 and March 2016, monthly medical locum use for rheumatology was significantly higher (24%) than the trust average (3%). The average locum use for care of the elderly was 14% over the same period.
- There was a middle grade rota providing 24-hour cover seven days a week for the wards that did not 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.
- Middle grade intensive care doctors and specialist nurses staffed the rapid response team. The rapid response team provided 24-hour cover seven days a week to support the wards with deteriorating patients.
- Daily medical handovers took place and we observed that medical handovers were efficient, and there was effective verbal and written communication regarding the location of patients and their conditions. Multiple specialist nurses and 12 consultants attended the handover and all of the medical specialties were represented.. At this meeting, every admitted patient was discussed and patients, who had not already been assigned to a consultant for ongoing care, were assigned to the most appropriate specialist. Medical staff confidently handed patients over to the appropriate specialty. 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.

Major incident awareness and training

- The trust had a major incident and escalation policy and business continuity plans. Senior staff we spoke with were aware of the trust's major incident plan and their role.

- All the staff we spoke with said that they had completed major incident awareness as part of their mandatory training.
- The associate director of operations told us the hospital had started planning for the implementation of the winter pressures ward and staff recruitment for the ward was currently in progress.

Are medical care services effective?

Requires improvement



We rated effective as requires improvement because:

- Patient outcomes were mixed and not always in line with the national averages.
- For example the trust scored below the England average for all in-hospital care indicators in the National Heart Failure Audit in 2014.
- The overall Sentinel Stroke National Audit Programme (SSNAP) score decreased from C to D between January and March 2016 (where band A is the highest and band E the lowest).
- Participation in the National Diabetes Inpatient Audit (NaDIA) 2015, showed that the trust performed worse than expected on 7 out of 21 questions though ten indicators were better than the England average.
- The risk of readmission at Addenbrooke's Hospital for all elective procedures is higher than the England average.
- The average length of stay for non-elective patients is higher than the England average.

However:

- We saw good examples of multidisciplinary team working, especially on the acute stroke and stroke rehabilitation wards.
- The risk of readmission for non-elective procedures are lower than the England average.
- The average length of stay for elective patients is lower than the England average.
- The trust performed better than the England average for all measures in the national lung cancer audit in 2013.

Evidence-based care and treatment

- Staff could access the trust's policies and procedures via the trust intranet.

Medical care (including older people's care)

- The medical specialities provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College of Medicine guidelines. Local policies were in line with these guidelines.
- There were specific care pathways, in order to standardise the care given. Examples included stroke pathways, sepsis, pulmonary embolus and chronic obstructive pulmonary disease pathways.
- The endoscopy department had been awarded Joint Advisory Group (JAG) accreditation. The accreditation process assesses the endoscopy department 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 during a working day and noted the professionalism and commitment of staff for the service they provided.
- The trust had a full audit plan in place for clinical audit, which included timeframes for completion of local and national audits and identified a project lead and coordinator for each audit.
- During our visits, we observed that patients had water jugs left within easy reach so they could access them when they wanted to. We saw support staff changing water jugs regularly on wards to ensure patients had sufficient fresh water.
- We observed patients receiving nutritional support via total parenteral nutrition and percutaneous endoscopic gastrostomy.
- Nursing staff assessed patient's nutritional needs using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. Staff recorded scores and included appropriate action in the patient's care plan in response to any identified risks, for example the completion of food and fluid charts. Staff made referrals to a dietician when patients were at high risk of malnutrition.
- Nursing staff undertook a swallow assessment for stroke patients on admission and then escalated those at greatest risk to Speech and Language Therapy (SALT) team if required.
- Protected meal times were in place on all wards we visited, protected mealtimes are periods when patients and service users are allowed to eat their meals without unnecessary interruptions, and when nursing staff and the ward team are able to provide safe nutritional care.

Pain relief

- We spoke to 15 patients across the medical wards. All Patients told us they had sufficient pain relief and staff regularly asked about their pain relief requirements.
- We saw 14 prescription cards evidencing that patients had been prescribed pain relief when required.
- 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.

Nutrition and hydration

- All the patients and relatives we spoke with were satisfied with the quality, range and choice of food provided.
- We saw meal times were calm and well managed. Staff assisted patients as required and volunteers were available to assist and chat with patients. Staff assisted patients into suitable and comfortable positions to enable them to eat and drink effectively.
- All patients on older people and stroke wards were offered assistance with eating.

Patient outcomes

- The trust submitted data to the Sentinel Stroke National Audit Programme (SSNAP), which aims to improve the quality of care by auditing stroke services against evidence based standards and national and local benchmarks. The overall SSNAP level score decreased from C to D between January and March 2016 (where band A is the highest and band E the lowest). The team-centred key indicator scores remained the same during the same period apart from standards in discharge and discharge processes, where the score fell from A to B and C to D respectively.
- 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

Medical care (including older people's care)

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 cardiologist against the England average of 94%. Fifty-nine percent of patients, including those after discharge were referred for or had angiography, which is lower than 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%.

- The trust participated in the National Diabetes Inpatient Audit (NaDIA) 2015 and performed worse than expected on 7 out of 21 questions including, questions covering medication, prescription and insulin errors, patients being admitted with foot disease, patients being able to take control of their diabetes care, patients receiving a foot assessment within 24 hours and overall satisfaction with care. This was an improved performance compared to the NaDIA audit of 2013. The audit showed that the trust scored better than expected in questions covering; staff knowledge and awareness of diabetes care, meal choice and timing, visits by specialist teams and whether patients received a foot risk assessment after 24 hours or any point during their stay.
- The trust scored below the England average for all in-hospital care indicators in the National Heart Failure Audit in 2014, which included the following areas; cardiology inpatient, input from consultant cardiologist, input from specialist and received echo. The trust scored below the England average for all but two indicators; ACEI on discharge and ACEI/ARB on discharge. The trust scored particularly poorly for referral to cardiology follow-up, which was rated at 3% where England average is 54%. The trust has appointed a group of heart failure nurses and a consultant on heart failure to resolve issues identified during the audit.
- The trust scored better than the England and Wales average for all indicators on the national lung cancer audit in 2013.
- The average length of stay at Addenbrooke's hospital from March 2015 to February 2016 was 2.3 days for elective patients, which is better than the England national average of 3.9 days for the same period. The average length of stay for non-elective patients was 7.4 days, which is worse than the England national average of 6.7 days for the same period.

- The risk of readmission at Addenbrooke's hospital for all elective procedures is higher than the England average whereas the risk of readmission for non-elective procedures is lower.

Competent staff

- Staff told us that all new employees attended an induction, and staff we spoke with confirmed they had received adequate induction. We observed 3 completed induction checklists for bank staff on one of the wards we visited.
- Staff we spoke with said there were no formal systems in place for regular supervision sessions with their line managers, but that managers offered informal support, which staff found sufficient.
- Information provided by the trust indicated that staff appraisal figures for the medicine specialities were at 98% for medical staff and 100% for nursing staff between April 2015 and March 2016, above the trust 90% compliance target and staff we spoke with told us they received annual appraisals.
- The trust and individual doctors took joint responsibility to ensure their revalidation was up to date. The trust had produced a comprehensive document outlining the revalidation process. The responsible officer for the process was the medical director for the trust.

Multidisciplinary working

- Wards teams had access to the full range of allied health professionals that are employed by the trust, for example physiotherapists, occupational therapists and neuropsychologists. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of people's needs, and we saw a consistent approach to ensuring assessments were regularly reviewed and kept up to date while inspecting patients' records. This was particularly evident on the Lewin ward and ward R2, the acute stroke ward.
- Patients' records were integrated through the trust's electronic recording system Epic. Doctors, nurses and therapists all used the system for recording all treatment. This meant that 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. Staff described the system as working well.

Medical care (including older people's care)

- Meetings on bed availability were held three times a day, to determine priorities, capacity, and demand for all specialities.
- We spoke to two members of the neuropsychology team, who said they had a good working relationship with medical staff and other allied health professionals.

Seven-day services

- Urgent and emergency imaging was available 24 hours a day and seven days a week and the trust had an internal imaging professional standard stating that all inpatient requiring imaging services would be seen within 24 hours of referral.
- There was consultant cover 24 hours a day, seven days a week. Two consultants supported the acute take admissions directly in the evening until 10pm with one consultant on call overnight during the week. 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.
- Pharmacy services were provided Monday to Friday 9am-5pm. and offered a dispensing service for non-stock items and "to take out" medications for patients being discharged at weekends (9am - 4pm on Saturday, 10am - 4pm Sundays and Bank Holidays). There is a limited medicines reconciliation service targeted to new medical admissions at weekends, on call services for emergency medicines supply and advice outside of normal working hours.
- All inpatients that are based on wards are assessed on the first full working day (Monday to Friday) after their admission. If a new patient requires assessment and treatment over the weekend, a nurse can contact an on-call physiotherapist between 8.30am and 4.30pm. A doctor can contact an on-call physiotherapist outside these hours. The physiotherapy staff covering the Lewin Stroke and Rehabilitation Unit had implemented Saturday and Sunday working with one physiotherapist and physiotherapist assistant.

Access to information

- During the inspection, we found that care planning had been incorporated into Epic. However, the method of recording care planning was not consistent across the

service, for example on Lewin Ward staff recorded care plans under a care planning tab, but on ward D9 patients care plans were recorded in their medical notes.

- Staff told us that they could access all necessary information and patient records through Epic as well as blood test and other investigation results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was included with safeguarding level 2 mandatory training.
- Staff we spoke with were aware of consent, Mental Capacity Act, and Deprivation of Liberty Safeguards requirements. Staff explained the systems for assessing people's mental capacity and gaining consent regarding treatment.
- Patients informed us that staff asked for their verbal consent before staff helped them, and before any procedures were undertaken.

Are medical care services caring?

Good



We rated caring as good because:

- Staff were friendly and approachable.
- We observed staff treating patients with compassion, dignity and respect on all wards throughout the inspection.
- Feedback from people who use the service and those close to them was consistently positive about the way staff treated patients.

However:

- The average response rate for the Friends and Family Test between June 2015 and May 2016, was 10% lower than the England average of 26%. In May 2016, only 83% of patients would recommend ward D10, which was significantly worse than the trust average.

Compassionate care

- We spoke with 18 patients and relatives throughout our inspection. Feedback was mostly positive about the way staff treated patients receiving care throughout the

Medical care (including older people's care)

medical wards. One patient told us they had seen staff sitting with distressed patients all night to comfort them. Another patient said that a member of staff always comes promptly when they use the call bell. A patient on ward E10 told us “staff are extremely friendly sincere and interested in their patients.”

- All patients we spoke with told us they felt safe in the hospital.
- Throughout our inspection, we observed staff treating patients with compassion, dignity and respect. 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.
- We saw staff carried out care interventions behind closed doors or used curtains to maintain patients' privacy and dignity.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This single question survey 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. The average response rate for the FFT between June 2015 and May 2016 was 10% lower than the England average of 26%. In May 2016, 83% of patients would recommend ward D10, 89% would recommend emergency assessment unit (EAU) and 88% would recommend the medical short stay emergency unit (MSEU), these were the lowest scores for the medical wards. All other wards that provided medical care scored above 90% in the same month. The best performing ward over the 12 month period was ward C9, which had scored 100% in ten of the 12 months between June 2015 and May 2016.
- The trust scored in the top 20% compared to all trusts for 12 of the 34 questions in the Cancer Patient Experience Survey for 2013/2014. Trust scores were in the bottom 20% for two questions and in the middle 60% for the 20 remaining questions. Trust scores worsened in 2013/2014 compared to 2012/2013 for 17 and improved for 16 of the 33 questions for which data was available.

- A patient led assessment of the care environment (PLACE) was carried out in 2015. Acute wards (which would have included some medical wards) achieved scores for privacy, dignity, and well-being as 84%, this was slightly below the England average of 86%.

Understanding and involvement of patients and those close to them

- We observed staff involved patients and those who were important to them in their treatment and care, by ensuring patients were aware of what treatment or procedures they were undertaking and what was happening to them.
- A patient told us that staff encouraged a family member to join him when doctors were discussing a plan of treatment to help him remember and understand his plan of care.
- We saw occupational therapists and physiotherapists working with patients on the rehabilitation ward; we observed that they always clearly explained what they were doing and the purpose behind any exercises the patient was undertaking.

Emotional support

- Patients and their relatives told us that 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. We observed a family being supported by nursing staff on the oncology ward in a caring and supporting manner.
- 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.
- A hospital chaplain 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.

Medical care (including older people's care)

Are medical care services responsive?

Good



We rated responsive as good because:

- The trust was either in line with or above the England average for referral to treatment times (RTT)
- The average length of stay at the hospital between March 2015 and February 2016 for elective patients was 2.3 days, which was lower than the England average of 3.9 days.
- There was evidence of learning from complaints across the medical division.
- Patients individual needs were met with some innovative practices such as pictorial food menus.
- Specialist equipment was available to meet the individual needs of patients.
- There was a learning disabilities specialist nurse who supported staff on the ward in caring for people with additional needs.
- The trust's Specialist Advice for the Frail Elderly (SAFE) team saw all patients who were over the age of 75. This multidisciplinary team provided a seven-day service and provided advice to staff at ward level that supported patients over the age of 75 years.

However:

- Ninety-three percent of inpatients experienced at least one move during their stay, with 36% experiencing two or more moves between June 2015 and May 2016.
- The average length of stay for non-elective patients between March 2015 and February 2016 was 7.4 days, which was higher than the England average of 6.7 days.

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.
- The ambulatory care unit provided assistance and training for patients to manage some of their care at home, for example the self-administration of some medicines.
- Divisional managers had recognised the increased demand for services and were working proactively with neighbouring trusts, CCG and NHSE to consider different

pathways for patients. The division also worked to ensure that patients who could be cared for closer to home were transferred as quickly as possible to a hospital closer to home.

Access and flow

- Patients who required medical care usually entered via the emergency department; however, some patients passed straight through to the ambulatory care unit or from the clinical decisions unit to a specialist service. A general practitioner could also refer patients. Once assessed by staff in the emergency department patients were admitted to a ward area.
- The trust had introduced pharmacy led discharge service, which had reduced the time taken for patients to be discharged.
- Co-ordination of patients discharge is taken over by the staff in the discharge lounge who arrange collection of medications and any supplements required on discharge. Discharge lounge staff are responsible for ensure patients travel to their correct discharge destination safely.
- From June 2015 to September 2015, the Referral to Treatment (RTT) performance ranged between 91% and 92%, slightly lower the England average of 94%. From October 2015 to May 2016, the trust was either in line or above the England average. Operational standards were that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral.
- The average length of stay at Addenbrooke's hospital between March 2015 and February 2016 for elective patients was 2.3 days, which was lower than the England average of 3.9 days. The average length of stay for non-elective patients during the same period was 7.4 days, which was higher than the England average of 6.7 days.
- In February 2016, the total number of medical outliers per month was 110, this fell to 76 in March 2016, and rose again to 95 in April 2016 and 80 in May 2016. Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space.
- During the period June 2015 and May 2016, 26% of patients at Addenbrooke's hospital experienced one ward move, 7% were moved twice, 3% three times and

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2% were moved four or more times. These results show that between June 2015 and May 2016, 38% of inpatients experienced at least one move during their stay with 12% experiencing two or more moves.

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 controlling and treatment of diabetes.
- 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 saw care plans that showed that doctors had assessed patients' needs and instructions given for nurses to follow. In addition, we saw that nurses undertook risk assessments.
- Staff were able to access interpreting services 24 hours a day for people who did not speak English as their first language.
- Specialist equipment was available on wards and in clinical areas including bariatric equipment and pressure relieving equipment. Additional equipment such as non-invasive ventilators were available to order and staff told us that there were no problems in ordering equipment required and it was delivered promptly.
- We saw that pictorial menus used throughout the medical and elderly care wards. This enabled patients 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.
- The trust's Specialist Advice for the Frail Elderly (SAFE) team saw all patients who were over the age of 75. This multidisciplinary team 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 supported patients over the age of 75 years.
- We found that there were arrangements to ensure patients were cared for in same sex facilities and had access to same sex washing and toilet facilities.

- The neuropsychology department offers a range of tier three and four specialist neuropsychological services for people with neurological disorders, which ranges from outpatient diagnostic assessment to inpatient acute rehabilitation.

Learning from complaints and concerns

- Between April 2015 and March 2016, the general medicine group received 72 complaints, which accounted for 20.34% of all complaints made to the trust. This was the second highest number of complaints across all the trust services. The highest proportion of complaints, were in relation to patient care (including nutrition and hydration) with 23. The other areas of complaint within general medicine were clinical treatment, with 15 complaints, admissions, discharge & transfers with 14 complaints, communications with 10 complaints, access to treatment or drugs with five complaints, and values & behaviours of staff with five complaints.
- Staff told us that learning from complaints was shared at team meetings. We saw evidence from minutes of clinical governance meetings provided by the trust for endoscopy and department of medical care for the elderly where complaints were regularly scheduled for discussion at meetings.
- We saw leaflets available in the wards telling patients and relatives how to raise a complaint and feedback to the hospital. All the patients we spoke with were aware of how to raise a complaint but they all said they had no reason to complain.

Are medical care services well-led?

Good



We rated well led good because:

- Staff felt well supported by local leaders, peers and by senior management and there was good communication between all staff grades and senior management.
- The culture within the hospital was friendly and the trust values were being upheld.
- Staff were aware of the vision for the service and trust and were committed to putting it into practice.
- Senior managers were aware of risks in the division and had taken appropriate actions to mitigate such risks.

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However:

- We identified concerns from staff that sufficient action was not being taken regarding the movement of staff between wards.

Leadership of service

- Addenbrooke's hospital consisted of five divisions and medicine was spread across the divisions. A divisional director, divisional head of nursing and an associate director of operations led each division.
- Staff spoke highly of ward managers and their divisional directors, but they consistently told us they did not see senior members of the executive team in ward areas.
- Staff shared concerns that senior management was not taking enough action regarding the movement of staff between wards and flow throughout the hospital.
- Senior leaders within the division were well sighted on the risks as well as new opportunities that were emerging. There was clear direction on the implementation of care pathways in a number of specialties to improve patient care and patient flow.

Vision and strategy for this service

- 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. Staff were aware of the values and we saw that staff provided a kind and compassionate service to people. The values of the trust were displayed in some areas around the hospital such as the ward areas and corridors. However, they were not prominently displayed on all wards.
- There was no separate strategy for medical services within the trust. However, staff we spoke with told us their individual wards embodied the values of the trust.
- Senior managers told us that most medical services sit within Division C and that the current structure works generally well at speciality level. However, the main disadvantage for medical services is that staff can sit across several services and divisions and this can make co-ordination more difficult. However, they were confident that this did not affect the overall care provided at the hospital.

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.
- There was a risk register for each of the divisions, which included risks relating to medical care and care for the elderly. Monthly governance meetings discussed and updated the risk register. The trust had identified numerous risk areas including, demand outstripping capacity, inappropriate staffing levels and skill mix, and delays in processing blood tests. The trust had developed plans to address all items identified on the risk register but these were not yet all fully actioned. The medical specialities risk register listed the highest risks, the lead member of staff responsible for each risk, review dates, and target completion ratings.
- The risk register included the ongoing daily use of the Medical Decision Unit (MDU) as an escalation area, particularly overnight, contrary to operational policy for the unit. A trust wide decision was made not to use MDU as escalation area and if this is required in extreme circumstances to ensure the staffing is increased to meet the needs of patients. During our inspection we found the MDU to be working in line with this policy.
- 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 were taking place.
- Mortality and morbidity meetings were held across the division. Minutes showed them to have a good attendance from different professionals and that an appropriate mix of cases were discussed.

Culture within the service

- Staff we spoke with were willing to speak to inspectors honestly and frankly during the visit.
- Nurses and healthcare assistants told us they felt valued and respected by colleagues and managers.
- There was an open culture of sharing and learning around complaints and incidents. We reviewed meeting minutes, which showed learning from complaints and evidenced sharing of this amongst staff.
- Nursing and medical staff we spoke with were all aware of the Duty of Candour. The Duty of Candour is a regulatory duty that relates to openness and

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transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Public and staff engagement

- Public engagement was through the patient advice and liaison service (PALS), and the Friends and Family Test (FFT).
- The trust had an online "have your say" web form to encourage members of the public to provide feedback.
- The trust had a "You made a difference" award scheme, which awarded staff who had been nominated by patients, visitors, or colleagues for making a difference to them.

- The wider hospital physiotherapy team had a monthly "Above & Beyond" award, which was designed to recognise a member of staff that had excelled or been innovative within the team and be nominated by colleagues.

Innovation, improvement and sustainability

- The trust had a "Great ideas in action" scheme, which recognises innovation and effectiveness. Staff members are invited to let the senior management team know about something new or exciting that has made a real, measurable difference to the trust or their service.
- In August 2016, the trust introduced a pharmacy led service which reduced the time taken for patients to be discharged. The pharmacist checked medicines and ensured medicines to take home were ready. Although the service was relatively new we were told by staff that it had "doubled the discharge rate" and had made a "huge positive difference".

Surgery

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

Information about the service

Adult surgery services at Addenbrooke's Hospital are provided across 13 surgical wards, including day surgery units. Surgical specialities include, 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 37 operating theatres, including the main theatres and designated ophthalmic day surgery theatres. There are also pre-assessment and day case surgery areas.

During our inspection we visited surgical wards treating patients within the following surgical specialities: neurosurgery, urology, ear, nose and throat (ENT) surgery, trauma and orthopaedics, major trauma rehabilitation, oral and maxillofacial surgery, plastic surgery, transplant, step-down unit from critical care, ophthalmic day surgery and the theatre admissions unit.

We also visited main theatres including anaesthetic areas and pre-operative assessment areas, day surgery theatres, recovery areas, and the discharge lounge.

We observed staff interactions with patients, relatives and other staff and watched a surgical procedure carried out in theatre. We spoke with 37 members of staff including the divisional and clinical leads, consultants, junior doctors, health care assistants, registered nurses, and housekeeping staff.

We also spoke with 14 patients and 5 relatives; attended a multidisciplinary team meeting and two bed management meetings; and reviewed 38 patient records across surgical specialities.

Between September 2015 and August 2016 there were 10,584 emergency surgery admissions; 8,502 elective inpatient admissions; and 18,093 elective day case admissions. In total there were 37,179 admissions to surgery at the trust during this period. Trauma and orthopaedics had the highest number of admissions within surgery, with 4,986 admissions during this period.

Surgery

Summary of findings

Overall we rated surgery at Addenbrooke's Hospital as good. The safe, effective, caring and well-led domains were all rated as good, with the responsive domain rated as requires improvement.

- There was a strong incident reporting culture and staff received feedback from incidents to minimise the risk of similar incidents reoccurring.
- Hand hygiene practices were consistently good in order to minimise the spread of infection. Equipment was in date and stored securely.
- Medicines were stored appropriately with one exception in plastic surgery, and staff carried out regular checks according to policy.
- Risk assessment of patients was consistently robust and there was evidence of appropriate escalation by staff in the event of a patient's condition deteriorating.
- There was good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, to reduce the risks of mistakes in surgery.
- Nurse and surgical staffing at the time of inspection was sufficient to safely meet patient acuity and needs.
- Surgery had a clinical audit programme which assessed compliance with National Institute for Health and Care Excellence (NICE) guidelines and local policy.
- Staff had the required skills and competencies to care for patients effectively and received robust training and induction to support them with this.
- There was good evidence of multidisciplinary team (MDT) working in all surgical areas to help maximise patient outcomes. Patient outcomes were monitored and reviewed through formal national and local audits.
- Staff were familiar with the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009) and there was evidence of obtaining appropriate consent.
- All observations of interactions between staff and patients and relatives were compassionate.
- Patients and relatives spoke highly of the care received and Friends and Family Test (FFT) results for surgery were consistently high.

- Clinical, divisional and ward leads showed good awareness of the risks within their service and had robust action plans to address them.
- Leads engaged with staff at all levels and responded to their concerns. The service was focused on continuous improvement to address the issues around responsiveness.
- Clinical governance was robust, and risks were highlighted on the risk register and appropriately mitigated as far as possible.
- There was a positive working culture amongst all levels of staff in all the areas we inspected, and staff took great pride in their work. Surgical services had several ongoing innovative initiatives to develop services and maximise patients' experience.

However:

- There were issues with access to surgery and flow through the hospital. The service was performing worse than the national average for cancellation rates and the number of patients not treated within 28 days of last minute elective cancellation.
- Data provided by the trust prior to inspection showed that the service was performing significantly worse than the national average on meeting targets for referral to treatment times (RTT).
- Recovery was regularly used to accommodate patients; from July to September 2016 there were 68 occasions where patients remained in recovery for non-clinical reasons.
- Between June and August 2016, there were 1,176 patients recorded as outliers on surgical wards. However, cancellations, out-of-hours discharges and RTT were showing gradual improvement since our previous comprehensive inspection and there was evidence of actions to address the main areas of concern.

Surgery

Are surgery services safe?

Good



We rated safe as good because:

- There was a strong incident reporting culture where staff were encouraged to report incidents and received feedback from incidents to minimise the risk of similar incidents reoccurring.
- Minutes of morbidity and mortality meetings documented comprehensive discussion of patient deaths and a breakdown of the contributory factors, which was beneficial for staff learning.
- Staff were aware of the duty of candour and could give examples of when they had used it.
- There was good infection control practice and hand hygiene.
- Medicines, including controlled drugs (CDs), we checked were stored appropriately, locked away and in date with checks completed for the period June-September 2016.
- The average staff mandatory training rate across all surgical areas and staff groups was 70% which was higher than the trust average of 65%.
- During our observations in theatres we found good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, designed to reduce the risks of mistakes in surgery.
- While some departments were busy, nurse staffing in all areas was sufficient to safely meet patient acuity.
- We found the surgical staffing and skill mix was sufficient in all surgical areas we visited in order to treat patients safely.

However:

- There had been two never events in surgery. These had been investigated and lessons learnt.
- The division cared for an increasing number of children. Safeguarding children level 3 training was below the trust target at 88% against a trust target of 90%.

Incidents

- Between August 2015 and July 2016 there had been 16 serious incidents reported across surgical areas. Three of these took place in ophthalmology.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations

that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Between August 2015 and July 2016 there had been two never events in surgery (in November 2015 and February 2016). The first involved a patient receiving an intravitreal injection in the incorrect eye because the incorrect information had been manually inputted in the scheduling instructions by the ordering clinician. The second was a wrong site nerve block administered to a patient undergoing an elective hip replacement.

- We reviewed the root cause analyses for the never events and found evidence of learning which was shared among surgical teams. There was evidence that duty of candour had been complied with in both events. There robust action plans to reduce the risk of similar incidents reoccurring.
- We reviewed incidents reported on the trust electronic reporting system (Datix) for the period July 2015 to June 2016 and found evidence of good reporting and appropriate grading of incidents.
- There was a strong incident reporting culture where staff were encouraged to report incidents and received feedback from incidents to minimise the risk of similar incidents reoccurring. All of the staff we asked were able to explain how they would report an incident and give recent examples of incidents and lessons learned.
- For example, on ward A3 (neurosurgery) an intravenous (IV) medication error had been reported as an incident, leading to a gap in the IV staff training to be rectified.
- There was evidence of sharing feedback on incidents via meetings, staff briefings and emails. Staff confirmed they received feedback from incidents. In day surgery, the ward manager told us about 'audit mornings' where feedback from serious incidents and how to avoid them in the future was shared.
- However two other members of staff on the ward were able to explain in detail how that never event had occurred and the learning that had been shared as a result.
- Minutes of monthly morbidity and mortality meetings documented comprehensive discussion of patient deaths and a breakdown of the contributory factors, which was beneficial for staff learning.
- Duty of Candour was included in the trust-wide incident reporting policy ('Being Open: A Duty to be Candid'). The Duty of Candour is a legal duty on hospitals to inform

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and apologise to patients if there have been mistakes in their care that have led to significant harm. All staff we asked could explain the duty and give examples of when they had used it.

Safety thermometer

- Safety thermometer data, including pressure ulcers, patient falls, catheter-acquired urinary tract infections (C.UTIs) and cases of Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. Difficile), was displayed in each ward and was up-to-date.
- However, data in some areas was not displayed, for example there was no information on pressure ulcers on ward J2.
- Between June 2015 and June 2016 there were 12 pressure ulcers reported in surgery services.
- Data provided by the trust showed that between June 2015 and June 2016 there were 25 patient falls reported. When we reviewed safety thermometer information on site we saw that in June 2016, there had been five patient falls on ward M5. In July there had been four and in August there had been two.
- On ward J2 there had been an increase in patient falls from July 2016 to September 2016. The nurse in charge was aware of this and told us that due to higher acuity on the ward at the time there was a higher risk of falls. Risk assessments were completed in these cases.
- Three C.UTIs were reported in surgery between June 2015 and September 2015.

Cleanliness, infection control and hygiene

- All theatres were audited yearly by the infection control team. Surgical wards had consistently scored 100% for hand hygiene compliance for June – August 2016 with the exception of trauma and orthopaedics where compliance was 96.2% in July and 98.2% on ward J2 in June 2016.
- There was evidence of action plans following audits on hand hygiene, infection prevention and personal protective equipment (PPE) being carried out by the infection control team in February 2016. Actions included ordering new drug cupboards as they had been found not fit for purpose, and reinforcing messages to staff about compliance with the correct assembly, use, and safe disposal of sharps in sharps bins.

- We saw staff regularly hand washing using the hand sanitiser dispensers in ward areas. We also saw reminders in the minutes from team meetings to staff to use sanitizing gel regularly. Patients reported frequent use of sanitizing gel by staff.
- All areas we visited were visibly clean, including storage rooms and sluice rooms.
- However, on ward M5 there was no formal cleaning schedule. The sister in charge told us cleaning was done as required. Data provided by the trust showed there to be cleaning schedules and weekly audits on all surgical wards. This meant there might be reduced accountability for cleaning duties and cleaning was at risk of being overlooked in busy times, although when we visited this was not an issue.
- On the transplant ward there was a side room to screen all patients for Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Difficile) before they were admitted to the ward.
- Screening rates for MRSA on surgical wards were 95% or higher between June and August 2016.

Environment and equipment

- Wards we visited were secure and locked with swipe card access for staff, with the exception of the plastic surgery ward where the entrance door was propped open at the time of our inspection.
- Wards were in the main, well-laid out to promote safety. However on the major trauma ward (J2) the nurse in charge raised concerns that some of the bays were around the corner from the nurses' station so patients could not be seen from there. They mitigated this risk as far as possible by placing the most acute patients' nearest to the nurses' station so they were visible. This was flagged as a red risk on the risk register due to the increased potential for patients absconding.
- On the neurosurgery ward work was being carried out to install another lift at the far end of the ward to create two emergency exit routes. This was in response to the potential risk of a fire on the ward as there was an exit at one end of the ward only.
- The service used red labels noted with the date to indicate that equipment was clean. We saw good use of this system in the areas we visited, although on ward M5 there was a syringe driver which was dusty despite a label indicating cleanliness. Also, on ward D8 we found

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dust on the commodes in the storage room even though they had the red tape to indicate cleanliness. We checked other areas to see if this was an issue elsewhere but did not find it to be widespread.

- Personal protective equipment (PPE) was readily available in all surgical areas and we saw consistent use of it by staff. However, on the plastic surgery ward disposable gloves were only available in size small and the other sizes required refilling.
- We checked a range of equipment in each area including blood pressure machines, syringe drivers and blood gas machines (both in storage areas and on the wards) and found they were all in service date.
- However, a small amount of equipment we looked at such as a blood pressure machine on the transplant ward did not have any obvious safety testing stickers on them to show they had been tested.
- All sharps bins we saw across surgical areas were stored safely and were under the fill limit.
- Surgical services used 'work stations on wheels' ('WOWs') to complete ward rounds; however, on ward M5 the sister was concerned that there were not enough to meet their needs because of the mixed specialities in the same ward.
- We checked resuscitation trolleys and equipment in all the surgical areas we visited and saw that the daily and weekly checks had been completed and signed off as required for the period June-September 2016. We saw that the equipment in the resuscitation trolleys was in date so checks were being completed thoroughly.

Medicines

- We carried out medicines checks in all surgical areas we inspected and found they were consistently in date.
- All controlled drugs (CDs) we checked were stored appropriately, locked away and in date with checks completed for the period June-September 2016. When we carried out checks of stock balances against records in the CD register they matched.
- Fridges for medicines storage were at the appropriate temperature and checks had been carried out daily on all fridges we looked at. Staff knew what to do if there were any temperature issues.
- However, on the plastic surgery ward the keys for accessing medicines (non-controlled) were stored in an unlocked drawer rather than with a member of staff. This drawer was in an unlocked room and at the time we inspected, the door to the ward was also open so

security of the medicines was a concern. This meant that unregistered staff could easily access medicines and no single person was accountable for the keys. We asked the sister about this and they said it was not usual practice and that they would put the keys there when on a break. However, the staff nurse did not seem to be aware that storing the keys this way was a problem or that it would not be usual practice.

- We observed a medication round on ward M5. Electronic prescription was in use across surgical services; however the nurse on this ward told us that sometimes the electronic system did not work so prescriptions had to be printed off, meaning that the medication round would be longer.

Records

- Overall we reviewed 38 patient records using the Epic electronic records system and saw they were all completed with the necessary documentation including consultant assessment, VTE assessment and nutritional needs.
- Nursing and surgical staff in areas including (but not limited to) trauma and orthopaedics and day surgery reported that now it was fully integrated, the Epic system had made it easier to manage and access patient records.
- On the transplant unit, a computer screen had been left on displaying a patient record without a member of staff using it. This meant anyone walking past would be able to see confidential patient information.

Safeguarding

- Staff in all areas were able to explain the escalation process for a safeguarding concern and could provide examples of where they had raised concerns to or sought advice from the trust safeguarding lead. (The trust chief nurse was executive lead for safeguarding.) They were able to make a referral through the 'Epic' system.
- Safeguarding was included in mandatory training, up to level two for both adults and children. We reviewed staff compliance with training in safeguarding adults and children. 98.8% of surgery staff had completed safeguarding adults level one training. 97.9% had

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completed safeguarding children level one; however the lowest rates were 50% for the administrative and clerical staff group in the pre-assessment unit. This was against a trust target of 90%.

- For safeguarding level 2, 97% had completed safeguarding adults training and 94% had completed safeguarding children training. The division had highlighted the increasing number of children that use the services. The annual safeguarding report demonstrated increased training in safeguarding children level 3 for staff in the division with 88% against a target of 90% of identified staff having received the training with full compliance met in March 2017.

Mandatory training

- We reviewed data on mandatory training rates provided by the trust prior to our inspection. Mandatory training completion rates were highly variable across surgical specialities and staff groups. Out of a total 57 reporting units, 33 (58%) of reporting units had an average training completion rate of 50% to 69%. Twenty (35%) had an average completion rate of 70% to 79%. Four units (seven per cent) had achieved over 80% completion, but no surgical units achieved the trust target of 90%.
- The average mandatory training rate across all surgical areas and staff groups was 70%, which was higher than the trust average of 65%, but still worse than the trust target of 90%.
- Mandatory training modules included, but were not limited to, resuscitation, information governance and infection control.
- However, at the time of our inspection, all staff we spoke with were up-to-date with mandatory training and reported they received reminders and encouragement when they were due refresher online training. When we reviewed training data submitted by the trust after our inspection for compliance up to August 2016, the average mandatory training rate across all surgical areas and staff groups had increased to 95.5% so was meeting the trust target of 90% overall.
- However, one foundation year two (FY2) doctor on the neurosurgery ward told us they found it difficult to find the time to complete online mandatory training, as they were too busy on the wards.
- We saw on the staff intranet that staff would be reminded when they were due refresher training via the trust's Direct Online Training (DOT) system.

- Nurse leads in all surgical wards we visited felt strongly about ensuring their staff were up-to-date with mandatory training and there was a good culture around completing it. For instance in day surgery the ward manager told us there were nurse mentors allocated to help trainee nurses sign off their mandatory training.

Assessing and responding to patient risk

- During our observations in theatres we found good compliance with the World Health Organisation (WHO) 'five steps to safer surgery' checklist, designed to reduce the risks of mistakes in surgery. Completion of the checklist was recorded electronically on the trust's 'Epic' IT system and staff filling it in could not move onto the next step until the previous one had been completed to ensure risk was minimised. The checklist was completed with the full surgical team.
- Nursing staff in all areas felt confident about alerting a senior member of staff if they had any concerns about a patient's condition.
- However, on day surgery the matron raised a concern that because they were a satellite unit, if urgent medical support was required at night due to a patient deteriorating it could take a long time for the doctor to attend.
- The transplant ward conducted daily 'lunch time reviews' of patients using a 'SAFER' tool which was adaptable to the needs of the patient. On this ward there was a room with a dialysis machine where a patient could be taken in an emergency during a procedure.
- On ward M5 we reviewed risk assessments and Modified Early Warning Score (MEWS) charts. The five patient records we looked at included risk assessments for falls, tissue viability and nutrition. The care plans all reflected what the nurse had explained and also the patient risks documented in the nurse handover, showing good awareness of individual patient risks.
- There was evidence of escalation when a patient was scoring as a risk on MEWS. We reviewed one patient on M5 who had scored as 3 on MEWS and saw observations had been conducted in line with MEWS. Overall on the ward we reviewed five MEWS observations charts which had been completed in line with national guidance. On ward J3 we also saw examples of this.
- However, on ward M5 we asked a sister about intentional rounding and they were not familiar with the

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concept and did not think it was being used on the ward. (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.)

- On ward J2 we reviewed a care plan and risk assessments for a patient receiving one-to-one care. Risk assessments had been completed appropriately. The health care assistant (HCA) with the patient was able to clearly explain his risks and told us staff took turns to sit with the patient as they would regularly become agitated.
- Where patients had scored as being at risk on MEWS there was evidence of escalation. We saw an escalation flow chart with which staff were familiar and which helped them respond rapidly and appropriately.
- There were processes for monitoring and responding to risk when patients were outliers. For example in ward J3 (regularly used for contingency), outliers were highlighted and the senior nursing team used the Safer Nursing Care Tool to assess the patient's dependency. This information was then shared with senior management and the bed operations team so they were aware of any potential risk and could review any patients inappropriately placed in the area.

Nursing staffing

- Data provided by the trust showed that overall across surgical specialities there were 1,014 nurses (whole time equivalent (WTE) of 946.8) in May 2016. This was an increase on the nurse staffing levels in the previous 11 months; for example in June 2015, the headcount had been 923 (WTE 858.8).
- Data provided by the trust showed that bank nurse use in surgical areas, for the period April 2015 - March 2016, was higher than the trust average of 16%. Ward J2 (neurosurgery and rehabilitation) had the highest use of bank staff at 31%. Wards L4 (Intestinal Failure/ Colorectal) and D8 (trauma and orthopaedics) were also particularly high at 22% each according to the data.
- However, at the time of our inspection there were no agency nurses in the surgical areas we visited. Nurse leads in different surgical specialities including major trauma rehabilitation, and neurosurgery told us they did not use agency nurses and if they needed to fill shifts would rely on in-house bank nurses. We reviewed rotas

from March to August 2016 to assess the level of bank/ agency use. On ward A5 (neurosurgery) this ranged from 8.2% to 14.6% for registered nurses and from 25.7% to 58.1% for health care assistants (HCAs) on the day shift.

- On ward J2 (major trauma rehabilitation) for the same period bank/agency use ranged from 2% to 12.4% for registered nurses and from 40.4% to 63% for HCAs on the day shift.
- We reviewed local induction processes for bank staff which were used in conjunction with mandatory training to ensure staff carried out their responsibilities safely. If agency staff were needed, the same process would be followed. This was a significant improvement from the last comprehensive inspection in 2015, where there had been high reliance on agency staff without always having the appropriate induction and competencies. We spoke with a bank HCA on ward J2 who said that induction was sufficiently robust to prepare them for their work.
- Data provided by the trust before the inspection showed that nurse vacancy rates were higher than the trust average of 11%. For registered nurses the average across all surgical specialities was 12%; for additional clinical staff the average was 17%. The worst performing unit was the vascular lab, which had a 58% vacancy rate (WTE of 2.5). Nine other units had vacancy rates of over 20%.
- However, some surgical units had no vacancies recorded in the data, including orthopaedics, clinic 8 (maxillofacial surgery) and clinic 4 (urology and general surgery).
- When we reviewed nurse vacancies at the time of inspection we did not find it to be concerning as the trust had recently had a nurse recruitment drive including significant overseas recruitment. By the time of our inspection, a vacancy had just opened on trauma and orthopaedics and the lead nurse was preparing for interviews, but the staff member had not yet left.
- On ward M5 there were three separate teams for the specialities of ENT, maxillofacial surgery and ophthalmology. Overall this department was overstaffed by 0.4 WTE registered nurses, and at the time of our visit the actual staffing levels were higher than planned by two additional unregistered staff. A nurse on this ward told us staffing had been a concern in the past 12 months but had now significantly improved.

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- Sickness rates among nursing staff were in line with the trust average of 3% for both registered nurses and additional clinical staff.
- The turnover was 11% on average across surgical services for registered nurses. For additional clinical staff it was 13%. The trust average turnover was 11%. Again there were significant differences across the reporting units for surgery as some had experienced no staff turnover including Ely day surgery unit, Cambridge eye unit (theatres) and vasculitis and renal nurse specialists.
- The nurse in charge of ward F5 told us that turnover was a concern for them as staff would often move on once they had completed training, for example to take up a job in London.
- While some departments, such as ward J2 (major trauma rehabilitation), were particularly busy during our inspection, staffing in all areas was sufficient to safely meet patient acuity. For example, when we visited ward G5 (transplant) there were seven registered nurses (RNs) and three HCAs on shift, to meet the needs of 29 patients.
- However, the nurse in charge on ward J2 told us that they were meant to be supervisory but due to staffing much of their time was spent in a clinical capacity.
- The sister on ward D8 (trauma and orthopaedics) showed us a new acuity staffing tool that was being trialled at the time which took into account particular patient needs as well as numbers, and nurse staff skills and numbers to assess the optimum staffing level required. It was not yet in use but was very easy and quick to use.
- Surgical areas including ward M5 would share nursing staff from other areas on occasions when they were understaffed. However, bank staff or staff from other specialities would be allocated to patients with more general needs or less acute patients to ensure that patients were cared for as safely as possible. However other areas did not share staff and would rely on in-house bank nurses, for example in neurosurgery.
- On neurosurgery staff felt that staffing levels were safe and manageable despite the ward being busy, which was an improvement from our last comprehensive inspection in April 2015. However, they raised concerns that staff were still regularly being reallocated to cover other areas.
- A senior nurse on ward J3 told us staffing could be a challenge because the planned levels did not account for the extra patients the ward regularly had to

accommodate for contingency. However, this was managed by the operations team sending staff from the bank nursing pool to ensure staffing was as safe as possible. The acuity tool was useful for staff on ward J3 to highlight patient dependency when additional staff were required.

- All nurses and HCAs we asked were happy with their induction procedures and felt well equipped for working on their ward.
- New staff were supernumerary for their first six weeks, which could be extended if they or their manager felt it was needed. We spoke with a staff nurse in urology working as a supernumerary and they felt their training was helping them rapidly build up the skills and confidence for working on the ward.

Surgical staffing

- Data provided by the trust showed there was full shift ward and emergency department (ED) cover provided by foundation/core trainees and Fellows in general surgery; transplant; orthopaedics; plastics; ear, nose and throat (ENT); oral and maxillofacial surgery (OMFS); and neurosurgery.
- There was resident middle grade consultant cover in general surgery, orthopaedics and neurosurgery. There was also non-resident cover 24 hours a day at middle grade level (senior trainees) in vascular; hepato-pancreato biliary; plastics; ENT, OMFS (joint cover with Peterborough); and neurosurgery specialities.
- Consultant level ward rounds occurred daily including at the weekends in all specialties. As a trauma centre, cover was provided as per the trauma network guidelines, including emergency lists at the weekends conducted by consultants.
- There was full medical cover for the transplant unit (Nephrology and Hepatology), and 24-hour cover for the donor retrieval service.
- However, the matron and a junior sister in day surgery raised a concern that there was no doctor on this ward at night and it might take some time to access an on-call doctor as this was a satellite ward separate from the main part of the hospital.
- Data provided by the trust showed there were 438 whole time equivalent (WTE) medical staff working across surgical services. This workforce was made up of 45% consultants, 3% middle career doctors, 37% registrars

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and 15% junior doctors. There was a higher proportion of consultants and junior doctors than the England averages (which were 43% and 11% respectively) across surgery overall.

- During our inspection the surgical staffing and skill mix was sufficient in all areas we visited in order to treat patients safely. This was confirmed by staff; for example a locum registrar in orthopaedics (ward C8) told us that consultant supervision was never lacking.
- This was supported by the rotas for medical staffing which were accessible via the trust intranet. For example within ward C8 (which was a 37- bedded ward) there were three registrars on call during the day at weekends.
- However, we spoke with a foundation year two (FY2) doctor on the neurosurgery ward, who felt that there should be at least two FY2s on the ward due to the demanding and busy nature of the speciality and rotas only provided for one during each shift.
- Data provided by the trust showed that locum use within surgical services was higher than the trust average of 3% for the period April 2015-March 2016 but there were large discrepancies between specialities. Transplant had the highest rate of locum use at 22% for this period. Anaesthetics, oral surgery and vascular surgery were also high at 12%, 9% and 8% respectively.
- However, on inspection we did not find that locum use was an issue. The locum registrar we spoke with in orthopaedics told us there was minimal locum use at middle grade and they were the only one within the speciality because it suited them to remain as locum. On ward A5 (female neurosurgery) a consultant confirmed they only used locum doctors occasionally and we saw that locum use for neurosurgery ranged from 2.2% to 8.7% for the period April-August 2016. Locum use on the transplant ward had also decreased for this period, to between 10.6% and 14.9%.
- We spoke with junior doctors across various surgical specialities who all reported that training and development were good. However one FY2 doctor on neurosurgery said that consultant support could be improved because of the busy nature of the ward and the fact that cover was only provided for one FY2 so they sometimes felt isolated.
- We observed a handover as a patient was taken into theatre and saw it was completed safely and according to recognised processes.

Major incident awareness and training

- The trust had a major incident plan (often referred to as MAJAX) and business continuity plan in place. Staff we spoke with were aware of this.
- Major incident plans outlined protocols for deferring non urgent surgery and admissions in the event of a major incident as well as a phased return of non urgent surgery once the major incident had been contained.

Are surgery services effective?

Good



We rated effective as good because:

- Trust and local inductions were in place for new staff to ensure they had the required skills and competencies to deliver patient care effectively.
- Patients received care and treatment by trained and competent staff.
- The service provided evidence based care and treatment in accordance with national and local guidelines including National Institute for Health and Care Excellence (NICE) guidance.
- Pain was assessed and managed in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015).
- There was good evidence of multidisciplinary team (MDT) working in all surgical areas to help maximise patient outcomes.
- Patient's surgical outcomes were monitored and reviewed through formal national and local audits.

However :

- Some audits, for example an audit of preoperative fasting times for adult patients undergoing elective surgery in main theatres, were past their completion dates and action plans were not identified.
- Bank staff did not always have a local induction to ensure that they had the competency to care for the specific needs of patients in some specialities.

Evidence-based care and treatment

- Surgery had a clinical audit programme which assessed compliance with National Institute for Health Care and Excellence (NICE) guidelines and local policy. The surgical team reviewed and implemented an action

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plan for areas that did not comply. For example we saw that an action plan was in place to implement the assessment and management of complex fractures in line with NICE guideline 37 (Feb 2016).

- Local policies were written in line with national guidelines. Staff confirmed that policies were regularly updated and that they were notified of updates.
- There was policy review team in place to ensure that policies were up to date and in line with current practice. We saw that in June 2016, 96% of policies were compliant with 4% due for review between March and September 2016.
- 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. For the year 2016 to date the service had a consent rate of 81% of the total 702 operations performed on hips, knees, ankles, elbows and shoulders. This was lower than the national average consent rate of 92%.
- The surgical audit plan 2016/2017 identified audits in which the surgical departments participated. The audit data identified dates of proposed completion. However, eight audits that were due to be completed indicated that they were still being planned. These included the documentation of IV post anaesthesia line flush second audit; an audit to assess the value of the soft tissue lateral neck x-ray in cases of Fish bone ingestion; preoperative fasting times for adult patients undergoing elective surgery in main theatres re-audit; and an audit to assess surgical tracheostomy referrals using a new pathway form.
- An audit had been done to assess World Health Organization (WHO) Surgical Safety Checklist for use in any operating theatre environment. It is a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. Audit data showed all checks were done consistently with the exemption of implant pauses with only 42% recorded. The trust planned to review items requiring an implant pause and implement staff training.

Pain relief

- Patients' pain was assessed in line with the Faculty of Pain Medicine's Core Standards for Pain Management (2015) 1-10 pain score. We saw pain charts recorded appropriately in all patient notes we reviewed. These included visual, verbal and observer scoring.
- Pictorial pain indicator charts were available for patients that were unable to verbalise their level of pain.
- We saw good examples of pre-op assessment for post-operative pain relief in the day surgery pre assessment unit.
- A dedicated pain team were available 24 hours a day, seven days a week and staff told us that they were very helpful in managing and reviewing patients' pain.
- A staff nurse on the transplant unit told us that the pain team visited every day for patients receiving pain management via an epidural. This was in line with the Faculty of Pain Medicine Core Standards 2015.
- Eight patients we spoke with told us that their pain was managed well. One patient told us that on one occasion their pain was not managed well. This was due to a complication that was not recognised by a bank member of staff. The issue was resolved when senior staff became aware and the patient's pain was then well managed.

Nutrition and hydration

- We saw water jugs filled and within easy reach for patients. Patients reported that the jugs were refilled regularly.
- There was a daily food menu available and patients were able to choose from a limited selection.
- Patients told us that the food could be improved. One patient told us that the selection was not always good. Another said that the quality was poor.
- The patient-led assessment of the clinical environment (PLACE) review from December 2015 showed that on ward L4 (colorectal surgery) the menu was not suitable for patients as due to their conditions white bread rather than brown bread for sandwiches. There was action in place to rectify this. The review also noted negative patient feedback about meals.
- There was a red tray system in place. Food served on a red tray highlighted to staff that patients needed help with eating and drinking.
- Patients' nutritional needs were clearly indicated in their notes and on the information boards by their beds.
- On the transplant ward a dietician came round every day to offer patients nutritional advice.

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Patient outcomes

- The bowel cancer audit programme 2015 showed that 100% of patients were seen by a nurse specialist compared to a national average of 93%. The 90 day mortality rate was 2.2% compared with a national average of 4.4%. The risk adjusted 2 year post - operative mortality rate was 22% in line with the national average of 22.7%.
- The vascular audit 2015, showed that the mortality rate for patients undergoing an aortic aneurysm was 0.8%, compared with the national average of 1.5%.
- The hip fracture audit 2015 showed an overall improvement from 2014 with 80.8% of patients having surgery on the day or the day after admission, higher than the national average of 72.1%. The perioperative medical assessment rate was 97.9%, significantly better than the national average of 85%. The number of patients not developing pressure ulcers was 96.7%, which was slightly worse than the national average of 97.2%.
- Patient Reported Outcome Measures (PROM) scores for April 2014 to March 2015 were mostly the same as the England average. Hip and knee replacement were in line with the England average, with a 91.6% improvement rate for hip replacement (compared to the England average of 89.5%) and an 84.2% improvement rate for knee replacement (compared to the England average of 81%). Groin hernia repair was slightly better than the England average with 58.7% improvement rate compared to the England average of 50.7%.
- The average length of stay for elective surgery was lower than the national average for all surgery apart from urology where the average length of stay was 2.4 days compared with a national average of 2.1 days. For non-elective surgery the length of stay for all surgery was 7.5 days which was more than the England average of 5.1 days.
- The risk of readmission for patients having elective surgery was above the England average for urology, neurosurgery and general surgery. However for patients having non elective surgery the relative risk of readmission was below the England average for all surgery including transplantation.
- Ninety per cent of medical staff and 99.9% of non-medical staff in surgery had had an appraisal in the last 12 months against the Trust target of 90%. All members of staff we spoke with told us that they were up to date with their appraisal.
- Staff told us that they felt well supported and senior staff were available for support and supervision.
- A staff nurse told us how she was participating in the 'Inspire' programme which supported the career progression of band five nurses.
- Three health care assistants (HCAs) told us that they were supported by staff and were never expected to work outside of their competencies.
- The trust had a formal induction programme which was compulsory for all new members of staff.
- On the day surgery unit we saw the competency folder which had a record of the competencies of staff on the unit. This meant that management could ensure that staff had the right skills to care for the patients on the ward.
- A staff nurse on ward A5 ward told us that they had completed a local ward induction. However, a nurse on ward N2 told us that there was no formal induction for bank staff new to the ward. Therefore they could not ensure that the bank staff member had the necessary skills to meet the clinical nursing requirements of the patients on the ward.
- The trust had a policy in place around nurse revalidation. Two nurses we spoke with told us that they were supported through the revalidation process.

Multidisciplinary working

- We went to a trauma and orthopaedic multidisciplinary team (MDT) meeting. It was attended by representatives from physiotherapy, social care, occupational therapy and consultants from various disciplines. We observed the review of five cases with all members contributing to ensure the best care pathway for the patients.
- Staff confirmed there was effective multi-disciplinary team (MDT) working throughout the service.
- Our observations of patient care showed surgical and nursing staff communicating effectively to maximise patient care.
- The majority of wards had designated physiotherapy and occupational therapy staff based locally to assist patients along their treatment pathway. Areas without designated allied health professionals could still access allied health professionals if required.

Competent staff

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- The discharge team worked closely with other health care professionals. This was to ensure the patient's discharge support needs were met prior to their discharge home or to another healthcare provider.
- A pharmacist was available to attend the pre op assessment clinic every afternoon. Medicines management referrals were made by the MDT for complex patients.
- Dieticians were available to offer nutritional support to patients.

Seven-day services

- Surgery was a consultant-led service. Wards had daily consultant ward rounds.
- Physiotherapists were available Monday to Friday and provided on-call cover at weekends.
- Emergency theatres were available out of hours.
- Diagnostic imaging including plain x-ray, Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) were available 24 hours a day, seven days a week.
- Pharmacy supported the wards during the week and on a Saturday. There were on call arrangements for pharmacy staff out of hours, Sundays and bank holidays.

Access to information

- Staff had access to the trust intranet system from any workstation in the hospital to access information including trust updates, policies and procedures as well as online training.
- The trust used the electronic health care record system 'Epic'. Staff we spoke with were positive about the Epic system and said it was easy to access patients' care records.
- Each ward had a number of workstations on wheels (WOWs) which allowed staff to access patient information as well as inputting information whilst on ward rounds or when administering medication or taking observations.
- There were sufficient numbers of WOWs and hand held units (rovers) to ensure rapid access to information. A staff member on day surgery unit told us that they no longer used rovers for medication rounds as there could be delays uploading the information.
- Patient investigation results were easily accessible; for example, the online patient x-ray (PACs) system provided staff with details of the patient's x-rays pre-operatively.

- We observed hand over notes and saw that they contained details of the patient's medical condition and details of their ongoing care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All 13 staff we asked were able to demonstrate an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (2009) (DoLS) and how they would be applied.
- All of the notes reviewed had signed consent forms.
- Staff were able to tell us the process of consent and recognise the impact of variable capacity which demonstrated a good knowledge of consent and the MCA.
- We followed a patient pathway through theatre and witnessed that appropriate consent was taken.
- Posters were in clinical areas with information about MCA and DoLS and how to access support if required.
- We reviewed a patient consent audit from March 2016, and found overall compliance to be high. Consent was taken by an appropriate health professional in 95% of cases. However, the audit had also identified areas for improvement, namely provision of patient information, which was very low at 7%. Three cases were found to have a note in the operation note on Epic that the patient had been given written patient information but no specific details provided.

Are surgery services caring?

Good



We rated caring as good because:

- All observations of interactions between staff and patients and relatives were kind and compassionate, and patients and relatives spoke highly of the care received.
- Friends and Family Test (FFT) results for surgical specialities were consistently high, with wards G5 and L4 performing particularly well (L4 scored 100% in 11 out of the 12 months between June 2015 and May 2016, and 95% in the remaining month).
- Staff showed respect for the privacy and dignity of patients at all times.

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- We spoke with 10 patients who all said they were kept well-informed by surgical and nursing staff as to their care and progress.

However:

- Some negative points were raised about the attentiveness of staff. One patient said that at busy times the specialist team did not come back to them with feedback despite saying they would. On ward J2 (rapid access acute rehab) the two patients we spoke with did not know the names of the consultants responsible for their care.

Compassionate care

- All observations of interactions between staff and patients and relatives were kind and compassionate, and patients spoke highly of the care, saying they were “treated as an individual” and they “couldn’t praise staff enough”. One patient on ward G5 said they felt “safe and looked-after” and that staff were chatty and friendly. A patient on ward F5 said the care was “the best I’ve ever received”.
- There was mixed feedback about the length of time patients could be waiting for staff to see to them. On ward M5 a patient told us they were waiting to be given an indigestion tablet having requested it a number of times. However, on ward G5 a patient told us staff were very responsive to the call alarm if they needed anything. On ward J2, two patients told us that although staff were very busy, they always came if needed and they felt well looked-after.
- Friends and Family Test (FFT) results for surgical specialities were consistently high, with wards G5 and L4 performing particularly well (L4 scored 100% in 11 out of the 12 months between June 2015 and May 2016, and 95% in the remaining month). The response rate for the FFT across surgery was in line with the England average, at 30%.
- All observations of patient care during our inspection showed respect for the privacy and dignity of patients, including in theatres and recovery. For example on ward M5 we observed a nurse ensuring a patient was covered as they got out of bed because their surgical gown had come open at the back.
- Staff in all specialities felt motivated by the gratitude shown by patients; one nurse in urology said there was a patient who regularly asked for her specifically.

Understanding and involvement of patients and those close to them

- We spoke with 10 patients who all said they were kept well-informed by surgical and nursing staff as to their care and progress.
- For example, the relative of a patient who had been on the neurosurgical ward for six weeks told us they had met with the discharge team that morning to discuss discharge plans and the patient’s progress. A patient on the plastic surgery ward told us they had been given lots of information about their aftercare. The relatives of a patient on ward J2 (rapid access acute rehab) told us the doctor in charge had discussed the patient’s progress and discharge plans with them.
- However, one patient on urology added that at busy times the specialist team did not come back to them with feedback despite saying they would and that better communication was needed to meet their personal health needs.
- On ward J2 the two patients we spoke with did not know the names of the consultants responsible for their care.
- During our observation of a patient journey through theatre the patient was fully briefed beforehand and their relative was informed about the likely duration and directed to waiting areas.
- In each area there were information leaflets for patients and relatives available in ward corridors and waiting areas/relatives’ rooms.
- Patient comment/feedback cards were available on wards in reception or in relatives’ rooms.
- On ward G5 a patient told us the ward was flexible with visiting hours so they could spend more time with their relatives.

Emotional support

- Surgical services had access to a hospital chaplain if patients or relatives requested this support and there was information about the chaplaincy service displayed on the wards. This service was available 24 hours a day, seven days a week.
- Staff could also access other religious services for support if requested.
- Patients on the transplant unit and urology, and a relative of a patient on neurosurgery, gave specific praise for the emotional support they had received from staff on the wards.

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- There was access to specialist bereavement services for relatives.

Are surgery services responsive?

Requires improvement



We rated responsive as requires improvement because:

- The service was performing worse than the national average for cancellation rates. Between January and June 2016 across all surgical specialities, there had been 454 elective surgeries cancelled for non-clinical reasons (out of a total 15,097 planned elective surgeries equating to a cancellation rate of 3%).
- In this timeframe, 43 of these patients were not treated within 28 days of last minute elective cancellation.
- The trust's vascular audit results from the last report in 2015 showed that for carotid endarterectomy patients, the crude median time from symptom to surgery was 28 days, which was significantly worse than the national aggregate of 12 days and the national recommendation of 14 days as recommended by the national Institute of Clinical Excellence (NICE).
- Data provided by the trust prior to inspection showed that the service was performing significantly worse than the national average on meeting targets for referral to treatment times (RTT). The national target is that 90% of elective surgery patients should undergo treatment within 18 weeks of being referred. The worst-performing surgical speciality was oral surgery at 29.6% (compared to the England average of 75.9%).
- Main recovery was regularly used to accommodate patients when their speciality ward did not have capacity. From July to September 2016 there were 68 occasions where patients remained in recovery longer than clinically necessary owing to lack of capacity.
- There were 31 unplanned overnight stays in recovery between April and September 2016.
- Between June and August 2016 there were 1,176 patients recorded as outliers on surgical wards. Staff reported this was a major concern for surgical wards and it was on the trust risk register.
- Bed management meetings involved comprehensive discussion about all elective surgery patients as well as an overview of any extra capacity patients and how to accommodate their needs.
- Cancellations in surgery, while still a concern, were showing gradual improvement since our last comprehensive inspection carried out in April 2015. In August 2016, there were 116 cancellations on the day, which was notably lower than any month of the previous 12 months.
- Between June and August 2016, there had been significant improvement in RTT. For example, RTT in oral surgery had increased to 78.3% on average for this period, compared with an average of 29.6% between June 2015 and May 2016). The overall average RTT across surgery from June to August 2016 was 90.7% so had begun to achieve the national target of 90%.
- Minutes of the quality and performance divisional team meeting from June 2016 showed consideration of performance against discharge targets. Within Division A the target number of discharges to date was 781 and the actual number was 833, 7% lower than the planned performance target. To address the issue of delayed discharges, planned actions included developing a pre-operative anaemia pathway and introducing a point of care testing pilot on L4.
- Staff were responsive to the particular needs of patients with learning disabilities and patients living with dementia.
- Ward J2 ran weekly 'music and movement' classes to help meet the holistic needs of patients during their long-term recovery. A volunteer specialising in music and movement ran the classes and staff encouraged patients and their relatives to attend.
- There was evidence of sharing feedback and lessons learned following complaints. Actions were taken to address complaints.

Service planning and delivery to meet the needs of local people

- At times of staff shortages, there was good communication between departments to reallocate nursing staff to ensure services could be delivered as efficiently as possible. During our inspection we saw this take place within neurosurgery. On ward G5 (transplant) an HCA confirmed they would share staff with ward F5 (the transplant step-down ward from the high dependency unit) if necessary.

However:

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- On day surgery the matron told us it was operational policy that no A&E patients were admitted here but that at times of high bed occupancy it was unavoidable.
- Staff in all surgical wards told us they worked very closely with the trust bed management team. However, this could sometimes cause difficulties in the wards; for example the matron on day surgery told us they had to “fight their corner” to keep their nurses, and in ophthalmic surgery the senior sister said they spent a lot of time contacting the bed management team which would pull them away from their own clinical and supervisory responsibilities.
- We observed a discharge form being completed appropriately in day surgery. The discharge nurse said they helped organise transport and ensured patients and/or carers were confident with aftercare and medicines administration.
- The pre-operative assessment clinic ran a prime clinic for the frail and elderly on two afternoons each week owing to the demands of the population there.
- There was a courtesy bus to take patients from outpatients to the pre-operative assessment clinic and we saw patients using this service.
- We observed a bed management meeting in ward J3 which took place at 9am daily including at weekends to give an overview of the day ahead. There was comprehensive discussion about all elective surgery patients as well as an overview of any extra capacity patients and how to accommodate their needs. There was also evidence of checking patients’ progression through the hospital against the agreed plan.
- We also attended a trust wide bed meeting. These took place three times daily at 9am, noon and 4pm. All surgical areas were well represented and extra capacity was a key focus in the discussion as the trust was on ‘black alert’ due to capacity. A staffing plan was agreed to accommodate areas being used for extra capacity and to meet the needs of outliers. The meeting was highly patient-centred. At weekends trust wide bleep holder meetings take place at 5am, 11am, 5pm and 11pm.

Access and flow

- The service was performing worse than the national average for cancellation rates. Between January and June 2016 across all surgical specialities, there had been 454 elective surgeries cancelled for non-clinical reasons (out of a total 15,097 planned elective surgeries

equating to a cancellation rate of 3%). In this timeframe, 43 patients were not treated within 28 days of last minute elective cancellation. However, it was a slight improvement on the findings from our last comprehensive inspection (where we saw that between October 2014 and April 2015, 129 patients who had their procedure cancelled on the day of surgery had not been treated within the specified 28 days).

- Overall, cancellations in surgery were showing gradual improvement. In August 2016, there were 116 cancellations on the day, which was notably lower than any month of the previous 12 months.
- In ophthalmic surgery the theatre sister told us that cancellations were frequent because the unit did not carry out pre-operative assessments on every patient. They added that patients were often operated on without a bed confirmed as available for them post-operatively. When we spoke with the lead clinician they confirmed that pre-operative assessments would not always be carried out on local anaesthetic patients meaning cancellations could occur, for example if the patient’s blood pressure was too high on the day of planned surgery. So far for the month of September 2016, there had been eight cancellations because of this. This also included a non-clinical example where there was no female bed available.
- In neurosurgery the junior sister and ward manager told us that while cancellations were still an issue the situation had improved in the last 18 months.
- Bed occupancy rates for June, July and August 2016 were below the trust target of 92%, at 91.6%, 88.6% and 87.7% respectively.
- The trust’s vascular audit results from the last report in 2015 showed that for carotid endarterectomy patients, the crude median time from symptom to surgery was 28 days, which was significantly worse than the national aggregate of 12 days and the national recommendation of 14 days as recommended by the National Institute of Health and Care Excellence (NICE).
- Data provided by the trust prior to inspection showed that the service was performing significantly worse than the national average on meeting targets for referral to treatment times (RTT). The worst-performing surgical speciality was oral surgery at 29.6% (compared to the England average of 75.9%). Trauma and orthopaedics; and ear, nose and throat (ENT) surgery had RTTs of 40.3% and 43% respectively (compared to England averages of 70.8% and 74.2%).

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- However, staff we spoke with during our inspection including an operations manager told us there had been improvements in RTT as a result of the initiatives to ease the blockages to access and flow through the hospital. We requested further data for the period June - August 2016, and saw significant improvement in RTT. For example, RTT in oral surgery was on average 78.3% for this period. The overall average RTT across surgery for this period was 90.7%.
- Since the last comprehensive inspection, several initiatives had been implemented to address the issues of access and flow. The surgical ambulatory care unit (SACU) pathway had been developed to improve patient care, patient experience, reduce in-patient admissions and length of stay. The SACU's remit was to offer urgent, high quality assessment and therapy avoiding unnecessary hospital admissions. The unit accepts patients directly via GP liaison or the Emergency Department as one way of managing the increase in demand for non-elective surgery.
- The Gastrointestinal Urgent Theatre Session (GUTS) list provided a next-day/48-hour ambulatory emergency theatre session, which also helped to avoid unnecessary admissions and reduce length of patient stay by providing the service within a short time frame.
- There was no policy in place to explain what should happen if no bed was available, which meant procedures regularly went ahead without staff knowing where the patient would be placed after surgery. In day surgery we found that operations were regularly carried out without a bed available post operatively; however we saw that staff managed this as best as possible and incident forms were completed when this occurred.
- All emergency surgery beds were arranged through the operational bed management team.
- There was a dedicated overnight intensive recovery area. Data provided by the trust showed there had been no overnight stays in the day surgery recovery areas. The day surgery unit was a 23-hour stay facility and surgery services ensured all other recovery facilities were prioritised to ensure appropriate flow.
- However, the main recovery area remained an issue as it was regularly used to accommodate patients when their speciality ward did not have capacity. From July to September 2016 there were 68 occasions where patients remained in recovery longer than clinically necessary owing to lack of capacity.
- There were 31 unplanned overnight stays in recovery for the period April – September 2016, 13 of which had occurred in April 2016.
- Staff in recovery found it challenging to manage this; one sister told us they were rarely allocated extra staff by the bed manager because staff would be called to theatres or wards first.
- We saw a review of discharge summaries for May 2016 within the Division A quality and performance team meeting minutes. This showed that across the division 2,485 discharge summaries had been sent within the target 24 hours, out of a total 2,502. Only 17 summaries had been outside the 24-hour timeframe.
- Meeting minutes also showed consideration of performance against discharge targets. Within Division A the target number of discharges to date was 781 and the actual number was 833, 7% lower than the planned performance target. To address the issue of delayed discharges, actions to take included developing a pre-operative anaemia pathway and introducing a point of care testing pilot on ward L4. This was suggested in response to the concern that one discharge every day was delayed waiting for blood results.
- Discharges in general surgery were noted as being at risk due to cancellations for bed shortage and the use of ward J3 as a contingency ward. To reduce the impact, the general surgery wards were working closely with Division C colleagues to maximise Ely and potential Saturday patient lists. This meant staff were aware of the main causes of delayed discharges and were committed to mitigating those factors as far as possible.
- In day surgery the discharge nurse told us delays in discharging patients were frequent due to a lack of rapid access to pharmacy and having to chase up doctors to discharge the patient.
- There were 99 out-of-hours (10pm to 7am) discharges to the surgical wards from June to August 2016.
- There were 94 out-of-hours (10pm to 7am) bed moves in surgery from June to August 2016 for non-clinical reasons. This included 35 patients who had experienced more than one out-of-hours bed move and 13 patients who had experienced more than two.
- Between June and August 2016, there were 1,176 patients recorded as outliers on surgical wards. This was a key concern for the service. However, this showed slight improvement on our findings from the last comprehensive inspection (where there had been on average 22 to 24 outliers per day within surgical wards).

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- During our inspection staff confirmed that outliers were regular in the wards due to the lack of bed capacity, for example on ward M5 and on the trauma and orthopaedics ward. They told us pressures caused by outliers had gradually reduced in the last 12 months but it was still a concern.
 - On day surgery staff said their main challenge was inappropriate patients placed on the ward. A junior sister on this ward told us it was not easy to refuse to take inappropriate patients and that it was a daily pressure. They also said it was a daily occurrence for patients to sit outside the main ward if no bed was readily available at the time which would cause undue stress to patients.
 - On ward M5 a nurse told us they regularly had medical outliers on the ward from multiple specialities which increased pressure on staff but explained how they managed these by seeking advice from the relevant speciality.
 - Ward J3 (surgical arrivals area) was regularly used as an extra capacity area to accommodate surgical patients. This was on the risk register and known to staff. There were systems to ensure these patients' needs were safely met and to prioritise patients of higher acuity. The senior nurse felt that the development of the ambulatory care unit would improve surgical patient flow.
 - However, surgical departments had implemented measures to care for outliers and minimise the impact on patients. For example, for orthopaedics patients there were nurse practitioners and two foundation year junior doctors responsible for monitoring outliers and organising separations. On ward M5 the sister in charge explained they used a "red and green" system to indicate and monitor capacity concerns.
 - A nurse in the plastic surgery ward told us that they worked very closely with theatre managers to make patient flow as efficient as possible. They said that if a patient needed a longer recovery time they would continue this within the unit.
 - While we were on the transplant ward, the orthopaedic team came to assess a patient with a fracture, showing good oversight of surgical outliers and ensuring they were safely managed.
- surgery said they would adjust the position of the bed or move it to a more appropriate area of the ward to make the patient more comfortable. In neurosurgery these patients could be in a side room which was quieter if needed.
- Staff were responsive to the specific needs of patients living with dementia. We saw door signs indicating this and the service was also using the 'forget-me-not' system to indicate these patients. There was a dementia link nurse, who ward staff reported to be very accessible.
 - In ophthalmic day surgery a band six nurse told us they would try to place patients living with dementia in quieter areas if it would reduce stress for them and that staff awareness around this had improved in recent months.
 - On the orthopaedics ward the senior sister told us they would avoid moving patients living with dementia to different areas as it could be distressing. There was an ongoing project to improve dementia awareness on the ward including an application for a grant for extra training in this. Ward staff also encouraged families of patients living with dementia to bring in photos or treasured belongings from home.
 - There was further evidence of an awareness of the needs of people living with dementia discussed in team meetings. For example, in the trauma and orthopaedic governance meeting minutes from May 2016 there was clear consideration of the difficulties that might be experienced by patients living with dementia in bed moves and a reminder to staff to seek a view from one of two named consultants as to whether a patient living with dementia, or a particularly frail patient, was safe to move.
 - Ward J2 ran weekly 'music and movement' classes to help meet the holistic needs of patients during their long-term recovery. A volunteer specialising in music and movement ran the classes and staff encouraged patients and their relatives to attend.
 - Surgical specialities worked to accommodate relatives or carers staying overnight if they were travelling long distances or had particular concerns. For example there was an on-site 'relatives' hostel' which was well utilised and appreciated by relatives of longer-term patients such as transplant patients travelling long distances.
 - In day surgery and neurosurgery we saw there was a 'pink phone' system to access translation services if required.
- ### Meeting people's individual needs
- Staff were responsive to the particular needs of patients with learning disabilities. For instance a nurse on day

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- In ward N2 (urology) we saw a red tray system in use to identify patients that needed assistance with eating. Other surgical specialities also confirmed they used this system.
- Staff in areas including trauma and orthopaedics, and day surgery, reported that the Epic system helped staff respond to individual needs as it highlighted specific needs and patients placed on an inappropriate ward so staff could manage their needs.
- The main negative point raised by patients about their experience was in relation to the food but they also acknowledged that it would be difficult for the service to improve the standard of food because of the number of patients.

Learning from complaints and concerns

- Data provided by the trust showed that between April 2015 and March 2016 there were 118 complaints relating to the entire surgical group. This formed 33.3% of overall complaints submitted to the trust.
- There was evidence of sharing feedback and lessons learned following complaints. For example in the trauma and orthopaedic governance meeting from May 2016 it was discussed that medication issues were a recurring theme in patient complaints. To address this, the department had arranged an Epic training session specifically relating to reconciliation of medications.
- There was also evidence within divisional team meetings of sharing positive feedback received from patients and families. For example, the comments from a relative who praised the neurosurgery team for their care were shared with staff in the June 2016 meeting.
- A patient in urology told us about a complaint they had sent to the trust regarding communication with consultants during their treatment and said they had received a satisfactory letter back which included input from the consultants.
- Staff told us there was a rise in complaints at times when bed occupancy and outlier numbers were highest and they tried to address this by keeping patients well-informed.
- A band six nurse in ophthalmic day surgery told us most patient complaints related to delays to treatment. For example, on the day of our visit there were issues with the Epic system which staff managed as best as possible by keeping patients informed and updated in the waiting area.

Are surgery services well-led?

Good



We rated well-led as good because:

- The clinical and divisional leads showed good awareness of the main risks within their service and had robust action plans to address them.
- The service was focused on continuous improvement in referral to treatment times (RTT), cancellation rates and outliers now that there was a surgical board meeting in place to manage theatre activity efficiently.
- The risk register was reviewed as part of clinical governance and risks were appropriately mitigated as far as possible. All risks identified by the inspection team were on the existing risk register and staff we spoke to were aware of the risks in their department.
- Surgical services were consultant-led and surgical staff in all areas reported that they were well-supported by consultant leads.
- There was a positive working culture among all staff levels in all areas we inspected and staff took great pride in their work. Several staff in different wards including transplant, neurosurgery and major trauma, told us that the culture was “like family”.
- Surgical services had several ongoing innovative initiatives to develop services and maximise patient experience. For example, the ophthalmic day surgery unit had recently introduced a Femtosecond laser designed to improve predictability and precision.
- Divisions A and C had begun a joint project to improve kidney transplant times. Funding of £500,000 had just been agreed to allow for an extended theatre list from Monday to Friday to achieve this goal.

However:

- Nursing staff on day surgery felt bed managers did not always listen to their concerns about outliers on their ward and not feeling adequately supported or equipped to care for them.
- There was some negative feedback from the Division A staff engagement survey. For example the statements ‘I

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feel valued and recognised within my area of work' and 'senior managers demonstrate the trust's values and leadership behaviours' scored only 52% and 48% respectively.

Leadership of service

- Surgery was split across five divisions within the trust. In each division there was a divisional director and one to four clinical directors. Leaders worked across divisions to monitor and improve services.
- Surgical services were consultant-led and surgical staff in all areas reported that they were well-supported by consultant leads. One health care assistant (HCA) on ward G5 described ward leadership as "fantastic".
- Staff we spoke with across different specialities spoke positively about the senior management team, for example describing them as "approachable" and "proactive".
- We spoke with the clinical leads for surgical services and found they were proactive at engaging with staff at all levels, representing surgical teams and responding to the main risks for the service. For example they told us how they had secured investment from the board to improve issues of access and flow. They were also identifying the main reasons for higher than average length of stay, focusing on patients staying longer than seven days. They told us a major theme from this was a lack of speech and language therapy resources so they were looking at ways of improving this.
- Service leaders were focusing on the issues with access and flow and implementing measures to manage this as much as possible. This was supported by staff on the wards; a healthcare assistant (HCA) on ward G5 (transplant) told us that bed managers tried to place patients in the most appropriate wards as far as possible.
- In theatres and recovery we observed good communication from team leaders with all staff involved in the relevant procedure or recovery care.
- However there was mixed feedback about the visibility of senior leadership. The senior nurse on ward J3 told us the chief nurse and chief operating officer visited regularly; provided direct support; and were very engaged with the capacity issues there. However, on neurosurgery, the lead nurse felt senior management was not visible, although a junior sister on the same ward said the chief nurse was "visible" and "encouraging".

Vision and strategy for this service

- Service leaders were focusing on recruiting ODPs and anaesthetic practitioners which were two of the most difficult posts to fill.
- The service was focused on continuous improvement in RTT, cancellation rates and outliers now that there was a surgical board meeting in place to manage theatre activity efficiently.
- The service was also committed to more united work between divisions to improve communication, which leads said was helping flow through the hospital as well as encouraging teamwork.

Governance, risk management and quality measurement

- The clinical leads showed good awareness of the main risks within their service such as the concerns raised about day surgery not being able to access rapid medical support at night due to being a satellite ward.
- Divisional leads within surgery had a good grip on the issues of responsiveness and were able to explain how they were working to improve them. They worked closely with staff on the ward and between divisions to manage capacity and outlier concerns as far as possible. In particular they were trying to reduce outliers in trauma as it was a particular concern in the speciality.
- We spoke with an operations manager in surgical services who also had a good grip on the responsiveness issues and was able to explain the service's recovery plan for RTT. They told us the service had active involvement with the STP and were working with three alternative providers for hip and knee replacement surgery to ease waiting lists.
- Service leads were also focused on ensuring that appraisals, training and induction processes were sufficiently robust to ensure staff were competent and supported and that patients were cared for safely.
- However, nursing staff on day surgery felt bed managers did not always listen to their concerns about outliers on their ward and not feeling adequately supported or equipped to care for them.
- The surgery risk register was reviewed as part of clinical governance and risks were appropriately mitigated as far as possible. All risks identified by the inspection team were on the existing risk register and staff we spoke to were aware of the risks in their department.

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- We reviewed minutes from governance meetings and saw constructive discussion about managing the main risks for the service relating to waiting times, cancellations and access to surgical services. For example in the trauma and orthopaedic governance meeting from May 2016, service leads highlighted that average length of stay had gradually reduced but that patient discharges needed to be done earlier in the day to improve access and flow and that “to take home” patient discharge forms should be completed the day before. They also highlighted the main reasons for readmission. This meant that progress and actions were being shared with staff and the service was actively monitoring its risks.
- The service showed awareness of its risks and evidence of implementing actions to improve or monitor them. For example, within trauma and orthopaedics, a concern had been identified that the service was performing poorly against the Trust Guideline for venous thromboembolism (VTE) assessment within 24 hours and re-assessment in 24-48 hours. To address this, they conducted a VTE assessment audit, looking at VTE risk assessment and prophylaxis. The audit of May to August 2015 showed 64.4% compliance in ward C8 and 84.0% compliance in ward D8. Between September 2015 and February 2016 this had significantly improved with compliance rates of 96.7% and 96.3% respectively.
- All consultants we spoke with were aware of their main risks and challenges, for example an orthogeriatric consultant told us that an increase in fractured neck of femur patients had led to an increased demand of orthogeriatric services from an average of 14 beds to 42 beds.
- We reviewed minutes of a divisional team meeting (June 2016) focused on quality and performance for Division A and saw there was constructive discussion about risk management and quality improvement for the service.
- This was supported by our observations during the inspection. We asked medical and nursing staff across a range of surgical areas about the Duty of Candour and they were all able to explain it and give examples of when they had used it.
- There was a positive working culture among all levels of staff in all areas we inspected. Several staff in different wards including transplant, neurosurgery and major trauma, told us that the culture was “like family”; another in pre-operative assessment said it was “a happy place to work”. Staff consistently told us they were proud to work for their speciality and for the trust.
- An HCA on ward G5 (transplant) told us they were being encouraged by their team to complete their registered nurse training and that there was a good relationship between nursing and medical teams. They said they “wouldn’t change anything” about the working environment.
- There was a mentor system for new nursing staff joining the service; a new staff nurse in urology told us this had been “very helpful” and that they had been well-supported through their university course and training.
- However, one consultant we spoke with felt that while the executive team listened to staff concerns there were conflicting priorities such as having to ring-fence beds at the expense of other specialities.
- The main frustrations experienced by staff related to the issues of access and flow, for example being told there was no bed available for a patient. On day surgery staff also felt disheartened when staff were moved to other areas.
- However, staff across surgery felt that the senior leadership team and clinical leads were working hard alongside ward staff to improve the issues of responsiveness.

Public and staff engagement

Culture within the service

- For all new staff Duty of Candour had been included in corporate induction as part of the safety culture session. For existing staff it had been incorporated this into the corporate refresher programme, undertaken annually. Senior leaders at the trust reported there had been “widespread communication and briefings” on this regulatory duty.

- We saw results from a staff engagement survey conducted by the Division A surgical group in which were shared in a team meeting. This showed an overall ‘engagement index score’ of 75% for the period January-March 2016, slightly lower than the trust average of 78% and similar to the results from previous months. This score was calculated by asking questions such as whether staff were proud to work at the trust, enjoyed their work and were motivated to make a difference to patients.

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- The survey had positive results for the statements 'I am aware of the trust's values and behaviours' (100%) and 'I am motivated to make a difference to patients (even if I don't have direct contact with patients)' (95%). However there was some negative feedback from the engagement survey. For example the statements 'I feel valued and recognised within my area of work' and 'senior managers demonstrate the trust's values and leadership behaviours' scored only 52% and 48% respectively.
- However, on inspection staff at all levels including within ward M5, neurosurgery and transplant told us that they regularly received praise from their respective leads, and felt valued and engaged. For example a senior nurse on the plastic surgery ward told us they received updates and feedback via monthly staff meetings, a monthly newsletter and emails to ensure staff were kept aware of any changes or activity in their department.
- Three nursing staff from different specialities felt that opportunities were available for training and development and that managers encouraged them to do this where possible and then share what they had learned with the team. However one staff nurse on ward F5 said that there were not as many training opportunities as they would like as external opportunities were limited by funding.
- On inspection our conversations with and observations of staff showed they were engaged with their work and respective teams. For example an HCA on ward G5 told us how they felt "satisfaction from helping relatives of patients receiving palliative care" and "really love working on the unit".

Innovation, improvement and sustainability

- Surgical services had several ongoing innovative initiatives to develop services and maximise patient experience. For example, the ophthalmic day surgery unit had recently introduced a Femtosecond laser designed to improve predictability and repeatability to surgical steps for cataract and corneal surgery and allow the surgeon to perform surgery with speed and precision without increasing clinical risks and complications. Service leads for eye surgery told us they hoped it would result in more surgical cases being performed within the standard theatre session and additional patient benefit.
- The service had bid for the new theatre to be dedicated to emergency rather than elective surgery. They were committed to improving the emergency pathway as this in turn would ease the burden on the elective pathway, helping to reduce cancellations. Ward staff in areas such as trauma and orthopaedics also highlighted this and supported it.
- Service leads were working on a laparotomy pathway in response to the national audit results. They also told us about a theatre productivity programme or 'surgical work stream' to improve patient-focused pathways through surgery.
- Divisions A and C had begun a joint project to improve kidney transplant times. Funding of £500,000 had just been agreed to allow for an extended theatre list from Monday to Friday to achieve this goal.
- Ward J2 had secured funding via the trust and a number of fundraising events which was to go towards landscaping a garden and outdoor area for patients and relatives.
- On ward J3, they were focusing on developing pathways for GPs to refer straight into this area. Owing to medical staffing this had not yet been implemented but ward leads hoped this would help ease the blockages to accessing services.
- The system of 'red and green days' had been introduced to highlight when surgical services were at particular risk of delays and cancellations so that staff could plan accordingly.
- There was a 'grow your own staff' initiative to help HCAs already working on a ward through their registered nurse training to try and improve staff retention in surgery.

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

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 eight open beds) over two floors and provides care for general medical, surgical and specialist liver services. Two beds in the side rooms, were kept as escalation beds for any surges in capacity. Between September 2015 to August 2016 care was provided for 941 patients.

The Neuro-Critical Care Unit has 23 critical care beds over two floors and provides specialist neuro-critical care and trauma critical care. Between September 2015 to August 2016 care was provided for 1066 patients.

The Intermediate Dependency Area has 12 beds and is an open unit for the escalation of ward patients requiring closer monitoring. 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). Between September 2015 to August 2016 care was provided for 1146 patients.

During the inspection we visited all the areas providing critical care and spoke with over 30 members of staff including consultants, junior doctors, nurses, allied health professionals and health care assistants. We also spoke to

15 patients receiving care or their relatives, examined 10 sets of electronic patient notes and observed care being provided within this service. We reviewed a range of data including staff rotas for May and June 2016 and the critical care minimum data sets provided to us by the unit.

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Summary of findings

We rated the critical care services provided at Addenbrooke's hospital as good overall, with caring and effective as outstanding.

- There was a good reporting and learning ethos throughout the unit. Staff told us that there was a “no blame culture”. Duty of candour was understood and discharged appropriately by staff. Morbidity and Mortality meetings were open to all staff which contributed to a positive learning and open culture across all disciplines of staff.
- Since the previous inspection in 2014, there had been significant improvements made in relation to nurse staffing levels, meaning that nurse staffing levels were sufficient to meet with the Faculty of Intensive Medicine Standards.
- There had been a dedicated supervisor introduced. Staffing levels, as well as patient acuity and dependency were reviewed five times per day to ensure that staffing levels remained safe and that patients were receiving high quality care.
- The previous inspection in 2014 had identified that data collection and upload to the Intensive Care National Audit and Research Centre (ICNARC) had been stopped, meaning that data had not been submitted for two years.
- However we found on this inspection that there was a dedicated team for ICNARC data collection, consultant engagement for review and accuracy check, mid-month review of any trends and themes, and training provided to staff, which included other staff being able to input data. Data had been submitted since quarter four 2015.
- There were numerous examples of outstanding team work across medical, nursing and allied health professionals. Staff worked collaboratively to provide the highest possible care for patients. Feedback from patients and relatives during our inspection was very positive. We saw examples of innovations from the focus groups, which were recorded and logged onto an action plan.
- The critical care Rapid Response Team (RRT), provided outreach services into wards, proactively

identifying patients who would benefit from closer monitoring. The team also ran bed side teaching as well as delivered on a number of internal courses, providing support and education to ward teams.

- There was a strong culture of service improvements and research. There were a number of research studies ran by the National Institute of Health Research (NIHR) studies, which the critical care unit were involved in. We saw poster presentation that had been presented at National conferences in 2016.

However:

- Data from the East of England critical care network showed that between April 2015 and March 2016 there were 776 delayed discharges (discharges delayed between 4-24 hours). It was recognized that the critical care unit was working hard to improve this by early identification of patients that could be discharged and escalating to the control and command centre. Bed capacity throughout the hospital contributed to these delays.
- The result of these delays meant that 32 patients in September 2015 across critical care, were transferred between 10pm and 7am. However, it was noted that numbers had been declining since the early months of 2015 to the latter months. This was due to actions, such as early identification of patients ready for discharge in the day and escalation to the control room.
- During August 2016, seven patients had been identified as requiring level one care, but remained on the unit. We were not assured that mixed sex breaches were being robustly reported, as we were told that only those delayed “overnight” were reported internally but not declared externally.

Critical care

Are critical care services safe?

Good



We rated safe as good because:

- There was an open culture around incident reporting and well established avenues for learning from incidents.
- Staff were very knowledgeable of duty of candour and we saw evidence of how this had been discharged in practice.
- There was clear learning from results of the safety thermometer. We saw evidence of how investigations and learning had taken place, for example in relation to a pressure ulcer.
- There was good compliance with hand hygiene and the use of personal protective equipment.
- There was a good working relationship with the pharmacist. Medicine safety information and learning was clearly displayed on a staff notice board.
- Records were completed including relevant risk assessments.
- The Rapid Response Team provided an excellent service in assessing, monitoring and planning care for deteriorating patients.
- Medical staffing met the requirements of the Core Standards for Intensive Care (2013).
- Nurse staffing levels were sufficient to meet with the Faculty of Intensive Medicine Standards, and levels were reviewed five times per day.
- There was a dedicated supernumerary clinical coordinator on all day shifts, and a bleep holder during the night.

However:

- Storage space was an issue and the ICU appeared very cluttered with equipment.
- Patient care plans were not fully developed on the Epic system. However this was an ongoing project with a dedicated lead who was continually working to develop care plans relevant for a critical care setting.
- Not all staff had been trained to safeguarding level 3 children.
- Mandatory training rates for medical, nursing and administration staff were all below trust target.

Incidents

- Between October 2015 and June 2016 486 incidents were reported. 475 incidents resulted with no harm and deemed as low risk. Nine incidents were considered moderate and two were recorded as severe.
- Between July 2015 and June 2016 two serious incidents (SI) were reported which were classified as: Confidential information leak/ Information governance breach meeting SI criteria and Surgical/ Invasive procedure meeting SI criteria.
- No Never Events were reported during July 2015 and June 2016. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There was an open culture of incident reporting throughout the unit. For example a member of the medical staff told us of an incident regarding a medication omission. They explained how this had been identified and reported by a doctor, who also informed the patient and family and carried out duty of candour (the duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provides reasonable support to that person).
- We observed an incident being discussed in a multi-disciplinary team meeting in relation to a patient undergoing a surgical procedure. The incident had been reported, and was in the early stages of investigation.
- Three root cause analysis were reviewed. All investigations had been completed had an action plan to support any learning or changes in practice. For example an incident in relation to the cleaning of a tracheostomy airway had resulted in a change of clinical practice. The guideline which had been subsequently updated in 2016 and staff had been communicated of the change through email and team meetings. Another example involved a specific piece of equipment. The outcome of this investigation had led to the withdrawal of the equipment until a full protocol had been written to ensure that there was a clear protocol in place. This was in progress of being completed at consultant level.
- Four Mortality and morbidity meetings were held jointly with the Neuro Critical Care Unit (NCCU) with a further four individual meetings held during the year, where

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readmissions within 48 hours were discussed. All staff were invited, and learning shared on: cambridgecriticalcare.net. One member of staff told us how beneficial the meetings were and that they were open to all staff that supported a learning environment.

Safety thermometer

- Safety thermometer data was displayed on a board in the entrance to critical care areas.
- In June 2016 there had been one unavoidable grade three pressure ulcer on ICU. We reviewed the root cause analysis, which had identified that all possible actions had been taken to prevent the pressure ulcer from occurring. Learning from this incident had been disseminated to staff.
- Between June 15 and June 16, three falls were reported (one on ICU and two on NCCU). No harm was caused to the patients involved. There were no themes identified, and in all three cases staff were with the patient who lost their footing and lowered to the ground.
- Between June 2015 and June 2016 no catheter acquired urinary tract infections were reported.

Cleanliness, infection control and hygiene

- Compliance with infection control care bundles in May 2016 showed compliance against the trust target of 95%. Hand hygiene 99.3%, central line insertion 97.6%, renal dialysis catheter care 98.3% and urinary catheter 96.9%.
- The cleaning audit for July 2016 achieved 98% in cleanliness.
- We observed nursing and medical staff complying with good hand hygiene practice, by using alcohol rub, washing hands and wearing personal protective equipment.
- Staff were bare below the elbows and complied with trust infection prevention and control policies.
- There was sufficient personal protective equipment available for staff including visors when required.
- There had been no reported MRSA infection since February 2012.

Environment and equipment

- A variety of equipment was checked including infusion pumps, cardiac arrest trolleys, difficult airway trolleys, blood gas analyser, oxygen and patient transfer trolleys. Overall equipment was found to be clean, in good working order and had safety check compliance

stickers, stating when the equipment was due to be re checked. However we found one arrest trolley in neuro critical care which had five daily checks missed over a period of three months.

- Both units had a difficult airway trolley, which were introduced following learning from a difficult intubation, and included guidelines on tracheostomy insertion. These were clean and we reviewed daily checks for the past month which were all completed.
- We reviewed the July and August 2016 checks on four patient transfer trolleys, and these had been completed.
- In Intensive Care Unit (ICU) the corridor area appeared very cluttered with equipment, and a resuscitation bag was found on the floor under a sink. We brought this to the attention of staff at the time.
- There was an internal lift between the two floors of the ICU unit, however this was for equipment only as it did not accommodate beds.
- 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
- 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

- Between January 2016 and March 2016 the intensive care unit had 18 recorded medication incidents. All incidents recorded did not result in any harm to the patient.
- There was evidence of learning from medication incidents. For example we reviewed two incidents in relation to a nasogastric feed and fluid administration. Both incidents identified learning needs, were recorded in the units "communication book" and fed back to staff through "theme of the week" communication. Learning was shared and discussed at fortnightly meetings. We were told by nursing staff that the 'Medicines Matter' newsletter was available on the intranet and was shared with staff. Medicine safety information and learning was clearly displayed on a staff notice board.
- The Rapid Response Team (RTT) were in the process of developing some patient group directives (PGDs). (PGDs

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provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor).

- The pharmacy department operated a seven day clinical service to the JVF critical care unit with 3 hours of appropriately trained Clinical Pharmacist time on a Saturday and Sunday. We were shown four examples of pharmacist interventions made on one Sunday. One example highlighted the importance of checking the length of antibiotic treatment at the correct dose. This intervention improved the treatment of the patient which might not have been identified until the Monday. Nursing staff said "the pharmacist here is brilliant. They pick up near misses. The seven day service is invaluable."
- Medicines were stored securely with secure access limited to nursing staff. Controlled Drugs which require special storage and recording were stored following good guidance procedures including daily checks by two nurses on quantities and records. Medicines requiring cool storage were stored appropriately in locked medicine refrigerators. Daily temperature records for the medicine storage room and for the medicine refrigerator documented that medicines were stored within safe temperature ranges.
- A pilot of a new automated drug dispensing system was due to take place on NCCU in November 2016. This new system would allow rapid access to medications and records the drug and which patients it is given to. There were a number of plans to support this pilot in place such as rolling training programme to staff and the integration with the Information Technology Epic system.

Records

- All clinical and nursing notes were documented electronically on the Epic system. All members of the multidisciplinary team put their notes on the electronic patient record, allowing for ease of access and review of notes.
- We reviewed 10 sets of notes. Records were comprehensive and completed by the multidisciplinary team. For example one set of records had all evaluations of care completed including intravenous line and skin integrity risk assessments.
- Each patient record had a number of assessments that required completion. For example there was a clear plan

in place in one set of records for the weaning off ventilation post-surgery. Consent was recorded by the physiotherapist, and there were daily reviews by the dietician.

- Between January 2016 and August 2016 in ICU between 91-100% of patients had Venous thromboembolism assessments completed, IDA had 96%-100% and NCCU 96-100%.
- Clinical notes included daily documentation of ward rounds, assessment of fluid status, review of sedation and evidence of input from the multidisciplinary team.
- There was a dedicated part time senior nurse who led on the on-going development of the Epic system, including developments of care plans.

Safeguarding

- Between March 2015 and April 2016 90% of medical staff had completed adult safeguarding and child safeguarding Level 1 and 2 (Level 1 provides a baseline understanding, Level 2 provides greater knowledge for those working regularly with children)
- Between March 2015 and April 2016 92% of nursing staff had completed adult safeguarding and child safeguarding Level 1 and 2. These were compliant with the overall trust target of 90%.
- Patients between the ages of 16-18 years were admitted to the unit. Between August 2015 and September 2015 a total of 49 16-18 years olds were admitted, 35 of these on the NCCU. The hospitals safeguarding team would be contacted if a young person was admitted.
- The trust completed a training needs analysis in 2016 in line with the intercollegiate document (2014) regarding children's safeguarding. Since the audit critical care areas had introduced Safeguarding level 3 to all Band 7 staff. This meant that senior staff who would be involved in the assessing and planning of care for children would be trained appropriately. At the time of inspection 24% of Band 7s had completed the training. A technical fault had occurred on the on line package, delaying completion, which was being resolved. The target was 100% by October 2016.

Mandatory training

- Mandatory training consisted of eight modules, including fire safety, infection control and basic life

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support. Between March 2015 and April 2016 80% of medical staff, 67% of nursing staff and 61% of administration staff had completed mandatory training. This was below the trust target of 90%.

- Mandatory training was monitored by practice development nurses and dates had been allocated to staff not meeting the requirements.

Assessing and responding to patient risk

- In October 2015 the trust undertook a deteriorating patient project to determine whether the service was implementing, and in compliance with, the National Institute of Excellence (NICE CG 50) guideline, 'acutely ill patients in hospital: recognition of and response to acute illness of adults in hospital.'
- The Rapid Response Team (RRT) aimed to see patients within 30 minutes of referral. Data for this target was not collected, however there was ongoing work to look at how data could be captured on the IT system of when the patient was referred to when they were seen.
- All patients who were discharged from ICU into ward areas were seen within 24 hours by the RRT team. Prior to transfer to wards all patient had three sets of MEWS scores recorded.
- There was a dedicated RRT flowchart on Epic which used the Situation, Background, Assessment and Recommendations (SBAR) format, which is a tool to provide clear communication, and included the Airway, Breathing, Circulation, Disability and Environment (ABCDE) assessment of patients.
- Referrals to the RRT team were made via a bleep, or could be requested via Epic system for review. The service which was available 24 hours per day. Patients were triaged for review by the team, based on their Modified Early Warning Score (MEWS), or if staff felt concerned by the patients clinical condition. The RRT would admit patients into the Intermediate Dependency Area (IDA) unit, if clinically indicated.
- In March 2016 1000 patients were seen by the RRT team, in April 800 and in May 850. Data was captured by Epic, and there was on going work to capture additional data such as telephone advice given, type of patients referred and time in which patients were reviewed.
- Monthly "track and trigger" audits were completed in all the critical care areas. Three areas were audited:

observations carried out as per prescribed frequency, MEWS scoring and action taken if MEWS scored above three. Between March 2016 and August 2016 all areas achieved the 95% target.

- All patients on high flow oxygen were reviewed daily by the physiotherapist and physiotherapy input was initiated at the start of the patient stay.
- On admission all patients had a treatment plan discussed with Consultant in Intensive Care Medicine as recorded on Epic.
- In the ICU multidisciplinary meeting we attended, the consultant microbiologist was present. Patient's sepsis markers were discussed using the "fever sheet" on Epic to review, for example antibiotic therapy and further investigation, if a patient's condition were deteriorating. All patients with intravenous lines and sepsis were reviewed to establish if lines could be removed early.
- All patients were assessed hourly using the Richmond Agitation-Sedation Score (RASS- a tool to detect delirium in intensive care unit patients)- to monitor signs of delirium.

Nursing staffing

- The Intensive Care Unit (ICU) nursing establishment was planned for 15 level three patients (requiring advanced airway support or support of two or more organs) and three level two patients (requiring single organ support). The Faculty of Intensive Care Medicine / Intensive Care Society Core Standards for Intensive Care Units 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 an 18-bedded unit, two supernumerary nurses should take on a leadership role within the department. The planned daily establishment for the Intensive Care Unit was 23 nurses (including the two supernumerary nurses).
- Staffing level across ICU, NCCU and IDA were reviewed five times over a 24 hour period to ensure safe staffing and in line with changes of acuity across the units. Managers from all three units worked collectively and spent time reviewing electronic rostering rotas to ensure that staffing was managed.
- Rotas were reviewed from ICU and NCCU for May and June 2016. Recommended staffing levels had been met during both months. Staff were occasionally moved from other unit. For example in June 2016 in NCCU four different shifts were supported with staff moved from ICU and one member of staff from the bed management

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team. For the same period in ICU two nurses were moved to support the intermediate dependency area. Agency staff had not been used in the unit for the past year.

- Any non-compliance in of staffing levels in line with ICS standards were reported to the trust board. We reviewed business unit meeting minutes from May and June 2016 and no adverse staffing levels had been reported.
- There was a dedicated supernumerary clinical coordinator on all day shifts. Overnight the coordinator held a dedicated bleep as they were not supervisory.
- Nursing turnover rate between March 2016 and April 2016 was 6% lower than the trust target of 11%.
- Nursing sickness rates between March 2015 and April 2016 was 4%, higher than the trust target of 3%.
- The RRT team ran a 24 hour service and consisted of 1.5 whole time equivalent (WTE) band seven nurses and 11 WTE Band six nurses.
- Nursing handover occurred at each shift change known as a “pod huddle”. The “pod huddle” consisted of staff dedicated to look after a group of patients, and the nurse in charge of the “pod” who would have an overall view of the patient’s condition, and would oversee skill mix and breaks.

Medical staffing

- A team of twelve consultant intensivists participate in the rota. A minimum of two consultants are on site from 8am to 8pm, with the on-call consultant frequently staying much later. Care over the weekend is consultant-led. This met the requirements of the Core Standards for Intensive Care (2013) for medical staffing, in which consultant range should not exceed 1:8 - 1:15 and the ICU resident patient ratio should not exceed 1:8.
- Neuro critical care unit (NCCU) was covered by ten intensivists holding dual FFICM and FRCA accreditation, fifteen higher-grade clinical fellows and two FY2 doctors.
- There was an on-call neuroanaesthesia registrar and one on-call NCCU consultant who responded to all referrals to the unit.
- The ICU consultants do at least two ward rounds per day. On Sunday evening the ICU weekend consultant does an hour long telephone handover to the incoming ICU long-week consultant
- There are three layers of junior doctors staffing: Foundation year 1(F1s) worked day shifts only with protected training time on Friday afternoons provided by the foundation school.

- Junior tier (FY2s and core trainees) – dedicated to ICU but allowed time with Rapid Response Team if the workload allows. Senior tier (ST3s and above – anaesthetics, ICM & acute medicine trainees; clinical fellows) spending 2/3 time on ICU, 1/3 with Rapid Response Team (RRT).
- There were two protected handover times. One at 8am, which included a full multi-disciplinary team (consultants and junior doctors, nurse-in-charge, physiotherapists and ODP) and one at 8.45pm for the day-to-night teams (junior doctors).
- The RRT medical team provided a 24 hour service. There was daily consultant cover from 8am to 8pm and an on call ICU consultant overnight. There was also an ICU registrar available 24 hours per day.
- Locums were not used as the unit maintained their medical staffing numbers.

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
- During our inspection an IT issue had occurred throughout the trust. Both ICU and NCCU had responded accordingly. For example, there was representation at the internal incident meeting, staff in both units had printed off documents such as prescription charts to ensure medications would continue to be administered and recorded.

Are critical care services effective?

Outstanding



We rated effective as outstanding because:

- Risk adjusted acute hospital mortality ratio in ICU was 0.92, better than similar units and in NCCU, risk adjusted acute hospital mortality ratio was 0.89. This was also better than similar units and within the ‘lower than expected’ range. This showed that survival rate was higher than similar units, which was positive considering the complexity of patients seen in this tertiary centre.

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- The critical care units were compliant with national guidelines including the National Institute for Clinical Effectiveness (NICE) and in the use of Department of Health “High impact interventions” 2007, for example in the management of ventilated patients.
 - There were a number of audits carried out locally and national. We saw how practice had been changed in response to audits, for example in the management of “peri procedure enteral feeding in critical care”
 - Best practice guidelines and policies were reviewed and updated and changed in line with recommendations, for example in the use of chlorhexidine dental gel in ventilated patients.
 - There was a proactive dietetic team, who led on a number of service improvements. We saw numerous examples of guidelines and protocols reviewed, teaching and education on patients nutritional requirements and a number of audits and research, which improved clinical practice. Work had been presented nationally at conference in 2016.
 - The unit was compliant in 42 out of the 45 standards in the peer review carried out by the East of England Critical Care Network Operation and Delivery in April 2016.
 - There was a strong educational culture across all the critical care areas. Staff had access to an educational platform, journal clubs, bed side teaching, formal teaching sessions, clinical based scenarios as well as nursing competencies in line with the National competency framework.
 - We observed excellent examples of multidisciplinary working in ward rounds, handovers and multidisciplinary meetings. Staff worked collaboratively and supported each other in delivering care.
 - There was a clear process in place and regular assessments of patient’s mental capacity. Staff demonstrated their knowledgeable about capacity in the critical care setting, and could give examples of when deprivation of liberty applications would be made.
- However:
- 48% of registered nursing staff held the post registration Critical Care award, which was slightly below the recommended target of 50%. Plans were in place for compliance to be achieved by October 16.
- Evidence-based care and treatment**
- There were a number of local audits within the department such as audit of tracheostomy practice, improving neurological assessment and compliance with gastric feeding.
 - The unit had recently written or updated many protocols and guidelines including neuro-muscular monitoring in paralysed patients, dentures policy, tracheostomy guidelines, remifentanyl guidelines, renal replacement therapy guidelines and peri-procedural starvation guidelines.
 - Medical staff we spoke with were able to show us a number of clinical guidelines that they worked to. For example the guidelines for central venous line insertions, which was in line with Department of Health guidance.
 - 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. For example the intensive care society had released new guidance in August 2016 regarding the use of chlorhexidine dental gel. Practice had been changed in both ICU and NCCU and guidelines updated.
 - The unit had introduced a number of measures in line with the National Institute of Clinical Effectiveness (NICE) sepsis guidelines 2016. For example sepsis training had been added into training for all new starters, the intermediate life support programme and all staff were required to have a yearly update.
 - The unit had recently introduced a new guideline in “peri procedure enteral feeding in critical care”. This was following an audit which looked at the adequacy of calorie intake and continuity in feeds. This change involved feeding regimes to be continued for ventilated patients who were waiting to go to theatre (as opposed to stopping feeding) to help prevent the rapid weight loss and interrupted feeds.
 - The dietetic team submitted data to a pilot for dieticians in critical care, to establish generic dietetic outcome measures to determine adequacy of feedings and if optimal nutritional delivery was achieved. This work was on going at the time of inspection.
 - The dietician team told us that a drugs and therapeutic committee submission had been made to change the formulary regarding parenteral nutrition bags with added vitamin and trace elements, to bring in line with NICE guidance CG32.
 - An internal audit had been completed in October 2015 to monitor compliance of the management,

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deteriorating and recognition of the deteriorating patient in line with NICE guidance CG83. One example of improved practice following this audit was the work to meet NICE guidance CG83 concerning rehabilitation.

- Therefore, 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’.
- In June 2016 63 out of 76 admissions had rehabilitation assessments completed. The remaining 13 were not applicable (exclusion criteria being stay of < 48 hours or death/palliation)
- In June 2016 out of 76 admissions, 36 had a pre discharge assessment completed. 31 were not applicable and nine had not been completed.
- The Confusion Assessment Method (CAM) for delirium that had been used in ICU in line with NICE guidelines 2010 had been validated for use in NCCU. This had improved assessment in neurological patients, and aided assessment of delirium as opposed if patients were frustrated or trying to communicate.
- We saw the comprehensive trust guidelines for management of tracheostomy in line with NICE (IPG462) guidelines. There was a dedicated tracheostomy nurse consultant who led the trust wide team, which reviewed all patients with a tracheostomy.
- A service evaluation of feeding critically ill patients had been carried out on 2014 as part of the units participation in the International Nutrition Survey. The results showed that there were interruptions and stopping of feeds, primarily for patients waiting for theatre. This was reviewed as part of the “peri procedure enteral feeding in critical care”, as previously referred to.

Pain relief

- A new pain assessment tool had recently been uploaded onto Epic which used a pain score of one to ten as well as recording facial expressions.
- Patients could be referred to the hospital pain team. We observed a ward round in which two patient with complex pain needs had in-depth assessments completed in conjunction with the pain team clinical advice.

Nutrition and hydration

- The dietetic team consisted of three whole time equivalent staff, which covered ICU, NCCU and IDA.

- There was a dedicated dietician to those patients who undergo transplantation.
- Patients had a nutritional risk assessment completed within 24 hours of admission.
- There was a clear nasogastric feeding protocol, which directed staff on feeding rate and how to check feed was being absorbed.
- An audit had been conducted in 2016 to review compliance with the 24 hour gastric feeding protocol (commencing feeding as early as possible). The results showed in ICU 100% of patient feeds were commenced and in NCCU 85% of feeds were commenced. A review had been completed for the patients in NCCU and it was established that feeding was not started in all cases due to clinical condition.
- A business case had been proposed to source additional protein supplements to ensure that critically ill patients have the appropriate feeds to meet their protein requirements. The outcome was not available at the time of the inspections.
- The dietetic team produced newsletters for staff. These included updates on clinical practice such as gastric feeding protocol and changes to gastric residual volume (GRV), which had been increased to improve nutritional delivery and reduce inappropriate feeding stoppages. Staff told us they received these letters, and they were also displayed in staff areas.
- On IDA there was a dedicated folder for staff which included assessments for malnutrition, out of hours feeding regimes and how to access specialised diets.
- We saw a number of posters in the units to guide staff on nasogastric management and awareness of re feeding syndrome (is a syndrome consisting of metabolic disturbances that occur as a result of reinstitution of nutrition to patients who are starved, severely malnourished or metabolically stressed due to severe illness)

Patient outcomes

- The John Farman Intensive Care Unit/High Dependency Unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The latest ICNARC data available at the time of our inspection was for the period from April 2015 to March 2016.

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- ICNARC data showed that in ICU unplanned admissions from the emergency department (17.4%) were lower than similar units (28.7%). Planned admissions following elective surgery (8.6%) were lower than similar units (10.6%); however, unplanned admissions following elective surgery (8.0%) were higher than similar units (3.2%). Transfers from other critical care units (19.7%) were higher than similar units (8.3%). However, this reflects that the unit is a large, tertiary centre for neurosciences and trauma intensive care, and patients are transferred into both ICU and NCCU.
- ICNARC data showed that in ICU, unit-acquired infections in the blood (rate per 1000 patient days) of 3.2. This was higher than similar units (2.1) but within the 'lower than expected' range.
- Risk adjusted acute hospital mortality ratio with a predicted risk of less than 20% was 0.59 in ICU. This was better than similar units and within the 'lower than expected' range.
- The Neurosciences Critical Care Unit (NCCU) contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The latest ICNARC data available at the time of our inspection was for the period from April 2015 to March 2016
- ICNARC data for NCCU showed that unplanned admissions from the emergency department (27.2%) were higher than similar units (16.2%). Planned admissions following elective surgery (22.7%) were higher than similar units (8.1%), unplanned admissions following elective surgery (4.8%) were higher than similar units (2.5%). Transfers from other critical care units (6.7%) were higher than similar units (4.1%).
- ICNARC data showed unit-acquired infections in the blood (rate per 1000 patient days) in NCCU of 1.6. This was lower than similar units (2.6) and within the 'lower than expected' range.
- Risk adjusted acute hospital mortality ratio was 0.89 in NCCU. This was better than similar units and within the 'lower than expected' range.
- Risk adjusted acute hospital mortality ratio with a predicted risk of less than 20% was 0.63 on NCCU. This was better than similar units and within the 'lower than expected' range.
- There was evidence of participation in a number of national audits, such as the National Cardiac Arrest Audit, and rehabilitation after critical illness (National Institute of Clinical Effectiveness CG-83).
- Each patient should receive a rehab assessment within 24 hours of admission to critical care. The trust was achieving 70%. A flow sheet was in the process being built into Epic to ensure 100%.
- A peer review was carried out by the East of England Critical Care Network Operation and Delivery in April 2016. The audit looked at compliance against the service specifications for adult critical care standards. The unit was compliant in 42 out of the 45 standards. Four standards were partially met, and three were non-compliant. The non-compliant areas were the provision of physiotherapy cover seven days per week, number of registered nurses who have completed the critical care course and delayed discharges.
- We observed an early rehabilitation session. This involved mobilizing a ventilated patient. Early mobilization therapy is an evidence-based intervention recommended to prevent or improve critical care-acquired weakness. Staff told us that the practice of early mobilisation and getting patients outside was embedded practice across all three areas.

Competent staff

- The trusts target for appraisals was 95%. Between April 2015 and March 2016 100% of administration staff had appraisals, 93% of medical staff and 96% of nursing staff.
- Nursing revalidation was flagged on the e rostering system. Staff due to revalidate received an email to remind them. To ensure compliance, staff could not add any requests onto e rostering until their revalidation had been completed.
- There was protected teaching for one hour per week for junior doctor with consultant contributions.
- There was optional teaching for medical staff before morning handover on Friday mornings; participation in the NCCU teaching programme was encouraged.
- Nursing staff new to critical care received a six week supernumerary period to develop competencies. Staff completed two levels of competency (the National Competency framework for Registered Nurses in Critical Care), which included drug administration, competency in using equipment and management of the acutely unwell patient.

Critical care

- New staff had the opportunity to rotate throughout the unit to develop skills, and experience different teams.
- There was a Clinical Nurse Educator responsible for coordinating the education, training and Continuous Professional Development.
- 48% of registered nursing staff held the post registration Critical Care award, which was below the recommended target of 50%. Plans were in place for compliance to be achieved by October 16.
- Across Critical Care there were in total of 129 staff skilled to care for patients on hemofiltration. All new staff had to achieve this at the end of their competency training. 28 staff were in the process of completing this and due to complete by November 2016.
- 100% of staff had achieved competency in using the blood gas analyser.
- The unit ran ad hoc training scenarios, in which the practice development nurse would lead. The sessions included medical and nursing staff. An example given was a recent session for the management of cardiac arrest. A debrief would be held after the scenario, discussing what went well, reflective accounts and identification of any competency concerns.
- All band 6 and Band 7 nurses had completed the advanced communication skills training. This training developed staffs ability in communication, especially in breaking bad news. The plan was to roll the training out to Band 5s across the unit.
- The RRT team ran three courses throughout the year on the management of the deteriorating patients, as well as providing ad hoc training to wards and teaching at a local university to pre-registration and post registration nurses.
- Four members of the RRT team had completed their non-medical prescribing course.
- All staff received sepsis training through a number of training routes, including new staff induction, basic life support, intermediate life support, the critical care course, and seminar and poster presentations. In August 2016 update training was rolled out to all staff to in line with the new NICE 2016 guidelines. 90% of all new staff had completed this training between 1st September to 21st September 2016.
- The delirium training was available through seminar sessions and the competency framework. From August 2016 48% of all registered nurses had completed the delirium refresher training package, with the target of 100% by October 2016.

Multidisciplinary working

- Meeting minutes from June 2016 were reviewed from the joint critical care governance and education meeting, which involved another acute trust. Minutes reflected multidisciplinary working for example discussions with dietetics and physiotherapists. Individual cases were reviewed of patients who had been transferred between units.
- A weekly multi-disciplinary rehabilitation meeting was held, where all patients were discussed and their rehabilitation prescription updated. These meetings were led by the dedicated rehabilitation specialist nurses.
- During the inspection we attended the multidisciplinary meetings in ICU and NCCU. Both meetings had representation from medical staff, dietetics, nursing, physiotherapist and occupational therapists. Patient pathways were discussed and recorded.
- We observed a ward round on the ICU unit. The multidisciplinary team were engaged during the round, and there was good communication and plan of care discussed for the patient.
- The RRT team told us that they felt well received throughout the organisation, and that there was a good working relationship which meant referrals were made pro-actively.

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 dietetic team provided cover Monday to Friday 8am to 5pm, with weekend cover from 9am to 5pm via a bleep system.
- The specialist nurses in organ donation were available 24 hours per day, seven days per week via a bleep system.
- The physiotherapist was available Monday to Friday with an on call service at the weekend.
- There were four dedicated acute respiratory physiotherapists from 8.30am to 4.30 am on the weekend to cover the critical care units. Overnight there was an on call service.
- The rapid response team was led clinically by a consultant and an outreach nurse with training in critical care. This service was provided 24/7.

Critical care

- Radiology services, including access to urgent CT scans were available 24/7.
- The pharmacy team provided a seven day service including Bank Holidays to ensure better medicine optimisation outcomes for patients.

Access to information

- All patient discharged from the unit had a detailed discharge summary completed, outlining key events on the unit and outstanding issues requiring management.
- Three discharge summaries were reviewed and all were completed appropriately.
- 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 aide on-going management within the community.
- There was a dedicated “white board” on the unit which identified what beds patients were in, level of care and consultant. This was covered with a dignity screen that maintained patient confidentiality. During the inspection this was in use and staff would raise the screen if they need to view the board.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients had a Mental Capacity Assessment (MCA) completed twice a day, or if there were any clinical changes in their condition. Ten sets of notes were reviewed and all patients had twice daily assessments completed. 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).
- The units would use posy mitts (mittens used for patients who disrupt medical treatment by pulling at their IV line/catheter), or arm splints for patient who may become agitated, following a MCA assessment and application of Deprivation of Liberty(DoLS). There were no patients on the units at the time of the inspection that required theses interventions.
- The unit worked closely with the safeguarding lead. Any patient, who required additional nursing supervision for example if they were agitated, had a Deprivation of Liberty safeguard application completed. There were no patients who required a DoLS, at the time of our inspection.

Are critical care services caring?

Outstanding



We rated caring as outstanding because:

- Staff provided compassionate care to patients. We saw staff talking to patients and explaining procedures, even if heavily sedated.
- Relatives gave overwhelming praise and positive feedback to all of the staff involved in their loved ones care.
- Staff were seen to go the extra mile in providing care to patients, for example enabling a patient to go home for their birthday.
- Relatives told us that they felt involved in the loved ones care, and that information available in the relatives room, for example on touching their relatives, had been invaluable.
- Staff listened to patients and relatives concerns and responded proactively, for example in extending visiting hours.
- Patients and their families could access a number of different staff for emotional support, including the chaplaincy service and psychology services.

Compassionate care

- A senior physiotherapist enabled a patient who had been ventilated on ICU for more than 100 days to go home for the day on a ventilator to celebrate their 80th birthday with friends and family.
- Staff helped a ventilated patient attend Sunday mass in the hospital faith room.
- A health care assistant had developed a ‘pampering box’ of beauty products which could be used for patients.
- A memorial service was organised to commemorate the lives of patients who had died on the intensive care unit. The first service was held in 2016, and both staff and families had attended the service.
- 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. We also saw a staff member using a communication board with a patient, who had limited speech.
- The Rapid Response Team (RTT) worked in “designated” areas of the hospital to enable continuity of care to patients.

Critical care

- A patient told us that the physiotherapist had assisted them for their first shower in a number of weeks, and that they felt safe, and well supported
- A staff member told us that a patient who had been on IDA for nearly a year returns every month with a cake for staff to express their gratitude.
- We saw evidence via letters that two relatives had wrote to the IDA unit after their relative's death. One spoke of how staff had been very anxious but the doctors and nurses guided them through this difficult time. Another relative had written that their relative has rapidly declined and that staff were honest and did not give false hopes.
- Each patient has a "patient profile". This provided information to staff, for example, patient's preference of name, hobbies and interests and if they wore dentures or glasses. This provided a holistic approach to the patient's needs.
- A forget-me-not symbol was used to identify those patients living with dementia.
- We observed a member of staff administering pain relief to a patient, and following up with reassurance, informing the patient they were close to them and would be by the bed with them.
- We observed care on IDA being delivered to a patient. Staff spoke with the patient, and provided re assuring prompts such as "you are doing really well"
- We heard staff talking to patents about their jobs, for example a member of the nursing team was asking the patient about their career, and how they enjoyed it.
- One patient told us that the staff were "exceptional" and that "everyone had been wonderful"
- Staff were observed introducing themselves to patients, curtains were pulled closed when care being delivered and staff knocked on side room doors before entering.
- Inpatient surveys showed that families of patients in the unit found the restriction of visiting times difficult, as patients were not always accessible due to having investigations, or timing was difficult for family to visit. The unit had responded to this by introducing an open visiting culture for a three month trial period which was due to end in November 2016.
- In the relatives room, staff had developed a notice board, in which information such as ward round times, could be displayed. Families had fed back to staff how it would be useful to have guidance on how they could touch their loved ones, whilst they were being monitored by various pieces of equipment. Following this, staff had produced information on how families could touch their loved ones, for example holding hands and assisting in personal care.
- We spoke with 15 relatives or patients. One family stated that everyone was "super" and could not fault the care. They stated that their relative had a daily timetable and daily target chart at their bed space. The enabled the family to be involved in their rehabilitation phase and ensured that they understood goals set and how the day was structured. The family stated that they were kept updated, as they were waiting for a bed at a dedicated spinal unit.
- One family stated that staff were "amazing" and nothing was too much trouble. They told us that they had used the onsite accommodation which had been very good, and allowed them to visit when they wanted to.
- A family told us that staff were "incredible", and explained everything to them. They told us that staff also supported them in ensuring that they had rest periods and always checked on them if they had been upset. They told us that staff always spoke to patients and explained what was going on and if they were giving care for example brushing the patient's teeth.
- A patient told us that they had not originally wanted a particular procedure done to them. They told us they were involved in all of the discussions regarding their care, and had tried a number of options, before undergoing the procedure, which was clinically needed.
- During the inspection we observed two multidisciplinary meetings. Following the teams meeting staff met with the families and patients to discuss plans, for example in relation to rehabilitation, nutrition and patient pathways.
- Feedback had been received from patients and families, that to help patients "piece together" the time they had

Understanding and involvement of patients and those close to them

- Families were given information packs when their loved ones were admitted, to provide information such as car parking, visiting, introduction to the ward team and therapies offered, such as pet therapy.
- We saw the use of the pet therapy dog. One relative told us that the pet therapy was very important to the patient as they had a dog at home. Since then the family had brought the patients' own dog into the garden so the patient could see them.

Critical care

spent in ICU or NCCU, they wished to take a photograph of the patient. After an agreed process was formalised (including working with the legal department), patient's photographs would be taken during their stay by medical photography, stored with the trust and then the patient could request a copy if they wished to do so, once they were able to consent.

- We saw a large, colourful, "rehabilitation chart" for a patient who had been in the unit for a substantial length of time. The chart was positioned so that the patient could see and work towards their goals.
- We observed a member of staff setting up a ventilator on a patient. The member of staff explained what they were doing, and spoke to the patient throughout.
- One relative stated that the physiotherapists were "brilliant" and explained everything and offered choices.

Emotional support

- There were three dedicated nurse specialist, who offered support for patients with complex needs. For example, families were provided with information on other services they could access to assist with financial or legal advice.
- Patients could be referred on to the hospital psychology services. The services supported patients and provided opportunities for patients to return to the critical care wards. This often helped in linking memories such as sound, to the patient's experience.
- Patients could be referred to a dedicated drugs and alcohol service.
- We observed that patient's psychological wellbeing was discussed in multidisciplinary meetings. For example discussion was held regarding a patient who may have benefited from going outside into the garden, or be seen by the pet therapy dog.
- There were six Specialist Nurses for Organ Donation (SNODS). The nurses supported families and staff through the organ donation process, which included completing last offices, taking hair locks or hand prints for memory boxes and following up with families once the retrieval had been completed.

Are critical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Data from the East of England critical care network showed that between April 2015 and March 2016 there were 776 delayed discharges (discharges delayed between 4-24 hours). Bed capacity throughout the hospital contributed to the delays.
- The result of these delays meant that 32 patients in September 2015 across critical care, were transferred between 10pm and 7am. However, it was noted that numbers had been declining since the early months of 2015 to the latter months.
- During August 2016, seven patients had been identified as requiring level one care, but remained on the unit. We were not assured that mixed sex breaches were being robustly reported, as we were told that only those delayed "overnight" were reported externally, and those not overnight were reported internally.

However:

- Patients discharged from critical care were followed up via an outpatient appointment. The appointments offered patients support and referral (if required) in relation to on-going rehabilitation needs as well as psychological support.
- There were numerous communication aids used, to help facilitate communication for patients, for example I pads and communication boards including pictures and letters of the alphabet.
- Repatriations were managed in a timely manner. Instances on when repatriations were delayed were escalated accordingly to the senior management team. Between April 2016 to August 2016 four repatriations were delayed more than 48 hours. Delays were caused by the availability of specialist neuro rehabilitation beds in conjunction with the demographics of patients.
- Complaints were managed and investigated. Learning from complaints was shared with staff.

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 NCCU 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
- Families were offered two nights free accommodation when a family member was first admitted to the unit.

Critical care

After this period families were offered reduced cost accommodation on the hospital site. This meant that families, who did not live in the area, could stay and be with their loved ones.

Meeting people's individual needs

- There were three specialist nurses whose role was to support patients and families who had complex needs. For example on admission families would be signposted to other organisations to support with financial help, or legal support, drug and alcohol services as well as charitable organisations which offered support outside of the hospital.
- Patient could access psychological support through referral to the hospital psychology service.
- Follow up clinics were offered to all patients discharged and were held twice a week. The clinics were consultant or nurse led and offered patients support and referral (if required) in relation to on-going rehabilitation needs. The service also offered the patient the opportunity to visit the unit, to help support the psychological recovery of being nursed and cared for in a highly intensive environment.
- Patient diaries were used 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. Patient diaries were also reviewed during follow up clinic appointment.
- There were a number of bariatric chairs available for patients, and bariatric beds were sourced from an external company if required.
- In the ICU multidisciplinary meeting we observed a discussion regarding a patients wish that the management of a patient who had requested for an intravenous line wish regarding an intravenous line not to be removed. Advice was sought from a clinical perspective and the patients request was upheld.
- Staff could access the trusts translation services if required.
- Staff used iPads to help communicate with patients who could not speak. There were also alphabet boards, paper, pens and pictures to support patients in communication.
- A new dementia lead had recently been appointed. The lead was working with the critical care units to look at

best practice in critical care settings, for example reviewing how frailty and dementia screening was assessed when patient were often sedated and ventilated

Access and flow

- Between June 2015 and May 2016 the critical care bed occupancy for adults ranged between 76% to 78%, consistently below the England average of 80%.
- ICU had two contingency beds which would be opened if required in times of capacity surge. This would be managed though the dedicated coordinator.
- Between September 2015 and August 2016 no non-clinical transfers had taken place (transfers that are made by local capacity shortfall as opposed to clinical need).
- ICNARC data from April 2015 to March 2016 for ICU showed: There were 162 delayed discharges of more than eight hours, or 2.2% of the 7320 available bed days. This was better than similar units nationally (5.0%).
- There were no non-clinical transfers out of the unit. This was better than similar units nationally (0.4%).
- There were 15 (3.1%) out of hours discharges from the unit. These are discharges which took place between 10pm and 6:59am. This was worse than similar units nationally (2.5%).
- ICNARC data from April 2015 to March 2016 for NCCU showed: There were 255.6 delayed discharges of more than eight hours, or 3.0% of the 8418 available bed days. This was similar to similar units nationally (2.8%).
- There were 15 (1.5%) non-clinical transfers out of the unit. This was worse than similar units nationally (0.6%).
- There were 34 (4.6%) out of hours discharges from the unit. These are discharges which took place between 10pm and 6:59am. ICNARC analysis showed that this was worse than similar units nationally (2.8%).
- The trust completed a retrospective review of discharges to wards occurring between 10pm and 7am in 2015. Data showed that there had been improvements of the number of patients discharged during these hours. Intensive care unit (ICU) peaked at 23 in January 2015; reducing to 10 in September 2015, neuro critical care unit (NCCU) reaching its lowest number of six in September 2015 and the intermediate dependency area (IDA) peaked at 23 in May 2015 reducing to 16 in September 2015. Overall there were 225 transfers between April 2015 to March 2016.

Critical care

- The mean length of stay on NCCU was 7.2 days. This was longer than similar units (5.3 days).
- The mean length of stay in ICU was 5.9 days which was about the same as similar units (6 days).
- The trust had developed a patient flow plan to look at way in which discharges from ICU, NCCU and IDA could be reduced between the hours of 10pm and 7am. The plan included early identifications of patients ready for discharge at the morning ward round, escalation to bed management when delays occurred and five times daily review of acuity and dependency of patients on the units.
- We saw through records and at multidisciplinary meetings, that patients discharge plans were completed and identified early in the patient pathway.
- Data from the East of England critical care network showed that between April 2015 and March 2016, there were 12 readmissions to ICU from wards and 776 delayed discharges (discharges delayed between 4-24 hours). There were no cancelled elective admissions during this period.
- Between April 2016 to August 2016 ICU had four repatriations, none of which were delayed more than 48 hours. NCCU for the same period had 15 repatriations, of which four were delayed more than 48 hours. Delays were caused by the availability of specialist neuro rehabilitation beds in conjunction with the demographics of patients. At the time of the inspection there were no patients waiting for repatriation.
- Between April 2016 and August 2016 one admission to ICU was delayed over four hours from referral out of 387 patients. In the same period for NCCU five admissions were delayed over four hours out of 426 admissions.
- Patient acuity was reviewed five times during a 24 hour period. This included reviewing patients who did not require level two or three nursing care. The Mixed Sex accommodation policy had recently been reviewed to include NCCU and ICU. This meant that all Level one patients (those patients not requiring intensive nursing care), would be considered as a mixed sex breach, if they were not transferred out to a ward setting, and remained in a mixed sex environment.
- During August 2016, seven patients had been identified as requiring level one care, but remained on the unit. We were not assured that mixed sex breaches were being robustly reported. For example we were informed

that only breaches that were delayed overnight were declared as a breach. Patients who were not delayed overnight, would be identified and escalated through to the operations centre, but not declared as a breach.

Learning from complaints and concerns

- Three complaints were reported between June 2015 and March 2016, one in the intermediate dependency area and two in intensive care unit.
- Two complaints were in relation to breakdown in communication. Relatives had met with staff and learning and been subsequently fed back to the relevant team.
- Once complaint was not upheld following the trust completing a full internal safeguarding investigation.

Are critical care services well-led?

Good



We rated well-led as good because:

- There was a clear governance reporting structure in the division. Risk registers were reviewed and high risks were clearly identified.
- There was strong leadership at ward level. Staff told us that leadership and communication had significantly improved, and gave examples of how the “8.27” (a morning meeting held at 8.27 each day) meeting facilitated communication from board to ward.
- We saw good working relationships between critical care departments, and this was reiterated by staff telling us that cross unit working had significantly improved.
- The nursing, medical and allied health professionals displayed a strong culture of placing patient’s needs first. There were patient forums that were well attended, and evidence of changes that had occurred following patients feedback.
- There was a strong culture of innovation and improvement within the departments. Both units had been involved in a number of research studies led by the National Institute of Health Research (NIHR).
- There were a number of innovative developments, for example the development of the Trauma Psychological Awareness e-learning module.

Leadership of service

Critical care

- The service is led by the clinical director, divisional head of nursing and matron.
- Senior staff told us that they felt listened to by the board and could raise concerns.
- Staff told us that the leadership of the services had significantly improved since the previous inspection in 2015. An example given was the successful recruitment of staff to ensure compliance with the Intensive Care Society core standards for ICU.
- There was consultant engagement with the ICNARC team, who worked collaboratively with the team checking data for factual accuracy.
- Staff told us that they felt confident to raise concerns with managers. One member of staff told us that they had recently contacted the chief nurse raising concerns regarding the appearance of the unit. The chief nurse had visited the unit and within two days painters had come in to decorate.
- Staff told us that senior nursing staff, for example the matron, specialist nurses and lead nurses, were visible and accessible and worked in the clinical environment, both in providing nursing care, but also supporting other nursing staff.
- The lead nurse had been rewarded for her leadership qualities by winning the East of England NHS inspirational Leader of the Year 2015 Leadership Recognition Award.
- At our inspection in April 2015 we had identified a lack of robust audit and data collection for national audit (ICNARC). This has since been addressed and the units now complete full data sets.
- Key performance indicators and any safety concerns were discussed as part of the senior staff meetings. These meetings had been redesigned to invite all staff which meant that they were fully inclusive.
- The risk registers in NCCU, ICU and IDA were reviewed. In total there were 178 risks identified. The risk register was in date, with a risk owner identified, mitigating actions and closed if resolved. All areas had identified their “high” risks, which included the lack of dedicated speech and language therapist in NCCU (however a new member of staff was due to commence in October 2016) and previously staffing levels (which had been closed since vacancies had been recruited to). However there were no set “review” dates on the system, so it was not clear if risks were being reviewed dependent on their severity.

Culture within the service

- There was evidence of good working relationships between medical and nursing staff. Staff told us that the cross unit working between the NCCU, ITU and IDA had significantly improved over the past year.
- Staff told us that there was a “no blame” culture in relation to incidents, and that learning was shared through emails, meetings and communication books.
- Staff told us that they felt proud to work in the units, and were committed to ensuring quality patient care was delivered.

Public engagement

- Patient focus groups and patient experience groups were utilised to inform future developments on the unit. An example of this was that feedback from this group had led to the refurbishment of the interview room and relative’s room.
- Two sets of meeting minutes in April and May 2016 were reviewed from the patients and relatives focus group. Meetings were well attended with over 45 patients, carers and relatives attending for one meeting. There were a good range of topics discussed such as the experience of post-traumatic stress in relatives and the role of follow up clinics after discharge. Concerns were recorded with clear actions. For example some patients

Vision and strategy for this service

- Staff we spoke with were aware of the trust vision and spoke confidently regarding providing excellent patient care and working as a team.
- Local values were displayed at reception across intensive care unit (ICU), Intermediate dependency area (IDA) and neuro critical care unit (NCCU)

Governance, risk management and quality measurement

- There was a clear governance reporting structure in the division. Monthly governance meetings were held across intensive care unit, neurological critical care unit, intermediate dependency and resuscitation. The directorate board and divisional boards meetings subsequently fed into the overarching executive board.

Critical care

had been concerned around the care received after discharge by their general practitioners. An event was discussed in which would be open to General practitioners to develop relations across services.

- An action plan was in place to capture points from the patient focus groups. We reviewed the focus group action plan. There were a number of initiatives which had been introduced from the group such as the staff photo boards which were on display at the entrance of the unit and the introduction of clocks in every bed space.

Staff engagement

- A staff news-letter and unit website had been developed to engage staff, maintain a positive culture and encourage learning.
- There were a number of award schemes for staff, for example a manager had won Eastern region leader of the year for their leadership skills, one staff received mentor of the year and another staff had received “made a difference” award for the introduction of the beauty boxes.

Innovation, improvement and sustainability

- The trust had subscribed to the University of Cambridge Clinical Medicine Programme. An innovative, two year programme delivering subspecialty training in Intensive Care Medicine credentialed by the University of Cambridge.
- The unit had developed the Trauma Psychological Awareness e-learning module. This module was designed to equip the multi professional workforce with knowledge and understanding around the impact of psychological trauma on mental health.

- The unit had run a multi professional symposium on “Acute Liver Failure in Critical Care”. The Symposium included seminars, case presentation, new therapies and round table discussion. This was held in November 2015 and attracted 80 delegates from within the hospital and around the region.
- A number of staff had presented at workshops and delivered “poster presentations” at the British Association of Critical Care Network and the Trauma Conference.
- The charitable trust was in the process of setting up a trauma ICU centre in Burma in which a number of the ICU/NCCU staff were involved, as well as the Burma nurse specialist visiting later on in the year.
- There was a dedicated research nurse, who had recently co-authored a recently published research article into intra cranial pressure. This had encouraged nurses in the unit to come forward with research ideas that could lead to improvement in patient care. A second research nurse was due to join in October 2016.
- There was a designated board research lead (university lecturer in intensive care medicine) and five consultants acting as research leads.
- There were plans to introduce a critical care nurse practitioner role, which would improve senior clinical decision making in the unit.
- The unit was undertaking nine National Institute of Health Research (NIHR) studies and two commercially funded clinical trials. Due to the improvement in research activity since 2015, the funding for the research nurse had been provided by the research network.

Maternity and gynaecology

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

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 in one division (E), led by a divisional director, clinical director and a head of midwifery.

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, postnatal ward (Lady Mary ward), an obstetric close observation area (OCOA), ultrasound department and an obstetric physiotherapy department. There are 92 beds dedicated to the women's and maternity directorate and during April 2014 and March 2015, the hospital had 5729 deliveries.

The Rosie Hospital underwent extensive structural development in 2012, which included the birth centre and the obstetric close observation ward.

We visited all areas with the exception of the Intra-vitro fertilisation (IVF) unit, which is provided by the trust but at another location.

Following the inspection we based our findings on the following activities. We spoke with 58 members of staff which included four senior managers and service leads, 22 midwives, six consultants, four registrars and junior doctors, six nurses, one anaesthetist, three sonographers, three maternity and healthcare support workers, four administrators and two ward domestics. We spoke with nine women who used the service and two relatives. We reviewed six care records and prescription forms, five birthing plans, two antenatal records, six postnatal and community records and six gynaecology records. We reviewed the electronic staff roster, policies, procedures, guidelines and incident data as part of the inspection.

Maternity and gynaecology

Summary of findings

We rated this service overall as good with findings in the following:

- The service had robust systems in place to report incidents and the number of serious incidents reported was 16, with no never events reported between January and September 2016.
- Throughout maternity and gynaecology services we saw the “NHS Safety Thermometer” displayed in public areas. We saw completed essential patient risk assessments including venous thromboembolism (VTE) and early warning score (EWS) assessment outcomes.
- Staff confirmed to us that the maternity record system was improved with smart text filters in place but there was still a combination of electronic and paper records in place. Smart text is similar to a predictive text with the most used status or treatment descriptors featuring first on the system.
- All equipment checked was safety tested and was on the pre-planned maintenance programme.
- Staffing shortages within the delivery suite were seen each day but we were informed of clear plans to fill those vacancies with staff already recruited to start in October 2016.
- Policies and procedures in place were based on up-to-date evidence-based guidance which had been followed: for example; fetal heart monitoring (FHR) monitoring, vascular thromboembolism (VTE) and early warning score guidelines.
- All staff were competent and understood the guidelines they were required to follow.
- Outcomes of women’s care and treatment were robustly collected and monitored. For example, a maternity dashboard was available.
- Staff also confirmed that electronic hospital (Epic) coordination between electronic and paper-based systems had developed and they were able to show a thorough history for patients including risk factors. Although day case risks were not all completed on our initial review.
- We observed good practice in terms of audit, effective multidisciplinary team working and that staff consistently had the right skills, qualifications and knowledge for their role.
- All staff observed were extremely caring and we found that people were treated with dignity, kindness and respect throughout the directorate. There were also exceptionally good support systems in place to meet people’s emotional needs, which included support following bereavement.
- The service consistently received more compliments than complaints.
- Women undergoing termination of pregnancy were cared for in a dedicated area that was accessed through a double door into soundproofed side rooms within labour ward but well away from labouring women or crying babies.
- Information had been provided in ways that the women could understand and which promoted women in being involved in making informed decisions about their own care and the delivery arrangements. Overall maternity and gynaecology services feedback received indicated that staff had a caring and compassionate approach. Women reported being treated with respect and dignity and having their privacy respected and dealt with in a sensitive manner across this service.
- Women could access and be discharged from the service in a timely way.
- The gynaecology referral to treatment time (RTT) had maintained at 95% (trust target 92%) from the previous inspection in February 2016. There had been no national standard for RTT since October 2015.
- Service planning across the directorate was seen with workforce planning addressed. The demand on the service was addressed when patient acuity or staffing could not meet the needs of the women. The maternity unit had 17 diversions between Dec 2015 and July 2016 mainly due to a lack of capacity or insufficient staffing numbers.
- Senior managers had responded appropriately since the last inspection.
- Risk registers were up-to-date with clear ownership and actions completed or in progress.
- Key performance data was collected and analysed which meant that responsibilities were clear and that quality, performance and risk were fully understood and managed.

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- The introduction of electronic hospital (Epic) caused problems with not meeting the needs of the service; for example, with data collection. Four out of six staff confirmed that improvements with the system had been a priority. "We are still on the journey but have moved forward since last year".
- There was an improvement with the completion of the neonatal early warning scores.
- All staff told us that senior managers were approachable and encouraged them to be open and transparent. Senior managers and staff confirmed their commitment and spoke about "the honour in being able to provide the best care possible to women and their families". Staff dedication and passion for delivering high-quality care was inspiring and there were numerous examples of outstanding practice in relation to innovation, improvement and sustainability.

Are maternity and gynaecology services safe?

Good



We rated safe as good because:

- The service had robust systems in place to report incidents, with the top three incidents being staffing levels, miscommunication and delays in care/waits. Evidence of changes in practice to improve staffing levels, safety and reduce the number of incidents in the future, were seen.
- Throughout maternity and gynaecology services we saw the "NHS Safety Thermometer" displayed in public areas.
- All equipment checked was safety tested and was on the pre-planned maintenance programme. Equipment had been cleaned and a trust infection control red "clean" label completed with the date and name of the individual staff member who cleaned it.
- Sonographers shared concerns at the last inspection relating to staff levels and outdated ultrasound equipment. At this inspection, the sonographer informed us there is currently one band seven sonographer full time or part time post advertised and that the equipment had been replaced.
- All medicine prescribing and administration was in line with trust policy. Medications were stored in locked cupboards appropriately.
- Staff completed patient gynaecology services risk assessments and the records management system Epic recorded the individualised care records.
- In maternity, we reviewed the risk assessments which were completed and the maternity electronic record system was seen as being complex but staff confirmed more patient records are now on the electronic hospital programme. In one month 500 women had electronic patient hospital notes with only 26 women having paper copies. This was an improvement on the previous inspection.
- Compliance was seen with mandatory training across the directorate

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- While there were concerns around staffing levels within the service, managers presented a clear plan to improve staff rosters with the recent recruitment of nine registered midwives commencing at the beginning of October 2016.
- Across the services the early warning systems for maternity and neonates were in place and being used correctly.

However:

- At the time of the inspection medical and midwifery staffing numbers did not meet national standards and there were concerns around the level of consultant hours.
- There had been 11 confidential information leaks during 2016. These had been investigated and a root cause identified.

Incidents

- The directorate had not reported any 'never events' in the past 12 months. 'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Between January and September 2016 there had been 16 serious incidents reported, 11 were confidential information leaks, three related to the baby, one was a diagnostic incident (delay meeting or tests results) and one was a maternity or obstetric incident involving mother and baby (from STEIS strategic executive information system).
- Three root cause analysis reports were checked and showed that there had been a full investigation, with evidence of the lessons learnt and practice being changed. All serious incident investigation reports were completed by the lead patient experience and engagement manager.
- Managers told us staff had received training for root cause analysis (RCA) completion and evidence submitted showed all 15 supervisors of midwives had completed this training to support staff while completing any investigations.
- Staff confirmed they could access the hospital's incident reporting system, and understood their responsibilities.
- Staff described to us what constitutes an incident and when they would raise one.

- The 'perinatal incident trigger list' for maternity services was displayed and staff confirmed they were aware of actions required to reduce harm to the deteriorating mother and baby.
- Staff confirmed that they were aware of the monthly perinatal mortality meetings. We saw the minutes of meetings held between April 2016 and July 2016 which reflected discussions and case reviews by the multidisciplinary team members. All changes in practice needed to improve outcomes for patients were considered and lessons learned discussed.
- Staff told us they were aware of the monthly gynaecology governance meetings which included mortality and morbidity. We reviewed minutes from three meetings held between April and June 2016 and saw cases discussed and lessons learned with a multidisciplinary team presence.
- Midwifery staff, nursing staff and medical staff were aware of their responsibility in relation to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and to provide reasonable support to that person. Examples of when they would instigate duty of candour were discussed and one example is included in the medicines section. We saw logged incidents where duty of candour was identified on the electronic reporting system.

Safety thermometer

- The NHS Maternity Safety Thermometer was used for Sara ward, Lady Mary ward, Labour ward and the birthing unit with results for the year to date (September 2016) that demonstrated of the 100% of data submitted, 98.7% harm free care was delivered across this service.
- The service displayed the NHS Safety Thermometer results for all patients and visitors to view at the entry to the clinical area.
- 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

- Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile rates are displayed, updated and known by staff. There were no reported healthcare

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acquired MRSA bacteraemia and no clostridium difficile for Division E since April 2016 against. There were 4 cases of clostridium difficile within the maternity service from April 2016 which included one case which was an unavoidable admission to gynaecology.

- Records checked confirmed that domestic cleaning schedules were robust and all clinical areas we visited appeared visibly clean.
- There were daily cleaning checks in place, which support workers and nursing and midwifery staff had responsibility for. This included daily birthing pool checks and cleaning schedules which were completed. Hygiene audits scored greater than 95% for audits between May and August 2016.
- All staff were compliant with the trust's infection control policies and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately and wore their uniforms in line with the trust policy, with strict bare below the elbows practice.
- Every unit had a monthly hand hygiene audit which demonstrated good hand hygiene. In August 2016 Daphne, Sara and Lady Mary ward scored 98-100% in hand hygiene compliance.
- The curtains used in all patient areas were disposable and clearly dated and were replaced in a rolling cycle programme (unless soiled or contaminated, when they were replaced by the ward housekeeper).

Environment and equipment

- The entrance to the Rosie maternity hospital was refurbished in 2013. There was clear signage to all areas and a receptionist at the main entrance. When the reception area was unattended there was a clear process to direct visitors or unplanned admissions to the correct area as witnessed during the inspection. Inpatient areas were secure with a buzzer entry system.
- The birthing unit situated within Rosie Hospital provided 10 birthing rooms all with birthing pools, bathrooms, mood lighting with access to mood music, 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. The unit

provided a calm and homely environment. All low-risk women were offered an appointment at 36 weeks which provided an opportunity for the promotion of normal birth and a walk around the maternity department.

- The main Rosie hospital theatres and staff supported this service with all surgical interventions.
- Resuscitation equipment had daily checks completed for the last three months.
- At our inspection in April 2015 we identified a nitrous oxide leak in the delivery rooms; this had been corrected by our follow up inspection in February 2016. The last Nitrous Oxide Tests showed compliance with recommended workplace exposure limits.
- All equipment seen was fit for purpose and had a pre-planned maintenance review and relevant safety test.
- All delivery beds were reviewed and were recently replaced with appropriate equipment to assist any women giving birth.
- All neonatal resuscitaires had completed daily checks and had front guards in position.
- We examined available cardiotocography (CTG) equipment (which records fetal heartbeat and uterine contractions), observational monitors, weighing scales and invasive fluid pumps all had received electrical safety tests.
- Ultrasound equipment reviewed was safety checked and staff told us that this equipment had been replaced with five new ultrasound machines seen across this service with all monitors on a pre-planned maintenance programme.
- The newly refurbished caesarean section waiting area on Sara ward had been refurbished with patient amenity funds.

Medicines

- Medicines were stored securely in locked cupboards in all areas inspected and medication checks showed all to be within date. Intravenous fluids were stored securely.
- Controlled drugs records confirmed that daily checks were completed by two registered nurses or registered midwives (RN/RM). We checked controlled drugs for the last three months, across the service and found that the controlled drugs register was correct in each area.
- Medications for resuscitation were checked with the emergency equipment and were found secured when not in use.

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- Fridge temperatures had daily checks recorded and we reviewed July, August and September 2016 records which assured us that they were being monitored appropriately. Actions were taken when the temperature was recorded as outside of the normal range within the limitations of the checking sheet which did not have a column for actions on all paperwork used. This was brought to the attention of managers who agreed to amend the form to allow more space for staff to document actions taken.
- Medicines were prescribed and administered safely. Medicine records were accurately completed.
- The medication self-administration project on Sara ward in January 2016 was being cascaded across the post-natal wards once the pilot is completed.
- We identified no prescribing or administration errors on the Epic system relating to medicines.
- There were 59 medication errors across the service between January 2016 and Sept 2016. All were closed following a review with actions implemented to prevent reoccurrence with documentation to confirm that no patient harm had occurred.

Records

- We reviewed 16 sets of records in this service where venous thromboembolism (VTE) risk assessments were completed on 12 women. The remaining four women were day cases who had been admitted that day. We reviewed the VTE assessments later in the day and found then completed assessments.
- All women's records were electronic and seen on the e hospital system with completed admission and risk assessments.
- Previously all women had paper antenatal maternity records. However, since the Epic system was introduced some women had hand held records, others electronic and some had a folder with a print out of their antenatal history. During labour all women had electronic maternity records and post-delivery women had paper postnatal records which they took home. This inconsistency was largely because the community midwives could not initially access the Epic system outside of the hospital (which had been resolved). The risks identified of having this mixed system included results not available in paper copy as available on electronic system and a backup system if the electronic system failed and was an identified on the risk register.

- There had been 11 confidentiality breaches reported. The service could demonstrate that discussion and actions had taken place to minimise future occurrence. This included staff writing the patient's full name and NHS number on the outside of the package in which records are placed.
- Patient hardcopy records were stored securely throughout the division with notes trolleys that were lockable or placed near to the nursing station away from the patient area.
- Two sets of notes were reviewed in gynaecology for women undergoing termination of pregnancy. All HSA1 forms had been completed appropriately and HSA4 documentation were submitted electronically.

Safeguarding

- The trust had a dedicated safeguarding team, consisting of a nurse, midwife specialists and consultants.
- The safeguarding policies and procedures incorporated relevant guidance and legislation and were up to date. Staff could access these via the intranet, and were knowledgeable as to what constituted a safeguarding concern and how to raise concerns appropriately.
- Staff gave examples of where they had appropriately managed a safeguarding concern; for example, with a teenager with a concealed pregnancy and what support was given to the mother and her family.
- The Epic system highlighted (flagged) patients with safeguarding alerts which were then discussed appropriately at the ward family support or safeguarding meetings with detailed plans developed.
- The minutes of two joint and safeguarding children meetings were reviewed for May and June 2016. These meetings were held monthly and well attended by nurses, midwife and paediatric leads. The minutes demonstrated that serious safeguarding cases were discussed at each meeting. During the inspection we were able to attend part of a family support meeting which discussed safeguarding concerns.
- Safeguarding training figures for August 2016 showed 100% of nursing and midwifery staff had completed level one safeguarding training for adults and children, 96% of nursing and midwifery staff had completed adults safeguarding training level two and 95% nursing and midwifery staff had completed children's safeguarding for level two. Additional clinical services staff had 100% compliance for level one for both children and adults safeguarding training and level

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two adults safeguarding level 98% and % for children's safeguarding training. 100% of nursing and midwifery staff were reported as completing level 3 safeguarding training though only 70% of doctors had completed it.

- The four staff spoken with in gynaecology services knew how to raise safeguarding concerns and told us what processes supported teenage pregnancies. They were knowledgeable and sensitive when dealing with teenagers under 16 years and discussed Gillick competencies and Fraser guidelines. These refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. Staff described what actions they take and how to contact support, including the teenage pregnancy midwifery team and what support they offered.
- The Trust Abduction policy was available on the intranet and was reviewed in Sept 2015. Staff informed us that they could easily access policies, including from home through the staff access page.
- The trust wide Female Genitalia Mutilation (FGM) policy was introduced following a three month pilot and FGM posters were seen across the service. Three staff spoken with knew how to raise any concerns and what support was available for women. Staff had received training in FGM, its identification and reporting.

Mandatory training

- This service achieved for April 2015 and August 2016 non-medical mandatory training 99.6% for corporate induction and 84.9% for local induction. Medical staff achieved 87.3% for corporate induction and 54% for local induction.
- There was 94% compliance with mandatory training across the directorate for nursing and midwifery staff. Mandatory training subjects included safeguarding adults and children, moving and handling, infection control, health and safety and information governance. The lowest attendance was for resuscitation training at 88.6%. The trust target was 90%.
- Medical staff mandatory training included safeguarding training for adults (70%), infection control and prevention 73%, fire training 73%, information governance 73% resuscitation 71% and moving and handling (70%) which were below the trust's target (90%).
- Maternity staff received additional mandatory training including obstetric emergencies, domestic abuse,

breastfeeding and CTG training. (This was delivered annually and over two days). The practice development midwife confirmed that 98% of staff had completed this training within the past 12 months. Data submitted showed 100 staff had attended CTG training between August and October 2016.

- Obstetric emergencies were practiced by live skills and drills as part of mandatory training for midwives.

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 is available 24 hours a day to attend any medical emergency or unwell patients in the hospital. During the inspection a female service user fall was witnessed outside of the hospital entrance with the RRT attending and dealing with the patient in a timely and appropriate manner.
- Staff are aware of the rapid response team and advertising posters were seen across the directorate.
- Gynaecology areas used the National Early Warning Score (NEWS) system and scores are being accurately completed for the five patients reviewed. The national early warning scores were developed by the Royal Colleges and introduced to standardise the assessment of illness severity and determine the need for timely clinical escalation during an acute illness or deterioration.
- Staff were observed completing patient observations using the "Rover" handheld monitor which linked directly to the Epic system. The system confirmed the calculated early warning score and senior managers confirmed that changes since the last inspection meant that staff are now aware of the Epic capabilities.
- In maternity services the Maternal Early Warning Score (MEWS) and neonatal Early Warning Score (NnEWS) system were in place for women and babies and calculated correctly from the six records reviewed.
- The "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" is in place throughout the division and we saw documentation used for each surgical procedure which consisted of six sections which are electronically signed by staff and witnessed. We saw evidence from seven completed procedures but with emergency caesarean section the audit submitted showed 33% of team briefs were completed before the start of the surgery. More team briefs may have been completed but were not recorded

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onto Epic, one obstetric sign in was completed but had not been verified and one completed sign in was not recorded. Two time outs were signed but not verified. The recommendation to ensure that Epic has “hard stop” fields to ensure that all stages are completed will support compliance with this checklist.

- The trust started collecting data from January 2016 relating to women being seen by a midwife. The guideline stipulates that all women are seen within 15 minutes to listen to the fetal heart rate. Data showed that this standard was met on 92% of occasions.
- A centralized CTG monitoring system on the delivery unit was purchased to improved patient safety.

Midwifery and gynaecology nursing staffing

- The midwife to birth ratio (1:33) was lower 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”. There had been ongoing recruitment of midwives and support workers and the midwife to birth ratio would fall to 1:30 when all these staff commenced in post.
- In March 2016 nine whole time equivalent midwives were recruited and six whole time equivalent midwifery support workers. This filled vacancies and reduced the need for staff to work extra bank shifts.
- Staff numbers across the remainder of the gynaecology and maternity service were confirmed and staff we spoke with raised no concerns about staffing levels. Staffing shortages within the delivery suite seen were discussed with the Head of Midwifery who informed us of clear plans to fill those vacancies with staff already recruited to start in the first week of October 2016.
- Senior doctors confirmed the lack of midwifery staff on labour ward gave them concerns but they were aware that new staff were due to start to fill the current vacancies.
- The trust had implemented a six monthly maternity staffing review using the Birth-rate plus tool from 2015 as part of the trust’s staffing strategy. Monthly data is gathered to measure staffing levels against the 1:30 ratio. This is recorded in the monthly maternity dashboard and discussed at the divisional executive group. There was evidence from the divisional meetings

that staffing had been discussed. The use of bank staffing across the division had risen between April 2016 and Sept 2016 was 14.6%. Managers had agreed a 20% enhanced rate to all midwives who worked bank shifts until new staff had commenced.

- Staff were mostly able to offer one-to-one care in labour on the labour ward as confirmed by July and August dashboard data, showing 87% compliance though for the preceding 12 months it had been 95% or better. These events were brought to the attention of the head of midwifery and clinical director at the morning midwifery risk meeting and through incident reporting.
- On the delivery suite the staffing levels for the day and night shift were. However during the inspection staffing levels were at six or seven midwives with one bank midwife on most shifts for the previous weeks.
- A handover of patients between nursing/midwifery staff was observed which was comprehensive, well-structured and we saw that staff communicated effectively with one another.
- We saw the “Just five” midwifery risk meeting which occurred each morning where those present discussed the areas of concern from the previous day, incidents, learning and any known concerns identified for the day ahead e.g. multiple pregnancies.
- A six week electronic duty rota between August and October 2016 was reviewed and we saw the nursing and midwifery skill mix for each shift. Bank shifts were requested for each shift on the delivery suite where one registered midwife was required or midwifery support worker and these shifts were covered. Whilst this service uses hardly any agency staff the bank usage for each area with permanent staff working extra hours to cover sickness or absence across the maternity service. 80% of staff worked extra hours according to the 2015 staff survey.
- Sick leave was seen as 2.8% with all maternity leave recorded separately which was near to the trust average of 2.7% and lower than the national average of 4.3%.
- The Local Supervising Authority (LSA) action plan 2015 produced from the LSA audit stated that there was no admin support for SOM team and no designated space for supervision to take place in this service. However, statutory supervision is to cease in February 2017 with the commencement of the NMC revalidation in April 2016.

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- Daphne (gynaecology) ward registered nurse staff levels was reviewed and although there was one registered nurse vacancy. Staff informed us this post has now been filled.

Medical staffing

- There were 2 whole time equivalent Consultant medical staff vacancies. In relation to middle grade and junior doctors, there was a good skill mix on duty at all times, which was supported by the use of locum staff on duty during the inspection.
- The compliancy with “The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007” standards state that any unit with more than 5000 deliveries per year requires 98 hours of consultant presence per week. On average The Rosie Hospital has 5,700 deliveries per year and 60 hours of consultant presence was provided per week. Therefore the trust was not meeting this standard. Staff did however tell us that consultants worked over their hours daily, meaning that the hours of consultant presence was more likely to be higher than 60 hours per week but this was not recorded.
- There was a consultant on call and anaesthetist available 24 hours a day 7 days a week for both maternity and gynaecology services.
- Monthly medical locum agency use for obstetrics and gynaecology was to fill the backlog created with absent Consultants and currently there are two locums covering 75 hours.
- There was a locum policy in place in relation to induction and orientation for locum doctors. The service had agreed a three month locum contract for one doctor which ensured locum consistency.
- Locum doctors felt they were well supported and received a comprehensive trust and local induction.
- Medical appraisal was 90% between April and July 2016 and revalidation process policy was reviewed in July 2014. The ten doctors spoken with had no concerns with obtaining support with revalidation.
- Medical staff within this division confirmed they were able to get Consultant support when required.
- Consultants on call available 24 hours a day seven days a week and come into the service on a Saturday and Sunday between 8am and 12.

- Three consultants confirmed that they were stretched and that the extra hours worked were not recorded. They all had job plans.

Sonography and administration staffing

- The vacancy rate for sonographers in post in the ultrasound scan department was one whole time equivalent. At the last inspection there was a shortage of sonographers with a 3.4 whole time equivalent vacancy rate. This was recorded on the risk register. The trust addressed this in a variety of ways including recruitment, internal development and a recruitment and retention incentive.

Major incident awareness and training

- The maternity and gynaecology services followed the trust’s major incident and escalation policy which was available for all staff to access on the trust’s intranet.
- The major incident plan was reviewed in December 2013 and the chemical biological radiation nuclear plan had been reviewed in June 2014. The trust had business continuity plans in place for various incidents, including fire, flood and a sudden increase in demand on service.
- The management of diverting woman across the region and to specialist centres was known by staff and knew how to access this information and what actions to implement.
- Two senior staff we spoke with estimated the last practice was about three months ago. Training numbers submitted from the trust did not include this data.
- There was an established business continuity plan for the service when an internal incident was declared relating to the information technology Epic system (which had been inaccessible for approximately four hours during this inspection). When declared and put into action, the multidisciplinary team provided a coordinated and effective service that had appropriate backup systems in place. The head of midwifery was fully aware of risks and ensured that women’s care remained safe.

Are maternity and gynaecology services effective?

Good



We rated effective as good because:

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- This service had a robust audit system at both local and national level, with action plans that were embedded into practice. The service demonstrated learning from national reports and recommendations as well as maintaining awareness of current guidelines.
- Policies and procedures in place were based on up-to-date evidence-based guidance and were being followed.
- Fetal heart rate monitoring, venous thromboembolism (VTE) assessments and early warning scores in maternity services were completed
- All staff we spoke with understood the guidelines they were required to follow and displayed their competency in their roles. There was evidence of good multi-disciplinary working.
- All staff spoken with confirmed that the electronic hospital system (Epic) had been further developed and evidence of the Epic computer system was more robust in providing required patient information than at the last inspection.
- Information about the outcomes of women's care and treatment was collected and monitored.
- The Maternity dashboard for the last six months was reviewed and had progressed with positive outcomes.
- The coordination between electronic and paper-based systems reviewed was more compatible but staff confirmed the e hospital system was still being developed.
- All Staff had the correct qualifications, skills, knowledge and experience to do their job.
- Multi-disciplinary team work across disciplines was good, and staff spoken with felt supported in their job role and in terms of their professional development.
- Consent to care and treatment was obtained in line with relevant legislation and guidance.

However:

- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 showed that the trust reported up to 10% higher than average stillbirth, neonatal and extended perinatal mortality rates. The crude stillbirth and neonatal death rates were suppressed as the numbers were so small. The adjusted stillbirth rate was 4.85 per 1000 births, Adjusted Neonatal Death rate 2.26 per 1000 births and the extended perinatal death rate 7.76 per 1000 births.

- National neonatal audit programme (NNAP) published in 2015 shows that the trust performed below the NNAP standard on four out of five measures.

Evidence-based care and treatment

- Staff assessed patients and provided care and treatment in line with recognised guidance, legislation and best practice standards. For example, 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, practice is based on recognised guidance, such as CTG monitoring and VTE practice and staff practice followed those guidelines which were in place.
- Policies and procedures were in place and based on up-to-date evidence-based guidance and being followed. All staff spoken with told us how they could access policies via the "Merlin" document library on the intranet.
- There was guidance to support the women who had a multiply pregnancy and between April and August 2016 there was 45 multiple pregnancy deliveries. Staff spoke of a recent water birth of a multiple pregnancy and the support offered by the specialist midwifery service.
- There was a robust protocol for midwifery led care and discharge which supported the women following a normal delivery.
- Based on RCOG recommended guidelines: monitoring of fetal growth from 24 weeks.
- There were 502 medical terminations and 279 surgical terminations carried out between April 2015 and March 2016. The termination of pregnancy care was delivered in line with the Abortion Act 1967 and supporting guidance issued by the Department of Health.
- We were told of a dedicated fund that supported the research midwife whose role had been to develop portfolio studies with the aim of launching seven studies by the end of the year. A midwifery research facilitator had been tasked to make research accessible for all registered staff and encouraged active research. A request was made for examples of projects but data not included with submitted data.
- New trust guidance is communicated to staff via unit meetings, email or through the 'Maternity Risk Matters' quarterly newsletter.

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- The audit programme for maternity and gynaecology was comprehensive and included local clinical audits, for example to reduce third and fourth degree tears during delivery with outcomes and changes in practice and participation in national clinical audit. Audits allow providers to determine if healthcare is being provided in line with national standard, if their service is doing well in relation to these standards and where there could be improvements. Local audits were seen displayed at ward level and included antibiotic audit, audit of length of stay following elective caesarean section, women delivering with a body mass index greater than 30 and major post-partum haemorrhage. The trust benchmarked itself against the findings and learnt from the key points.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 had been reviewed by the maternity team. Lessons learnt from the review were shared at the trust audit committee, the quarterly division meeting and at local governance meetings.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 showed that the trust reported up to 10% higher than average stillbirth, neonatal and extended perinatal mortality rates. In the report, the crude stillbirth and neonatal death rates were suppressed as the numbers were so small. The adjusted Stillbirth rate was 4.85 per 1000 births, Adjusted Neonatal Death rate 2.26 per 1000 births and the extended perinatal death rate 7.76 per 1000 births.
- There were three stillbirths confirmed between January 2016-March 2016 which is comparable with the activity.
- CTG monitoring guidelines was in line with "The National Institute of Health and Care Excellence; Intrapartum care" guidelines which were published in December 2014, the FHR should be listened to after a contraction for at least a minute, at least every 15 minutes.
- Minutes from the gynaecology meeting showed in March, April and May 2016 that audit data was presented and improvements required were discussed and addressed.

Pain relief

- All women spoken with confirmed that staff assessed their pain regularly, offered them a choice of pain relief

when required and that these medicines are given in a timely way. Patient information leaflets were available in paper format and on the trust's website for before, during and after labour.

- Alternative therapies to reduce pain included supporting women who choose to labour in the birthing pools and hypnotherapy.
- Five care records were checked for pain scores which were seen completed with the use of the international pain rating scale (faces depicting smiling as score nought as no pain through to a crying face with worst pain score as 10)are used in the maternity and gynaecology service.
- Staff confirmed that anaesthetists respond promptly to requests for specialist pain relief, such as epidurals and women spoken to confirmed that they received pain relief in a timely manner. We checked five birthing plans in maternity care records and saw that analgesia was given appropriately while women were in labour.
- The maternity team confirmed that they are now developing an ambulatory epidural service for woman to normalise the perinatal period whilst supporting the woman in early labour.
- Women undergoing termination of pregnancy were assessed and offered a choice of pain relief to meet their individual needs.

Nutrition and hydration

- Two antenatal records were reviewed and we saw staff discussions documented for infant feeding choices with women both prior to, and after birth. There was an infant feeding specialist midwifery team which consisted of two midwives who job shared one whole time equivalent post and were supported by the maternity healthcare support workers.
- The maternity service had achieved UNICEF Baby Friendly stage two accreditation. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast feeding. Managers confirmed they had applied for the level three accreditation baby friendly initiatives which would acknowledge the support to women and their babies.
- Protected Mealtimes were in place and advertised. Meal times had a variety of food choice. One woman raised concerns that she was offered a hot meal at midday and sandwiches in the evening. This was discussed with the senior staff, who confirmed that hot meals can be obtained in the evening.

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- Breastfeeding statistics in terms of initiation were 84% for data submitted between Sept 2015 and Sept 2016, breast feeding statistics for 10 days and 6-8 weeks after delivery are collated by the Health visitor across or outside the county.
- We checked the breast milk refrigerators found in the post-natal areas for the storage of expressed breast milk and found that this was stored, labelled appropriately and was in date.
- The post-natal areas displayed information about community network and support groups for breast feeding and alternative groups offering support to new mothers.
- Feeding information was displayed throughout the service with alternative options for women who are not able or did not want to breast feed.

Patient outcomes

- The service was not indicated as an outlier for maternity and gynaecology care at the time of inspection. 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.
- Outcomes of women's care and treatment were robustly collected and monitored. For example, a maternity dashboard was available which documented the patient outcomes over the past month.
- The service participated in local and national clinical audits which included multiple pregnancy and women with a high risk during pregnancy.
- Maternity readmission rate was 80 women in 2015 and 59 women between January 2016 and September 2016. We saw four maternal unplanned admissions to intensive care in total for 2015 and between January 2016 and September 2016 there had been two maternal admissions to intensive care.
- During 2015-2016 the hospital had 5,583 deliveries. The proportion of delivery methods based on trust data from July 2015 to June 2016 is as follows. Elective caesarean section 12.1% higher (worse) than the national average of 11%, emergency caesarean section 15.9% higher (worse) than the national average of 15.2%, normal vaginal delivery 58.3% lower(worse) than the national average of 60.1%, low forceps 7.2% higher (worse) than the national average of 3.5%, and ventouse 4.4% lower (better) than the national average of 5.8%.The trusts total caesarean section (CS) rate for the past year was 28% which was higher than the England average at 24%.
- In May and June 2016, the caesarean section rate had increased to 30% but we saw had dropped to 26% in July 2016.
- The community midwives were trained in Vaginal Birth after Caesarean Section (VBAC) and were undertaking VBAC assessment and discussion with relevant women. All women who requested a caesarean section now see the consultant and there was a consultant midwife clinic for women with complications who need a plan of care.
- Evidence seen showed that 3% of women had experienced third or fourth degree tears between April 2016 and July 2016 which was below the trust target of 5%.
- In 2015 there were 451 unexpected admissions to NICU reported and 290 between January 2016 and September 2016, this data was for all babies born within this trust. The main reasons for admission to NICU included respiratory distress, jaundice, hypoglycaemia, infection and poor condition at birth.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 had been reviewed by the maternity team. Lessons learnt from the review were shared at the trust audit committee, the quarterly division meeting and at local governance meetings.
- The Maternal Newborn and Infant Clinical Outcome Review Programme (MBRRACE) report for 2015 showed that the trust reported up to 10% higher than average stillbirth, neonatal and extended perinatal mortality rates. In the report, the crude stillbirth and neonatal death rates were suppressed as the numbers were so small. The adjusted Stillbirth rate was 4.85 per 1000 births, Adjusted Neonatal Death rate 2.26 per 1000 births and the extended perinatal death rate 7.76 per 1000 births.
- National neonatal audit programme (NNAP) published in 2015 shows that the trust performed below the NNAP standard on four out of five measures. The trust met the standard for the number of babies born before 33 weeks gestation who received their mother's milk when discharged from the neonatal unit.
- However, the NNAP standards were not met for babies below 28 weeks and 6 days having a temperature recorded within the first hour after birth, mothers given

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antenatal steroids when delivering between 24 and 34 weeks gestation, retinopathy of prematurity (eye) screening for babies born below 32 weeks gestation and a documented consultation with parents and a senior member of the neonatal team within 24 hours of admission to the neonatal unit.

Competent staff

- We had been informed that the appraisal rate was 88% for Sept 2016 (mid cycle) and data for clinicians and midwifery staff appraisal for the past 12 months had been requested. This showed all staff had received an appraisal for the last full year (2015/16).
- The annual Supervisors of Midwives (SOM) report for 2015 showed that the ratio for SOMs to midwives was 1:14 making the trust compliant with national expectations.
- Staff confirmed they are supported to gain additional qualifications and to maintain their continual professional development. An example was a senior midwife who had completed her degree pathway and was now undertaking the trust's leadership programme.
- All newly qualified midwives confirmed they had a local induction including the completion of a competency framework and that they were allocated a mentor and SOM during this time.
- Maternity healthcare support workers had trust competencies which were completed prior to practice.
- Maternity support worker staff had been supported to complete the care certificate for maternity support workers (MSW) which was introduced nationally and we were informed of four staff who had completed this training.
- Four staff spoke of how they were supported in completing specialist training examples included caring for the women in gynaecology, the loss of an unborn baby, counselling support and examination of the newborn infant.
- Cardiotocography (CTG) monitoring is performed to check the unborn baby's normal heart rate and variability and how the fetal heart rate (FHR) responds to uterine contractions. CTG training was delivered with 98% of staff compliance.
- CTG training meetings are held and were an opportunity for staff to learn from CTG analysis.
- Training modules for CTG interpretation and annual CTG training session run by the trust are supported by the practice development midwife. CTG results were visible

and a recent peer review confirmed compliance to trust policy which reflected NICE guidelines. This was supported by evidence of 'fresh eyes' practice where another midwife checks the CTG trace every hour to analyse the reading was seen and posters present across the service area reminding staff to complete.

- The supervisor of midwives (SOMs) raised concerns relating to their role with the Nursing and Midwifery Council (NMC) revalidation introduced in April 2016. Supervision will be phased out from 2017
- Teenage Pregnancy Midwife had completed the Family Planning course and had also extended the qualification to include local authority research consortium (LARC) which has been supported and funded by Cambridge City Council.
- Additional training days were seen advertised on staff boards across the wards and departments on the staff board were dates for 2016 for CTG training, Safety thermometer feedback sessions and supervisor of midwifery breakfast sessions.

Multidisciplinary working

- We found effective multidisciplinary team working across all disciplines, inside the hospital and staff coming into the hospital from the community.
- During the inspection we observed two multidisciplinary (MDT) team meetings and discussions were detailed and everyone was allowed to contribute.
- Care and treatment plans were documented and communicated to relevant health care professionals, such as GPs and health visitors, to ensure continuity of care.
- Staff from other directorates including the special care baby unit and theatres confirmed the two directorates worked well together and that support from this service is good.
- The managers held daily a "Just 5" morning meeting to discuss any patient safety concerns, trust wide communication essentials or any anticipated problems in the day ahead, for example, information technology concerns. We attended a "Just 5" meeting and were shown the communication book which recorded the last six months key points from those meetings for staff not able to attend, which was good.
- There were quarterly Maternity Service Liaison Committee meetings which included GP and health visitors from the local area which enhanced MDT working.

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- Daily ward rounds were undertaken on the gynaecology, antenatal and postnatal wards and supported by the multidisciplinary team comprehensive documentation had been completed with clear plans for individualised care.

Seven-day services

- There was an anaesthetist and consultant available 24 hours a day, seven days a week for both gynaecology and maternity services.
- The neonatal resuscitation team are available 24 hours a day, seven days a week.
- 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.
- The community midwifery teams rotated into the hospital and had a roster to provide cover for 24 hours a day, seven days a week.
- The early pregnancy scanning operated a weekend clinic from 0800 until 1400. This was for women who had gynaecological emergencies or who were less than 13 weeks pregnant.
- Gynaecology outpatient services ran Monday to Friday, with some Saturday clinics to support women.
- Neonatal cover was provided 24 hours, seven days a week with an on call roster.
- There was a midwife on each day shift on the postnatal ward to complete the newborn and physical examination checks.
- Chaplaincy team were available through an on call rota 24 hours a day, seven days a week.
- Sonographers were available through an on call and out of hour's roster system 24 hours a day, seven days a week.
- On the postnatal ward there was ward administration cover every day until 1400.
- Support services, such as pharmacy, physiotherapy and imaging service, were available out of hours to meet the needs of women following surgery or following a difficult delivery; for example, with third or fourth degree tears.

Access to information

- Electronic and paper records were used and were readily available to staff to refer to during the woman's care or admission within this service.

- Staff were able to access patient record system, diagnostic imaging and pathology results.
- During the previous inspection electronic care planning was not achievable on the electronic hospital (Epic) patient record system but some care planning had been incorporated into the system. Staff told us smart text sections (similar to predictive text) helped input data in a more timely manner but that similar to coding a comprehensive list of patients' treatments or conditions presented that covered a wide range of options other than the top five most commonly used within this service.
- Paper records seen used within the service were kept in secure areas to maintain confidentiality as much as possible.
- Patient discharge information was sent electronically upon discharge of all woman to her general practitioner and community midwife where appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment is obtained in line with national legislation and guidance, including the Mental Capacity Act.
- Four staff we spoke with confirmed that that had received training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards (DOLs) and learning disability which remain separated from the mandatory training for all staff. Data provided by the trust showed that in almost all areas, greater than 90% of staff had completed this training. However, allied health professionals in ultrasound were 60% compliant with this training though it related to a small number of staff.
- All staff grades were observed gaining verbal consent before undertaking interventions such as taking clinical observations or giving medication.
- Patient records were reviewed for two termination of pregnancy cases and staff informed us how the HSA1 and subsequent HSA4 forms were completed and submitted electronically for notification. We saw two registered medical practitioners had signed prior to the termination and the HSA1 form was stored with the women's records.
- Two staff were able to explain Fraser guidelines and Gillick competency when caring for those under the age of 16 years of age.
- Consent taken on paper consent forms were signed and uploaded by administration staff to Epic.

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- There is a named nurse and midwife for safeguarding and a specialist midwife for mental health to support vulnerable women and staff who cared for these women.

Are maternity and gynaecology services caring?

Good



We rated caring as good because:

- Overall maternity and gynaecology services feedback received indicated that staff had a caring and compassionate approach. Women reported being treated with respect and dignity and having their privacy respected and dealt with in a sensitive manner across this service.
- Information had been provided in ways that the women could understand and which promoted women in being involved in making informed decisions about their own care and the delivery arrangements.
- Staff took into account the individual needs of the women and their partners and ensured appropriate support was provided to them.
- The Friends and Family Test scores were generally in line with or above national averages scores in all aspects of antenatal, perinatal and postnatal care.
- The service consistently received more compliments than complaints.
- The services provided bereavement support to women who experienced the loss of their baby. Additional support systems were in place to meet the women's emotional needs and supported her family which included support following bereavement through people experiencing trauma and loss (Petals Charity).
- Staff were caring, friendly and approachable", "The staff never sat still and worked so hard", "Staff explained to me exactly what was happening and I had every confidence in them providing me with better care than I would receive if I had gone privately".
- One partner was upset as he was taking his wife home from gynaecology following receiving bad news but took time to inform the inspectors that they saved his wife's life."
- "Friends and Family Test" (FFT) scores for recommending antenatal and birth services were displayed in all areas as between 98.7 and 100% for August 2016.
- Trust scores in the "CQC Woman's Experience of maternity services survey" were the same as other trusts for all but two indicators where it scored worse for staff introducing themselves and receiving information after birth. We saw "my name is" principles used when staff introduced themselves to the women in their care and we saw information leaflets on each ward area.
- All ward area display boards featured thank you cards from patients and families for the care they had received.
- During the inspection patients were observed with curtains closed around their beds in bays for privacy and staff knocked on doors before entering patient side rooms.
- We were told about one woman who said on entering the birthing unit that "I am NHS not a private patient the standard of these rooms are like a five star hotel and they must be for private patients".

Understanding and involvement of patients and those close to them

Compassionate care

- Staff responded compassionately when people needed help and supported them to meet their needs.
- We spoke with five women post-delivery and one woman attending the antenatal clinic about their experiences, four partners and two visiting relatives. All comments were positive about the care they received and the kindness they received from staff.
- There were 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.
- We checked two antenatal records and both had birth plans in place and documented that pregnant women had been involved in the development of their birth and infant feeding plan.
- We asked women across this service if they felt well informed and involved in decisions about their care and treatment. All confirmed that midwifery, nursing and

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medical staff informed them of their choices of treatment before proceeding with any care and they felt they were able to ask if more detail was required if they did not understand anything.

- “My wife was nursed on the close observation unit and even though the baby was in the NICU she was still able to visit”.
- This service’s website had information about key members of staff that may be involved in patient’s care. This included the names and photos of gynaecology consultants, nurses and allied health care professionals.
- The midwives delivered parent education classes which included information about labour, birth and the postnatal period and were held at numerous local children’s centres across the area.
- Women and their families are encouraged to contribute to “Have your say” information online. Comment cards were also distributed on the ward with visible comment card boxes, which encouraged people to give their opinion about the service.

Emotional support

- Staff showed a sensitive approach when addressing difficult or complex issues. Staff encouraged parents to participate in the care of the baby as much as possible to ensure that the maternal and paternal bond stayed strong. Midwife and clinical nurse specialists were available for gynaecology, colposcopy, diabetes and bereavement who provided support and guidance to women and relatives.
- Maternity services had a specialist mental health midwife who supported women living with mental health conditions during and after pregnancy. However, there was no community perinatal mental health team working alongside this service to support women.
- Gynaecology and termination of pregnancy service also provided the same support to women as those services offered through maternity. Staff had considered all aspects of emotional care and support that any women required following the loss of her baby.
- The trust wide spiritual care and chaplaincy team were available to women, their families and supported staff. The chaplaincy service offered emotional support to women and their families as requested.
- The bereavement support team of specialist midwives and maternity healthcare support workers were

available Monday to Friday. Their contact details were given to the woman at the time of any pregnancy loss by hospital staff and were easily accessible via the trust’s website which included a confidential phone line.

- This service worked with a local bereavement charity called, “Petals”, who support the clinical team to deliver specialist and approved counselling services when required. Women and partners were also signposted to numerous other support groups and charities that were specific to their needs; for example, “a contact a family” charity.
- The bereavement care follow-up “Birth Afterthoughts” service 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.
- Consultants who cared for the women follow up with the opportunity to meet and to answer any questions following their discharge and at an agreed time to suit the individual’s needs.

Are maternity and gynaecology services responsive?

Requires improvement



We rated responsive as requires improvement because:

- There were continued closures of the delivery suite to high risk admissions. We have reported these concerns previously and that a full strategy was not in place to address these issues.
- There was a high number of patients documented as being discharged between the hours of 10pm and 7am.
- There were delays in induction of labour between April and September 2016 for 22% of patients requiring this intervention.

However,

- There was a clear escalation process in place to address actions prior to diversions or transfer of women
- Women were given informed choice about where to give birth to meet their clinical needs.
- The service had developed the gynaecology service to include the inpatient ward area and clinic areas were women could self-refer to the gynaecology ambulatory

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service. The waiting times for elective and emergency gynaecology were good and meant that women's pathways were generally delivered within 18 weeks. The gynaecology referral to treatment time (RTT) was maintained at 95% with the trust target set at 92%.

- Termination of pregnancy for fetal anomalies had been carried out on labour ward after 12 weeks of pregnancy. Women undergoing this service were cared for in a dedicated area that was accessed through a double door into soundproofed side rooms within labour ward but well away from labouring women or crying babies.

Service planning and delivery to meet the needs of local people

- The division has a developing business plan which detailed aims and action plans in regard to future service planning, including an aim to "be 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". Women were given informed choice about where to give birth to meet their clinical needs. The delivery and birthing unit had a number of birthing aids, birthing pools and women were offered choice for delivery between a home delivery, the birthing unit and the delivery suite. This was in line with completed risk assessments.
- The community midwives rotated into the hospital service to support mothers who planned for a homebirth.
- There was a dedicated midwifery team for teenage pregnancies who would support the teenage mother outside of the hospital and encourage antenatal services and teenage parent craft classes to prepare for the birth.

Access and flow

- People were able to access services in a timely way for initial assessment, diagnosis or treatment.
- We requested the current percentages of women seen in the labour ward within 30 minutes by a midwife as five staff confirmed women were seen within that timescale. Data supplied showed that 98% of women were seen in this time.
- Staff stated there were minimal delays in induction of labour or discharge.
- Evidence submitted by the service in relation to delayed discharge and delayed induction of labour (IOL) showed that between April and September 2016 there were a

total of 507 induction of labour with 142 experiencing delays (22%). The service had developed a new guideline to reduce the delays in the induction of labour pathway with a daily meeting to look at all IOL with a multi team presence. Induction of labour is where women are artificially started into labour with the use of prostaglandins for their or their baby's wellbeing.

- The trust has a policy which outlines planned actions in the event that the maternity unit required diversion from the delivery unit but long-term plans such as reducing the number of diversions from the maternity unit to meet the needs of local people remain unresolved.
- Between December 2015 and July 2016, the maternity ward had not closed but on 17 occasions high risk admissions had been diverted to other maternity units.
- The bed occupancy rates had been below the England average from quarter three 2014/15 to quarter four 2015/16. The bed occupancy rate in quarter two was 54.1%; on resubmission to NHS England, the England average is at 60%.
- The high number of diversions (closures) was concerning, though the trust was reporting these closures of the delivery suite correctly, the remainder of the maternity unit was open and staff actions kept women and babies safe, which was good practice.
- Regular call bell audits which determined length of time it took for staff to answer patient call bells and 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.
- In gynaecology services the Referral to Treatment Time (RTT) for both admitted and non-admitted patients had been maintained at 95% (trust target 92%) from the previous inspection in February 2016. Data reviewed was between April 2016 and August 2016. There had been no national standard for RTT since October 2015. RTT means that patients have the right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral.

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- 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 was not using national benchmarks for monitoring. We obtained assurance that women were being booked in a timely way.

Meeting people’s individual needs

- The maternity service delivered a range of specialist obstetric-led clinics for women e.g. diabetic, hypertension, Vaginal Birth after Caesarean Section (VBAC), Lupus and autoimmune and drug and alcohol clinics.
- Women were supported by specialist midwives such as the consultant midwife, safeguarding, teenage pregnancy, substance misuse, mental health and a diabetic specialist midwife, where required.
- The trust had 24 hour access to a translation service and support services were available for those who were visually impaired, blind or deaf.
- Staff were aware of how to access these services if needed and we saw each patient had an identified requirements sign which had coloured symbols; for example, a leaf to indicate that a patient was at risk of falling, an indicator to show diet, an ear if hearing problems with flags to indicate language used and if a translator was required.
- Patient information leaflets were available in alternative languages and larger font.
- 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 knew how to access this support.
- The Birthing Unit was situated within The Rosie Hospital and provided excellent facilities, including 10 birthing rooms all with birthing pools and bathrooms, mood lighting, music systems and a fold-down double bed,.

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. The unit provided a calm and homely environment.

- Termination of pregnancies (TOP) for fetal anomaly, were carried out on labour ward after 12 weeks gestation. The two rooms used are soundproofed and accessed through a double door which was well away from labouring mothers and crying babies on the main part of the ward.
- The vulnerable women support system at the hospital is well established with support from the specialist midwife and the teenage pregnancy team.
- There were information leaflets for women, dads and partners regarding their pregnancy and baby needs, which covered pregnancy, birth and after birth.
- We saw the use of “night packs” across the wards which supported women by providing eye masks and ear plugs if the environment was not promoting rest.

Learning from complaints and concerns

- There were 106 complaints reported between January 2015 and March 2016 whilst between April 2016 and Sept 2016 there had been 33 complaints reported. The top three themes for 2015 were complaints categorised as medical care, midwifery care and poor communication. In comparison, the top three themes for 2016 were categorised as values and behaviours (staff), clinical treatment (which included any delay or failure in acting on or ordering tests) and communications (included patient not listened to, incorrect entry in medical records or failure within department).
- Complaints were discussed in ward newsletters, quality briefings and handovers with learning shared amongst staff.
- All staff spoken with knew how to deal with people’s concerns and stated that they were supported in dealing with concerns straight away before they developed into more significant complaints.
- Information on how to complain was available in each area we visited. Display boards on ward areas reading, “You said, we did” were updated which demonstrated that the service learnt from complaints.

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- An example given was a patient who had raised a concern about not being able to sleep at night within the antenatal ward and an airline style pack of eye mask and ear plugs are now offered to promote sleep and the woman's wellbeing.
- Clinical areas had comment boxes for women and their relatives to use. Posters were displayed on how to make a complaint. None of the women or relatives we spoke with raised any concerns or complaints to us during the inspection. The hospital used the Patient Advice and Liaison Services (PALS). PALS was easily accessible within the hospital and information on how to contact PALS was available in all clinical areas. Staff we spoke to knew how to contact PALS.

Are maternity and gynaecology services well-led?

Good



We rated well-led as good because:

- Staff expressed they were positive about working at the hospital and being part of the team within this service. They shared a commitment to the vision and strategy in place for the service and the trust.
- Staff reported having good leadership and of feeling involved and valued. Senior managers had responded to staff concerns which had been dealt with in a prompt manner. An example was when managers had listened to staff concerns following the introduction of the electronic hospital system (Epic) and responded appropriately.
- The nursing, midwifery, medical and operational leadership team were respected and staff spoke highly of the divisional leads and how involved and approachable they were. All staff spoken with confirmed that improvements implemented since the last inspection had been well supported by managers who were open, visible and supportive. Staff confirmed their determination to improve the service for women who used this service.
- Governance and risk management systems within maternity and gynaecology services were robust and established. Staff knew how to escalate concerns. Risks were added to the risk register, monitored, managed with clear actions to minimise risk. There was

confidence in reporting events which would be investigated and learned from to ensure that women using the service had the "best care possible". The maternity dashboard had developed so women and staff could understand the outcomes of care provided within this service.

- The introduction of electronic hospital records (Epic) caused problems with not meeting the needs of the service; for example, with data collection. Four out of six staff confirmed that improvements with the system had been a priority. "We are still on the journey but have moved forward since last year".
- Six neonatal early warning scores seen were completed and we heard there was a weekly review of all scores to ensure that patient safety was protected.
- The service worked well engaging with women who used this service, local mother and baby groups and the maternity service liaison committee to seek feedback on services for the hospital.

However;

- There was a clear business plan for the number of consultant hours to be increased but this had not been implemented since the last inspection and consultants spoken with reported they felt stretched.
- There were ongoing capacity issues within maternity services meaning the unit diverted high risk deliveries on 17 occasions between December 2015 and July 2016.

Leadership of service

- The maternity and gynaecology services was in one of five divisions across this trust with a Divisional Director, an Associate Director of Operations and a Head of Midwifery leading the division.
- All midwifery and gynaecology staff we spoke with gave us positive feedback about the leadership provided at departmental level, visibility and approachability of the head of midwifery and lead matron who were supportive and pro-active in their approach. The staff also felt that the Chief Executive Officer and Chief Nurse were visible and communicated regularly.
- Clear leadership principles and the trust's values were embedded in the service.
- Four staff confirmed they had completed or were currently on development pathways in leadership and management
- Junior doctors and staff told us of their experience at this hospital and confirmed they were well supported by

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their line managers and consultants. They said consultants were “always around” and everyone “worked well together”. A registered nurse and a support worker confirmed that consultants requested to be called by their first name and took everyone’s opinion into consideration.

- This service supported the development of staff and two staff gave examples where they had commenced as support workers and their management skills were developed and they have gained promotion.
- Succession planning in view of future promotion opportunities was open and staff described a fair and equal approach for all staff.
- All staff spoken to confirmed that senior managers were friendly and visible.
- Regular team meetings or newsletters were circulated to all staff.
- There was a manager’s on-call rota and an out of hours rota to ensure staff were supported.
- Staff spoke about attending the leadership development programme and being supported by the service.
- Managers had agreed a 20% enhanced rate to all midwives who worked bank shifts during the weeks when staff were working extra bank shifts until the substantive posts had commenced.

Vision and strategy for this service

- All staff spoken to quoted and confirmed that they were aware of the trust’s vision. All staff we spoke to were aware of the service vision. Posters displayed across the service confirmed the trust vision and strategy was visible on all wards and corridors.
- The service had a local vision and strategy which supported further developments to deliver the best care possible for women.
- Medical staff told us that the challenge was to meet the women’s choice and being able to respond to the needs of the increasing capacity of women locally and those who through choice had come to this service.

Governance, risk management and quality measurement

- There were robust arrangements for governance, risk management and quality measurements across the service.

- The safety performance dashboards displayed across the service were dated August 2016 and gave up to date information relating to monitoring of safety.
- We reviewed the risk register for both maternity and gynaecology and saw action plans with clear ownership for the risk identified. This included identifying and understanding the most significant risks, agreeing acceptable levels of risk and approval of actions to mitigate these and to receive assurances that actions taken to manage risks were managed appropriately.
- Monthly governance meetings were held in both maternity and gynaecology and we reviewed minutes from those meetings where we saw discussions about complaints, audit outcome, risk and incident analysis which then fed into the trust wide governance meeting.
- 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.
- An information sharing newsletter was circulated to each member of staff. Staff confirmed that the midwife risk manager distributed a monthly “Risk Matters” newsletter which were seen on the ward areas and included an analysis of recent complaints, incidents and other necessary information updates.
- Examples of good governance information sharing included the reporting of serious incidents that occurred outside of this service so staff could learn from other areas.
- Every weekday morning at 8am there is a five minute session on labour ward whereby senior managers communicate risks and key information to staff of all levels from maternity. Staff told us that they were able to attend the five minute session and they praised the Head of Midwifery for introducing this.
- We reviewed the communication book on the delivery suite which included all the key points raised for the past year which was good, as any staff who were not able to attend could immediately be aware of points of discussion.

Culture within the service

- A junior nurse spoke to us about how they had been encouraged to apply to work at this hospital by a colleague. All staff confirmed the nurses and midwives worked well together and were happy to work in this

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service. A consultant confirmed that he was very lucky to work here with the team of dedicated staff who were dedicated in the delivery of high quality care for this service. The culture was said to be “something embedded in the service” and everyone “feels valued”, “lucky to work here” and “the culture comes from the top”.

- Student midwives we spoke with provided us with positive comments on the culture within the hospital and the department. This included positive aspects of their relationship with colleagues who were friendly and supportive.
- The staff confirmed that the senior team were open and honest and they felt able to speak openly and their concerns were listened to.
- Staff stated that following the last inspection senior managers took appropriate responses and supported them with any concerns and the open door style was mentioned by four staff members.
- The service celebrated staff success and we heard about the nominations for the International day of the midwife and nurse.
- Domestic and volunteer staff told us they were made to feel part of the team. The domestic staff explained how they took a pride in their area of work and worked hard to ensure they supported their team outcomes.

Equalities and Diversity – including Workforce Race Equality Standard

- The WRES trust group had supported recruitment processes, performance management and disciplinary cases. A leadership scheme led by executives and senior leader improved awareness of line managers and interview panel’s guidance on equality and unconscious bias.
- The equality and diversity staff group had planned equality events cultural diversity including: Windrush cultural diversity celebration event planned to celebrate long service and welcomed new staff from overseas and events for Black History month.
- Other areas of development for equality included mentoring and coaching schemes for staff, continued promotion of positive action programmes; improved awareness of line managers and interview panel’s guidance on equality and unconscious bias.

Public and staff engagement

- The maternity leadership team involved women and their families in the development of this service through the maternity services liaison committee and local parent craft groups. Examples included the improvement of the birthing unit environment, the pre caesarean section lounge area for women with their families.
- The Maternity Services Liaison Committee (MSLC) held meetings quarterly and the Head of midwifery or senior midwife attended.
- Members of the public including women who used the service were encouraged to provide feedback on their experiences through the completion of commentary cards. There are arrangements in place to raise a complaint and have this investigated and responded to, with guidance displayed in all areas.
- The local groups which actively support the Rosie hospital include the Doula group, National Childbirth Trust and the patient amenity charitable trust which was evidenced with equipment purchases across the service and supported the women’s hospital experience.
- The service worked closely with voluntary organisations and all volunteer workers wore their red banners and were seen supporting visitors and the inspection team across the hospital site.
- Friends and Family Test questionnaire and patient feedback forms were distributed daily.
- Staff took pride in informing us that they or their team had been nominated for a “You made a difference” staff award.
- Staff were encouraged to attend regular unit meetings and were provided with up-to-date literature about the service through newsletters and email.
- Staff told us they were supported by managers to attend trust wide forums for their own development.

Innovation, improvement and sustainability

- The maternity service were accredited at level two of “Baby Friendly Status” from UNICEF and staff informed us that they were now working towards achieving a level three accreditation.
- Two specialist midwife posts, a smoking cessation and infant feeding midwife remained in post supported by Cambridge City Council.
- The supervisor of midwives (SOM) network support at the trust remained strong with breakfast meetings advertised.

Maternity and gynaecology

- The maternity service had set up a Facebook page and twitter account to collect feedback and general comments from women who had used the service. An example of how information had been used was with the encouragement of partners stopping overnight with their partners in the antenatal ward area.
- The Lady Mary Ward had major reconstruction work which was funded by the “Addenbrooke’s Charitable Trust (ACT)” and last year Daphne Ward underwent similar refurbishment. Donations included birthing balls, used to assist comfort and delivery during labour, and breast expressing pumps, from the local Doulas group. (A Doulas is a non-medical experienced person who offers emotional and practical support to women and their birthing partner before, during and after birth).
- The consultant midwife role included leading and developing the maternity workforce agenda and working closely with the head of midwifery in developing a culture of normalising birth. She supported women in providing a normal birth (VBAC) with following a previous caesarean section.
- The reviewed Induction of labour pathway including outpatient induction in Clinic 23 is working with the transformation team and assistance with analysing data.
- The initiative for ‘Family Facetime’ proposed the purchase of two technology tablets to enable mums on the Obstetric Close Observation Area (OCoA) who are too unwell to visit their baby on the neonatal intensive care unit to receive a video link via Facetime with their baby. This will aid bonding/oxytocin (supports breast feeding) and improve patient experience.
- Rosie Maternity had applied to become one of the choice and personalisation maternity pioneers which was launched in May 2016 where seven maternity hospitals will become maternity pioneers and early adopters in implementing changes.
- The introduction of a training programme to use a new episiotomy scissor has been discussed to improve patient safety and quality of care by reducing the incidence of anal sphincter tears during childbirth and subsequent faecal incontinence. This meets the Royal College of Obstetricians and Gynaecology and Royal College of Midwifery with a joint aim to reduce the incidence of obstetric anal sphincter injuries.
- Sara Ward (antenatal ward), completed a pilot from Feb to end of May 2016 which allowed partners to stay on the ward for the duration of their stay. There were approximately 100 partners who stayed overnight during this time. Positive verbal feedback from the women we spoke with confirmed that they liked the option. The only negative feedback was regarding the discomfort of the chairs. Staff informed us that they noticed a reduction in the number of overall complaints. Managers are now considering partners staying overnight on Lady Mary ward.

Services for children and young people

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

Information about the service

Children and young people's services include all services provided for children up to the age of 18. This includes inpatient wards, surgery, outpatients and end of life care, along with the interface with maternity services. Children's services at Cambridge University Hospitals NHS Foundation Trust are based at Addenbrooke's Hospital and the Rosie Centre.

Children and young people's services at Addenbrooke's Hospital include outpatient services, children's medical and surgical services, the regional neonatal service (including neonatal surgery) and the regional children's critical care services. The service treats and supports patients from birth to 18 years.

Children and young people's services have 34 acute medical and surgical beds, 13 intensive care beds and 17 oncology beds. Neonatal services (including neonatal intensive care and special care baby unit) have 58 cots; however, the hospital staffed only 40 of these. Children's services had 11,220 episodes of care across Addenbrooke's Hospital and the Rosie Centre between March 2015 and February 2016.

During the inspection, we visited 10 clinical areas, including children's intensive care, medical and surgical wards, theatres and outpatient clinics. In addition, we visited two adult wards where young people aged 16 and 17 years old were being treated.

We spoke with 49 members of staff including nurses, care assistants, doctors, allied health professionals, support and

administration staff. We spoke with three patients and three relatives. We looked at seven sets of medical notes and reviewed policies, procedures and incident data as part of the overall inspection process.

Services for children and young people

Summary of findings

We rated this service as good because:

- The service managed safety well. Staff knew how to report patient safety incidents and what should be reported as an incident. Managers investigated when things went wrong and shared lessons to be learnt with all staff to help prevent further similar incidents.
- Medical and nursing staff knew that when things went wrong with care and treatment they needed to inform patients honestly, give them support and apologise to them verbally and in writing. This process is known as duty of candour.
- Duty of candour training and knowledge was good across medical and nursing staff.
- Equipment servicing was up to date and equipment checked was safety tested.
- Clinical areas were visibly clean.
- The service had enough staff to keep patients safe and to provide the care they needed. Staffing levels for senior doctors, nurses and healthcare assistants consistently met demand.
- We found good transitional care services at Addenbrooke's Hospital for patients transferring from children's services to adult services.
- The hospital had good systems in place to continually improve the quality of their services and protect high standards of care.
- The divisional leadership team were knowledgeable about the service and understood the constraints within which the service was working.
- There was a strong culture of openness and transparency within children and young people's services.
- Staff provided kind compassionate care to patients and families in all areas we visited.
- Patients and relatives felt informed and included in the decisions being made about their care.

However:

- Not all staff on adult wards caring for young people aged 16 and 17 had undertaken children's safeguarding level three training in line with the Intercollegiate Role Framework.

- Staff management of controlled drugs in children's intensive care was a concern. Staff left controlled drugs keys unattended and hung on portable workstations.
- Senior management raised concerns about the lack of acute paediatric beds available across children's services.
- The children's divisional management team told us that 250 scheduled admissions were cancelled between January 2016 and August 2016 due to a lack of beds.
- Between September 2015 and August 2016, the trust cancelled 132 procedures for children and young people. Of these 121 were rebooked within 28 days of the procedure being cancelled and 11 patients waited longer than 28 days to be rebooked.

Services for children and young people

Are services for children and young people safe?

Good



We rated safe as good because:

- Safeguarding knowledge amongst staff was good. The hospital had an effective children's safeguarding team.
- Staff followed required infection controlled precautions, including hand washing and using personal protective equipment. This helped reduce the risk of cross infection.
- Medicine management was generally good across children and young people's wards. Staff knew their responsibilities in relation to controlled drugs.
- Staff documented all care interventions on an electronic patient record. Patient records reviewed contained the required risk assessments and staff completed early warning scores for patients to establish deterioration.
- Equipment servicing and safety testing was up to date.
- Ward areas were visibly clean. The play specialists had cleaning rotas in place to ensure all toys were cleaned before being used by another child. Specific procedures were in place to clean toys used by a patient with an infection.

However:

- Medicine management on the children's intensive care unit was a concern. Staff left controlled drugs keys unattended on portable work stations.
- Children could access cleaning equipment and the sluice room on ward D7. This posed a risk to the health and safety of children and young people.
- Adult staff caring for young people did not have children's safeguarding level three training, as required in the Intercollegiate Role Framework.

Incidents

- Children's services had reported one never event and three serious incidents between July 2015 and August 2016. The three serious incidents related to confidential information leaks. The one never event reported by the trust related to the incorrect placement of a feeding tube on a child within paediatric intensive care. Children's services reported 1,638 incidents between July 2015 and June 2016.

- Neonatal services had reported no never events and 538 incidents between July 2015 and June 2016.
- A serious incident is an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Children's intensive care held mortality and morbidity meetings every other month, attended by multiple professions, including medical and nursing staff. Minutes from the April 2016 mortality and morbidity meeting recorded discussions about patients that had been admitted to children's intensive care. The minutes also contained actions with allocated people to carry these out.
- The neonatal intensive care unit held weekly mortality and morbidity meetings, attended by consultants, junior doctors and advanced neonatal nurse practitioners. We reviewed minutes from the last two mortality and morbidity meetings held on 16 and 23 August 2016 and found staff discussed neonatal deaths in depth, including cause of death and the care delivered in the hours leading up to death. Learning points were documented and shared amongst staff at the mortality meeting.
- Data submitted by the trust at the request of CQC showed 100% of medical, surgical and intensive care staff (both medical and non-medical) had completed duty of candour training.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- We requested three 'root cause analysis' (RCA) from the trust following the inspection. The RCAs were linked to an information breach, a pressure ulcer and a fall. However, the trust only supplied the RCA for the information leak.
- The RCA sent by the trust contained information regarding the incident, a timeline for investigation with comments and a 'lessons learnt' section. However, the action plan was brief and lacked detail. For example, the

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“person responsible for action” column stated “information governance team”. There was a lack of contact information or designated person to undertake the action. This meant no one person was accountable for the improvements, making accountability difficult.

Cleanliness, infection control and hygiene

- Waiting rooms and clinical areas were visibly clean.
- Hand sanitiser was available at the entrance and exit of each clinical area.
- We observed staff using hand sanitiser and washing their hands as required. We observed staff using personal protective equipment (such as gloves and aprons) as required across all clinical areas.
- Clinical areas undertook monthly hand hygiene audits. Data for April, May and June 2016 showed that all children’s areas achieved the hospitals target of 95% or higher in hand hygiene audits.
- The hospital had recorded no incidents of MRSA or clostridium difficile in children services between September 2015 and August 2016.
- The children’s risk register noted that ward C2 could not be ‘fogged’ during cleaning of a room following the discharge of a patient with an infection. This was due to the inability to ventilate the area and the increased risk of opening windows and introducing air born infections. Following review by the trust, current control measures, including full cleans up to the point of ‘fogging’, were deemed sufficient and the risk minimal to patient safety. Ward C2 treats children and young people with complex conditions and those with lowered immune systems.
- Each clinical area had cleaning schedules in place to ensure all equipment was cleaned between uses. Staff used cleaning wipes for general cleaning of equipment and chlorine based wipes for cleaning equipment following exposure to infection. For example, staff on ward D2 cleaned multiuse equipment (such as blood pressure machines) on a daily basis and other equipment (such as toys) after each use.
- Play specialists across the children’s hospital kept cleaning schedules for toys. This ensured toys were cleaned between uses. Ward D7 had a ‘blue box’ system for all used toys to be left in after use to ensure that another child could not use them until they had been cleaned.

Environment and equipment

- All children and young people’s wards had secure access via swipe card. Ward staff challenged CQC inspectors before allowing access to clinical areas. This demonstrated an awareness of safety within clinical areas by ward staff.
- We checked 30 pieces of equipment across children’s services including monitoring equipment, medication pumps and patient transfer equipment. All equipment checked was within its required service date and visibly clean.
- We checked seven resuscitation trolleys across children’s services. Staff checked resuscitation trolleys daily for an intact seal and weekly for a fully equipment check. We saw evidence of these checks for July, August and September 2016 (up to the inspection date) on each ward visited.
- The main theatre suite had children’s resuscitation equipment and a difficult intubation trolley. Staff checked resuscitation equipment and the difficult intubation trolley daily and we saw evidence of recent checks.
- The buildings, although dated, appeared well maintained. We saw evidence of refurbishments taking place on ward F3 to create a further six overnight beds and improve the environment for patients and relatives before and after visits to theatre.
- Staff recorded fridge temperatures daily where food and breast milk were stored. Staff recorded room temperatures at the same time. We saw evidence of this recording for July, August and September (up to the inspection date) 2016 and escalation when temperatures fell outside the accepted ranges.
- However, we found wards to be cluttered and storage space was limited. The children’s intensive care unit (or PICU) lacked storage space and equipment was stored in corridors making access with beds and cots difficult. Staff on PICU told us they used space on the adult intensive care unit to store ventilators and other equipment when not in use. The children’s outpatient department was cluttered with a large number of toys around the waiting area which posed a slip, trip or falls risk to people visiting this area.
- Due to the refurbishment of ward F3, patients had moved temporality to ward D7. We visited ward D7 and found the cleaning cupboard unlocked and accessible. The cupboard contained soap, hand cream, cleaning solutions (containing chlorine) and cleaning equipment

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on shelving units starting at floor level. There was a risk children could access cleaning material which could be hazardous to their health and it did not meet Control of Substances Hazardous to Health (COSHH) regulations.

- We found the sluice room on ward D7 (where all waste was disposed) without any door lock or door handle. The sluice room had two rubbish chutes for waste bags and laundry. There was a risk that children could gain access to clinical waste and cleaning equipment. There was a risk children could injure themselves on the rubbish chutes.
- We raised our concerns regarding D7 to the ward nurse in charge at the time of inspection. During the unannounced inspection seven days after the main inspection, we found no improvement in the condition of ward D7. We escalated our concerns to the children's matron. The children's matron contacted the estates department and requested the unit be made safe and secure for children to receive treatment on.

Medicines

- Medication in all areas inspected was stored securely in locked cupboards. Staff stored intravenous fluids securely and managed controlled drugs effectively.
- However, we found staff did not keep the keys to the controlled drugs cupboard secure on the children's intensive care unit. Staff left controlled drugs keys hanging on portable workstations at the end of patients' beds. Staff told us that this was to allow easy access for staff when they needed them. The medication room on children's intensive care did not have a door and therefore was an open space. This meant anyone with the keys could access the controlled drugs cupboards.
- We raised our concerns to the Medication Safety Pharmacist and Chief Pharmacist at Addenbrooke's Hospital who were unaware of the current practice for controlled drug keys on children's intensive care which was not in line with Trust policy.
- During the unannounced inspection, seven days later, we found the nurse in charge held the controlled drug keys. The lead nurse told us this was now the process until a further risk assessment and review into the storage of controlled drug keys had been undertaken.
- We checked 12 controlled drugs across multiple children's wards and found that the amounts matched the controlled drugs register in all cases.
- Medical staff prescribed medication on the hospital's computerised records system. At the time of the

inspection, staff prescribed all medication, except chemotherapy, on this system. Medical staff documented patient's allergies on the patient's electronic record and nursing staff could view these easily during medication rounds.

- During the last inspection of children and young people's services in April 2015, we found prescribing errors due to the implementation of the electronic patient recording system. During this inspection, we did not find any prescribing errors and found the system was fully embedded and functioning well across all areas.

Records

- All patient records at Addenbrooke's Hospital were electronic. We reviewed seven patient records.
- All the records reviewed had fully completed demographics (name, address, date of birth and GP details) and fully completed admission documentation.
- All the records reviewed had applicable risk assessments completed, for example fall risk assessment, nutrition assessment, and moving and handling risk assessment.
- Staff prescribed all medication, with the exception of chemotherapy, through the electronic patient record. All prescriptions reviewed were in line with the British National Formulary and appropriate for the patient. Prescribers signed the prescriptions electronically. This allowed nursing staff to identify the prescriber and easily query any errors or concerns with prescribed medication.
- All nursing staff asked found the electronic system useful and easy to use with practice.

Safeguarding

- The hospital had a dedicated children's safeguarding team, consisting of nurse specialists and consultant paediatricians.
- During the inspection, we spoke with the children's safeguarding team. The children's safeguarding team demonstrated a strong understanding of how to support staff and report safeguarding concerns. The team recorded safeguarding concerns on the patient record system and we saw examples of this. The electronic record system highlighted patients with safeguarding concerns; however, detailed information

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could only be accessed once inside the patient's records. This helped maintain patient confidentiality when staff used computer workstations in bays or public areas.

- Staff on children's wards demonstrated a good understanding of their responsibilities in safeguarding children and young people.
- Across the division, including neonatal care, children and young people, 94.9% of registered nurses and 90% of medical staff had completed safeguarding level three training, as required by the Intercollegiate Role Framework for Looked After Children published March 2015.
- Across the division, 94.74% of healthcare assistants had completed children's safeguarding level two training, which equalled 52 healthcare assistants. However, only eight healthcare assistants had been identified as requiring children's safeguarding level three training. Of these eight, seven had completed the required training.
- During the inspection, we found six young people aged 16 or 17 years old on adult wards as inpatients. The Intercollegiate Role Framework for Looked After Children define a child or young person as anyone under the age of 18 years. Staff caring for young people in adult areas had not undertaken children's safeguarding level three training as required. Nursing staff in adult areas told us they did not see the relevance of level three training as it focussed on young children and not teenage patients. However, the annual safeguarding report had identified this concern and demonstrated increased training in safeguarding children level 3 for staff across the divisions with 88% of identified staff having received the training with full compliance met in March 2017.

Mandatory training

- The trust had a mandatory training target of 90% for all staff. Overall, neonatal, children's and young people's services achieved 97.5% compliance with mandatory training amongst nursing staff. Nursing staff achieved above 90% compliance in all areas of training with the exception of moving and handling, which staff were 89.1% compliant.
- On average, healthcare assistants were 94.91% compliant with mandatory training, against the 90% target. However, compliance with fire training was 82.84%.

- On average, medical staff were 95.3% compliant with mandatory training, against the 90% target. However, compliance with resuscitation training was 85%.

Assessing and responding to patient risk

- Children's services at Addenbrooke's Hospital used the paediatric early warning score to assess patients for deterioration. Neonatal services at Addenbrooke's Hospital used the neonatal early warning score system to assess and monitor for deterioration in neonatal patients.
- Staff assessed young people cared for on adult wards using the adult national early warning score system.
- The early warning score (NEWS) is a simple physiological score whose primary purpose is to identify patients at risk of deterioration. The early warning score system takes account of various physical observations, including pulse, respiratory rate, temperature and blood pressure.
- We reviewed seven patient records. All records contained up to date observations. Each set of observations taken had a NEWS score. We saw documented evidence of appropriate escalation to senior medical staff when a patient had a high EWS score.
- The hospital had two escalation systems in place for deteriorating patients. Nursing staff could 'fast bleep' the children's registrar for urgent advice or the review of a patient. Addenbrooke's Hospital used the nationally recognised '2222' number for emergencies, such as patients in cardiac arrest.
- Staff we spoke to were fully aware of how to use the emergency systems and when each one would be appropriate.
- Staff understood general risks to children and young people and measures were put in place to reduce risks. For example, parents were not allowed hot drinks in clinical areas to prevent the risk of burns to young children.

Nursing staffing

- We found planned staffing had been achieved on all clinical areas visited during the inspection.
- Senior staff used acuity tools to identify staffing numbers on a day-by-day basis. Senior nursing staff reviewed staffing throughout the day to ensure wards maintained safe staffing numbers.

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- Children's intensive care staffing complied with the Paediatric Intensive Care Society standards December 2015. For example, each shift had a supernumerary coordinator and staff to patient ratios of one staff to two high dependency patients and one staff to one intensive care patient were maintained.
- Data supplied by the trust at the request of CQC showed between January 2016 and August 2016 wards filled an average of 96.4% of registered nurse or midwife day shifts and 98.4% of registered nurse or midwife night shifts.
- Between January 2016 and August 2016, wards filled an average of 120% of healthcare assistant day shifts and 99.7% of healthcare assistant night shifts.
- Children's services used little agency staff. Senior management told us that children's services used its own 'bank' of staff to fill shifts. This helped continuity of care and ensured that temporary staff were converse with computer systems, policies and processes.
- Nursing handovers took place between each shift change. Staff told us the use of the electronic patient record system made handovers easy and quicker as all relevant information was easily accessible.
- Clinical areas inducted agency staff using a 15-point local induction checklist. The agency staff member and nurse in charge signed to say the induction had been completed. The checklist included medication safety, fire procedures, orientation to the clinical environment and familiarisation with medical equipment.

Medical staffing

- Children's services at Addenbrooke's Hospital had the same number of consultant level doctors as the national average (39%); 3% were middle grade doctors, below the national average of 7%; 53% were registrar level, above the national average of 47%; and 5% were junior doctors, below the national average of 7%. This ensured a good level of senior cover throughout children's services.
- We found sufficient numbers of doctors on duty to provide safe care to patients. Nursing staff told us that both senior and junior doctors were accessible and reviewed patients when requested to.
- We attended doctor's morning handover on the morning of 22 September. The handover was concise and appropriate and covered relevant information for all levels of medical staff. Medical staff of all grades attended handover.

- A registrar and a number of junior doctors supported each speciality consultant. Nursing staff told us this made ward rounds each morning difficult to coordinate due to the number of medical staff on the wards.
- A consultant was on call 24 hours a day for advice and support and was organised through a rota system. Junior medical staff and nursing staff told us that consultants were prepared to come in overnight and at weekends to review their own patients in the event of deterioration or significant change.
- There was no use of locum doctors with children's services.

Major incident awareness and training

- Children and young people's services had a winter pressure plan in place. The plan consisted of opening a further six beds on F3 (once refurbished) in November 2016. A further 20 beds could be made available on F3.
- Senior medical and nursing staff did not believe that the winter pressure plan was sufficient and had concerns over the effectiveness of the plan. Senior staff raised concerns that a further six beds, rising to 26 when needed, would still not provide enough inpatient beds to successfully meet the needs of 'winter pressures'. However, senior staff accepted the winter pressure plan had to work within the constraints of Addenbrooke's hospital.
- Addenbrooke's Hospital had business continuity plans in place for various incidents, including fire, flood and a sudden increase in demand on services.
- During the inspection the hospital's electronic patient record system failed and was inaccessible for around four hours. The response of the divisional management team was coordinated and effective. The divisional lead nurse was fully aware of patients at risk across the hospital and had assessed staffing, patient numbers and acuity to ensure patients remained safe, and care continued.

Are services for children and young people effective?

Good



We rated effective as good because:

Services for children and young people

- Nursing staff administered prescribed pain relief as required. Nursing staff undertook pain assessments and reassessments of children's pain. Appropriate pain assessment tools were in use across children's wards.
- The trust was compliant with all but one of the Faculty of Pain Management Core Standards for Pain Management (2015) acute pain management guidelines.
- Appraisal rates for nursing and medical staff were good across all areas of neonatal, children's and young people's services.
- Policies were updated and referenced appropriate national guidance and best practice.
- Children and young people had access to appropriate food and drink options.
- Multidisciplinary meetings took place for each speciality.
- Addenbrooke's Hospital had the regional Acute Neonatal Transfer Service based on site. Children's Acute Transfer Service undertook children's intensive care transfers.
- The latest National Neonatal Audit Program results show that neonatal services at the Rosie Centre performed better than the national average in all key performance indicators.
- We requested audits on the correct completion of prescriptions; however, the trust did not supply the data. The trust stated that the hospitals computerised records system "enforces prescribing standards". The sole reliance upon technology to highlight and enforce prescribing errors with no audit oversight could lead to errors within the system not being identified.
- The trust undertook an audit into pregnancy testing 13 to 16 year olds prior to surgery, published February 2016. The audit looked at 40 patients and found 82% had their pregnancy status documented prior to surgery. The audit also looked at how many pregnancy tests were undertaken with the consent of the patient, in line with the Royal College of Paediatric and Child Health Pregnancy Checking Guidance. The trust found that none of the patients sampled had documented evidence of consent. A five-point action plan with designated professionals for each action and an agreed completion date was in place. A re-audit was due July 2017.
- The trust undertook an audit into the comprehensiveness of surgical documentation following the insertion of a central line (a line used to give medication and monitor patient's blood pressure). The trust submitted the action plan following the audit. The action plan consisted of clear actions and nominated people to undertake them. Clear completion dates were documented and a re-audit date of August 2017 was agreed.
- We reviewed policies including the Children's Safeguarding Policy, Resuscitation Policy and Mandatory Training Policy. Where relevant, trust policies referenced national guidance any policies. For example, the resuscitation policy referenced the UK Resuscitation Council and the Mental Capacity Act, and the Children's Safeguarding Policy referenced guidance from the Department of Health, National Institute for Health and Care Excellence and Royal College of Paediatric and Child Health.
- The trust demonstrated that it reviewed and updated policies on a regular basis. Each policy checked had a version number, publication date and review date. For example, the trust was updating its Children's Chaperone Policy at the time of the inspection. The trust published their Children's Safeguarding Policy in February 2015 and had a review date as February 2018.
- Staff we spoke to were aware of relevant policies and procedures and where to access them.

However:

- The trust had mixed outcomes from the latest national audit results in intensive care, diabetes and epilepsy.
- The trust did not meet the recommendations of the Faculty of Pain Management Core Standards for Pain Management (2015) for procedural or chronic pain management. A multidisciplinary working group was being formed to review the recommendations and implementation of them.
- The trusts electronic patient record system did not allow for preloaded care plans to be altered to reflect individual needs of patients. The available care plans were not child or young person orientated and reflected the needs of adult patients.

Evidence-based care and treatment

- The hospital had an annual audit plan in place containing 65 audits due for completion in 2016 or 2017. These audits ranged from national audits (such as the national neonatal audit program) to in house audits (such as an audit of surgical notes).

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Pain relief

- We reviewed five medication charts on the electronic patient record system. The system allowed prescribers to review, add or change pain relief from anywhere within the hospital.
- The medication charts reviewed showed appropriate prescribing of pain relief. Medical staff prescribed anticipatory pain relief for children and young people following procedures.
- Staff told us medical staff would prescribe pain relief for patients to take home if required.
- The trust had a pain team within children's services. A consultant anaesthetist led the pain team, supported by a senior nurse specialist. A further nurse specialist was in post until April 2017.
- The trust was compliant with some of the Faculty of Pain Management Core Standards for Pain Management, published October 2015. Children's services met all but one recommendation for managing acute pain in children. However, children's services did not meet the recommendations of procedural pain management or chronic pain management. The trust told us a multidisciplinary working group was being set up to look into the development of chronic pain management systems for children and young people at Addenbrooke's Hospital.
- Children's services had up to date and well referenced pain management policies in place, including the use of intravenous pain relief and epidural management and care.
- Children's services participated in national audit programmes, including the national children's epilepsy, diabetes and intensive care audits. Addenbrooke's Hospital showed mixed performance across the audits we reviewed.
- The children's national epilepsy 12 audit, published in November 2014, demonstrated that Addenbrooke's Hospital performed better than the national average in 17 of the 24 performance indicators.
- The national paediatric diabetes audit 2014/15 showed the hospital performed at or around the national average in the majority of the key performance indicators. The hospital performed much worse than the England and Wales average for children receiving the seven key care processes as recommended by National Institute of Health and Care Excellence. These include patients having their blood pressure, cholesterol and eyes examined.
- The Paediatric Intensive Care Network Annual Report, published November 2015, showed Addenbrooke's to be at or around the national average for most indicators. However, unplanned admissions to intensive care following surgery with infection shown as the primary reason for the admission were nearly twice the national average at 10.2% (national average was 5.7% in 2014). However, unplanned admissions to intensive care following gastrointestinal surgery were significantly lower than the national average at 10.2% (national average was 19.5% in 2014).
- The National Neonatal Audit Program Annual Report, published September 2016, showed that the neonatal unit at the Rosie Hospital performed better than the national average in all nine of the audit measures recorded as part of the audit.

Nutrition and hydration

- Staff assessed and documented babies, children and young people's nutritional requirements on the hospitals electronic records system.
- Patients could access hot and cold food throughout the day and cold food at night.
- Staff we spoke to could explain the process for administering total parenteral nutrition (TPN) and the risks and precautions in place to reduce these risks. We found no children or young people receiving TPN at the time of the inspection.

Patient outcomes

Competent staff

- We requested information from the trust on staff appraisal compliance. Staff should undertake an appraisal every year to ensure they are progressing, any concerns are raised, and action plans implemented.
- The data submitted by the trust showed all registered nurses received an appraisal within the last year. The data also showed that an average of 96.4% of medical staff had received an appraisal within the last year. The teenage cancer unit averaged a compliance of 83.3% and general paediatric doctors averaged a compliance

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of 89%. The trusts target for appraisal compliance was 90%. All other clinical areas for neonatal and children's and young people's care achieved over 90% compliance with appraisals.

- We saw evidence of all staff on ward D2 having had an appraisal within the last year. The ward sister kept detailed records of when staff appraisals were due, when their professional registration lapsed and when mandatory training was due. The ward sister reminded staff two to three months before any aspect of competency expired to ensure that staff remained registered, trained and appraised.
- Information provided showed that a number of staff had been supported to complete additional qualifications relevant to their job role including post graduate qualifications.

Multidisciplinary working

- We found effective multidisciplinary team (MDT) working across all specialities visited. We observed discussions between medical staff, nurse specialists and allied health professionals (physiotherapists and occupational therapists) to agree plans of care or the safe discharge of patients.
- All children's inpatient areas had access to play specialists. The play specialist team provided support and distraction to children and young people to allow care to proceed with as little distress as possible.
- All clinical areas had access to psychology support for patients, relatives and staff following distressing situations. Staff knew how to contact the psychology team and spoke positively about their input.
- The regional acute neonatal transfer service (ANTS) was based at Addenbrooke's Hospital. The service was commissioned to undertake neonatal transfers within the East of England area. The Children's Acute Transfer Service (CATS), was commissioned to undertake all children's intensive care transfers for the East of England.
- All specialities transferred young people to adult services at 16 years of age. MDT working happened between adult and young people's services to ensure the transfer of care was as effective as possible. Clinics would consider on an individual basis continuing with the care of young people with specific or complex needs, for example those with delayed development.
- We found good transition services for young people with chronic or complex conditions. The diabetes service ran

a transition clinic once a month. Children's doctors and nurse specialists, and adult medical and nursing staff, jointly ran the diabetes transition clinic. Young people were encouraged to attend appointments and consultations without their parents, if they felt comfortable to do so.

- The hospital had adolescent in transition guidance to assist staff when supporting young people through the process of transition from children's services to adult services. The guidance clearly set out suggested time scales and milestones for young people. The guidance suggested a three-stage process to promote a smooth transition from children's to adult services.

Seven-day services

- Children's outpatient services ran Monday to Friday, with some specialties trialling Saturday clinics to ease demand.
- All clinical areas visited were capable of caring for children and young people 24 hours a day. Ward D7 (day case surgery unit) had the capability to support six patients overnight, whilst closing the remaining day case beds until the following day.
- Staff told us consultants were contactable 24 hours a day and would come in during the night if a patient deteriorated. The hospital had a registrar level paediatric trained doctor on site 24 hours a day.
- A consultant intensivist and consultant neonatologist were available 24 hours a day to support children's intensive care and neonatal intensive care units. Out of hours, advice was via telephone.
- Support services, such as pharmacy and imaging services, were available out of hours. Play specialists were available Monday to Friday.

Access to information

- During the previous inspection of children and young people's services at Addenbrooke's Hospital in April 2015, we noted that care planning was not achievable on the hospitals electronic patient record system.
- During the current inspection in September 2016, we found that care planning had been incorporated into the system; however, staff could not edit, remove or add to care plans. Staff told us that care plans were adult orientated and did not reflect the needs of children and young people.
- We reviewed the available care plans and found that they did reflect the needs of adult patients more than

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those of children and young people. For example, the continence care plan reflected the needs of adults and the use of commodes; however, did not mention the needs of babies or toddlers.

- On discharge, patients and their relatives were given information, including what to do if the child or young person deteriorates, and after care advice for wounds and dressings. GPs received discharge information electronically upon discharge of a patient.

Consent

- We saw all grades of staff seeking appropriate consent from patients and relatives (where required) before undertaking any intervention.
- Nursing staff gained verbal consent before undertaking interventions such as taking clinical observations or giving medication. Where children and young people were unsure about a procedure, the play specialist supported the patient to make an informed decision.
- Consent was taken on paper consent forms. Administration staff uploaded signed consent forms to the electronic patient record; however, staff told us this could take several days sometimes. Medical staff took consent again for patients where a consent form had not been uploaded in time for the procedure.
- A new process for storing consent forms had been implemented at the time of inspection. Nursing staff kept paper consent forms securely on the ward until after the patient had been to theatre. Administration staff uploaded consent forms to the hospitals electronic patient record system after discharge of the patient. Nursing staff told us this had reduced the number of missing consent forms.
- We requested training data for the number of medical staff trained in taking consent and assessing Gillick competence of young people. The trust told us that 10 doctors required delegation of consent training and eight of these had completed the required training. Delegation of consent training informs senior doctors how and when to delegate the process of consent to another member of staff, rather than the process of taking consent.
- The trusts consent policy for examination, and treatment (April 2015) states that all junior doctors and registered nurses receive consent training as part of corporate induction when starting work at the trust. Data provided in the board reports showed that all staff receive this consent training.

- We requested all mandatory training data from the trust for medical, nursing and non-registered staff. Mental Capacity Act training is not part of the trusts mandatory training modules for staff working with children and young people. Data provided showed that greater than 90% of staff across the division had completed this training.

Are services for children and young people caring?

Good



We rated caring as good because:

- Staff were friendly and approachable.
- We observed staff talking to patients in an age and developmentally appropriate manner.
- Patients described staff as “really nice” and “amazing”.
- Patients felt involved in the care decisions being made by staff.
- Psychologists were available for patients, relatives and staff in each clinical area visited.
- Staff on neonatal intensive care provided emotional support and reassurance, especially during times of loss or trauma.

However:

- Friends and Family Test data was inconsistent across children’s services with a very poor response rate. Ward F3, ward C3, the paediatric day unit and clinic six had worse results compared to other similar areas.

Compassionate care

- All patients and relatives we spoke to told us staff were friendly, approachable and considerate of their needs.
- We observed all staff speak with children and young people in an age and developmentally appropriate way. We observed telephone calls between staff and patients and relatives at home. Staff were reassuring and empathetic with the patient and their relatives.
- One relative described the staff as “amazing” and did not want to move back to a hospital nearer home. The patient told us they felt respected and had their fears of being in hospital acknowledged.

Services for children and young people

- Another patient told us that staff were “really nice” and that staff listened when they needed pain relief. However, the patient had spent time on another ward due to needing a side room. The patient told us that this was distressing and ward staff did not respond to this.
- The hospital participated in the NHS Friends and Family Test. The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients were happy with the service provided, or where improvements were needed. The results show how many people would recommend the service to friends and family.
- The trust provided FFT data for April 2016 to August 2016. Wards C2 and D2 scored over 93% and Charles Wolfson ward scored 100% for all five months. Ward F3 scored 100% in April (2.3% return rate) and May (1.9% return rate) 2016; however, in July 2016 ward F3 had 0% for patients recommending the service from a return rate of 5.6%. Ward F3 had no responses for August 2016 to assess improvement.
- Ward C3 received response in July 2016 only. In July 2016, 66.6% of respondents said they would recommend the service. This was against a response rate of 3.9%. The paediatric day unit (PDU) provided data for April, May and August 2016. The PDU scored 100% in April and May, with return rates of 0.8% and 4.2%. However in August 2016, 30% of patients would recommend the service and 70% stating they would not recommend the service. This was against a return rate of 6.6%.
- Children’s outpatient clinic six scored an average of 80.5% between April and August 2016. Clinic 31 supplied data for April and May, scoring 100% in each month.

Understanding and involvement of patients and those close to them

- All of the patients and relatives asked told us that they felt informed throughout their treatment process and felt involved in decisions being made.
- Play specialists used games to engage with children and explain the treatment and care they were receiving.
- Staff encouraged young people to make decisions themselves and attended clinic appointments without their parents, if they felt happy and comfortable to do so.
- Nurse specialists supported young people during transition from children’s to adult services, encouraging participation in treatment options.

- One patient, who was being cared for on an adult ward told us that staff listened and involved them in all decisions and changes to their treatment plan.

Emotional support

- Staff showed a sensitive approach when addressing difficult or complex issues. Staff showed consideration for the emotional needs of patients, parents and siblings.
- Staff on the neonatal intensive care unit (NICU) provided support to parents, particularly when babies were critically unwell. Staff encouraged parents to participate in the care of the baby as much as possible to ensure that the maternal and paternal bond stayed strong.
- Staff on NICU encouraged parents to keep an ‘emotion string’, which is a string that a bead is added to each day that the baby is in NICU. Each bead represents the emotions of that day and acts as a lifelong memory bank for parents.
- Clinical psychologists were available for all patients, relatives and staff. Counsellors were available within NICU and the chaplaincy service offered emotional support to parents and patients as requested.
- Nurse specialists were available for nearly all specialities. Nurse specialists provided support and guidance to patients and relatives throughout their treatment.
- Staff on the neonatal intensive care unit had a good understanding of the needs of babies and their parents in times of crisis.
- The hospital had no specific children’s bereavement service; however, nursing staff showed a good knowledge and understanding of the needs of families during a bereavement.

Are services for children and young people responsive?

Requires improvement



We rated responsive as requires improvement because:

- The capacity of children’s services was insufficient for the numbers of patients being admitted with 250 planned admissions having been cancelled within 6 months.

Services for children and young people

- Young people aged 16 and 17 years had no choice in the where they were cared for when admitted for inpatient care. Adult wards admitted all 16 and 17 year old patients.
- Staff did not always meet the needs of 16 and 17 year old patients during in patient stays as all 16 and 17 year old patients were admitted to adult ward areas. Ward managers on two adult where young people were being cared for during the inspection had inconsistent knowledge of the need for education, social interaction and parental support that young people may want during an admission.
- The trust did not monitor or audit delayed discharges of children and young people.
- Unplanned admissions to children's intensive care following surgery accounted for 9.1% of all admissions, which was higher than the national average of 4.9% this, coupled with a lower than national average planned admission rate for intensive care, suggested a lack of appropriate pre-operative planning.
- The neonatal intensive care unit closed on nine occasions between August 2015 and July 2016 due to overcapacity. This resulted in the movement or relocation of 19 neonatal patients.
- The neonatal intensive care unit had 58 cots; however, the hospital staffed only 40 of these.

However:

- The teenage cancer unit was excellent in the services and environment it provided for young people.
- Compliance with the 18 week target for non-admitted patients was 93.5% on average between July 2015 and August 2016.
- Children's intensive care did not close or refuse an admission between August 2015 and July 2016.

Service planning and delivery to meet the needs of local people

- Children's wards and outpatient clinics provided an inviting and child friendly environment, with separate areas for very young children and teenagers.
- Clinical areas adopted various techniques to make clinical areas more children friendly. These included the use of wall decorations, an interactive projector and access to a secure walled garden for parents and patients to use.
- The teenage cancer unit had recently been refurbished and had outstanding facilities for young people aged 14

to 25 years. There were separate areas for younger and older patients, with age specific activities and entertainment. For example, young people had a 'thought wall' to write, draw and graffiti on to express themselves.

- Play specialists supported children and young people in ward areas and outpatient clinics.
- The hospital had the challenge of providing both local district general services and regional specialties, including the regional trauma centre and neonatal services.
- The hospital provided facilities for parents of children and young people staying at the hospital. Children's wards had quiet areas where families could relax away from the bedside. Children's intensive care did not have a specific family room; however families could access the facilities on the joining ward.
- Families had access to a variety of shops and food outlets within the hospital. Staff offered parents of children and young people food vouchers for discounted food at the outlets within the hospital. A parent could stay on the ward overnight and beds were provided for them.
- Adult wards had inconsistent approaches to a parent staying overnight with a young person, which was standard practice on children's wards.
- One ward sister from an adult ward told us they would allow a parent to stay with the young person on the ward, if the young person wanted it. Another ward sister told us a parent would be allowed to stay with the young person if they were the same gender as the young person. The ward sister cited same-sex accommodation policy as the reason for this.
- Neonatal intensive care offered parents overnight accommodation if they wanted to stay. Food vouchers were available to allow parents to get discounted food in the hospital.
- We requested audit data to show that a consultant reviewed children and young people within 14 hours of arriving at hospital, in line with London Quality Standard 2013. However, the trust told us that they do not monitor review times by consultants and therefore could not assure us that a consultant reviewed children and young people admitted as an emergency within 14 hours of arriving at Addenbrooke's Hospital.

Access and flow

Services for children and young people

- The children and young people's service consisted of 13 intensive care beds, 17 oncology beds, 22 beds for patients aged over two years and 12 beds for patients aged less than two years. Neonatal services consisted of 58 cots; however, the trust staffed 40 of these at the time of the inspection.
- The hospital did not have a children's admissions ward. All children and young people admitted to the hospital as an emergency attended the emergency department for assessment before being admitted to an acute bed. Children and young people being admitted as electives attended the wards relevant to their speciality. For example, patients attending for day surgery attended the surgical day case unit and oncology patients attended the oncology unit.
- Children's services had 11,220 inpatient spells between March 2015 and February 2016.
- The hospital reported a higher than national average emergency readmission rate for children and young people aged one to 17 years, following an elective admission, in oncology, surgery and ear nose and throat services.
- However, emergency readmission rates for children under one year old were better than the national average following elective and non-elective admissions.
- Young people aged 16 or 17 years old were automatically admitted to an adult ward for care. The divisional leadership team told us this was due to 'bed pressures' and the inability to accommodate 16 and 17 year olds on children's areas. The lack of bed capacity across children's areas was a documented risk on the risk register. The development of ward F3 will give a further 26 day case beds, with six of these able to open overnight. The remaining 20 could be opened for overnight care with agency staff. This has formed part of the winter pressure contingency plan.
- The divisional leadership team told us that the lack of beds was having a significant impact on patients being able to access beds. The divisional leadership team told us that 250 patient's admissions had been cancelled or delayed between January 2016 and August 2016 due to bed capacity problems.
- Between September 2015 and August 2016, the trust cancelled 132 procedures for children and young people. Of these, 121 were rebooked within 28 days of the procedure being cancelled and 11 patients waited longer than 28 days to be rebooked.
- The neonatal intensive care unit (NICU) moved 19 patients to other centres between August 2015 and July 2016 due to insufficient capacity. The NICU closed nine times between August 2015 and July 2016 due to overcapacity. Information provided by the trust showed this equated to 122.25 hours of closure within the 12 month period. The neonatal intensive care unit had 58 cots; however, the hospital staffed 40 of these.
- We requested information from the trust about cancer referral times for children and young people. The trust told us that they were "100% compliant" with all national cancer targets between September 2015 and August 2016. The Trust did not provide data in support of this information.
- The children's intensive care unit (PICU) did not refuse a patient for admission between August 2015 and July 2016. We reviewed clinic data for patients requiring appointments or treatment within 18 weeks of a referral being made. Between July 2015 and August 2016, an average of 93.5% of patients were seen within 18 weeks of a referral. August 2015 saw the lowest compliance with 88.9% of patients being treated in 18 weeks. May 2016 saw the highest level of compliance with 96.1% of patients seen within 18 weeks of a referral.
- Children and young people waiting for transfer to another hospital are highlighted within the electronic records system. Senior management review the 'work queue' of delays to other hospitals and escalate through the clinical engagement team to reduce the waits as much as possible. We requested data from the trust around delayed discharges, including how the trust monitors delayed discharges. The trust did not submit any data however; the trust told us that they do not monitor delayed discharges.
- The latest national paediatric intensive care audit, published November 2015, showed a higher than national average unplanned admission rate to intensive care. Unplanned admissions to intensive care accounted for 9.1% of total admissions in 2014, compared to the England and Wales average of 4.9%. This is worse than in 2013 when 6.7% of patients were unplanned admissions following surgery.
- The national intensive care audit also showed that planned admissions to intensive care were lower than the national average. In 2014, 25% of admissions were planned following surgery. This compares to the England and Wales average of 34.4%. This demonstrates a lack of planning for patients undergoing surgery.

Services for children and young people

Meeting people's individual needs

- Staff met the needs of children and young people within children's wards and clinics.
- Specialist nurses were available to provide advice, support and reassurance to patients and relatives in most clinical specialties, including diabetes, haematology, oncology and respiratory.
- The hospital did not have a specific children's palliative care or bereavement team. However, we found that senior nursing staff had a good understanding of the needs of children and parents when a baby, child or young person was receiving palliative or end of life care.
- The senior nursing team for children's services gave an example of a baby in neonatal intensive care that died and the family were practicing Muslims. The neonatal unit, along with the mortuary, ensured that the required paperwork was completely swiftly to ensure the family could take the baby back to their hometown in time to observe Muslim traditions following death.
- Staff had a good understanding of how to support children and young people with additional needs, such as learning or developmental difficulties. The play specialists supported children and young people throughout their hospital experience. Play specialists explained procedures to children and young people in a way that removed fear but supported reality. Play staff explained and showed us some of the techniques and activities used to support children and young people. These included the use of puppets to explain procedures, role-play to explain what will happen in theatre and the use of teddies to demonstrate procedures. Play staff explained the importance of quiet spaces for some children, for example with autism, to allow them to remain calm during discussions and procedures.
- We observed a play specialist assisting and distracting a child through a medical procedure by sitting on the floor with the child as this is where the child felt safest.
- Play specialists on ward D7 used a teddy bear in a hospital gown to demonstrate having blood taken and what happened when a patient is taken to theatre. This allowed children and young people to visualise a procedure or experience prior to it happening to reduce anxiety.

- The children's cancer unit had its own cook that prepared food to order. Children could ask, within reason, for any food they wanted and the cook would prepare this.
- Staff on one adult ward showed a good understanding of the needs of young people, for example access to education, social interactions and developmental needs. However, another adult ward could not give examples of additional support that a young person may need during a stay in hospital.
- Staff had access to a translation service 24 hours a day for patients or relatives whose first language was not English.
- The hospital did not routinely provide wireless internet access for children and young people to use. However, the teenage cancer unit did provide wireless internet for the young people admitted there.

Learning from complaints and concerns

- Children's and neonatal services received 66 complaints between June 2015 and June 2016, which was 6.1% of the total received by Addenbrooke's Hospital.
- None of the patients or relatives we spoke with raised any concerns or complaints to us during the inspection.
- Information on how to complain was available in each area we visited. Clinical areas also had comment boxes for patients and relatives to leave comment cards.
- The hospital used the Patient Advice and Liaison Services (PALS) as its main provider of complaints support for patient and relatives. The PALS was easily accessible within the hospital and information on how to contact PALS was available in clinical areas. Staff we spoke to knew how to contact PALS.
- We saw complaints discussed in ward newsletters and learning shared amongst staff, for example the September 2016 newsletter on ward D2 contained information about a complaint that had been received and shared learning from that.

Are services for children and young people well-led?

Good



We rated well-led as good because:

Services for children and young people

- Children and young people's services had a comprehensive risk register with updates documented. Each clinical area had a local risk register in addition to the divisional risk register.
- The divisional leadership team were knowledgeable and informed of the risks and concerns across the division.
- Staff across all areas visited were positive about the children's service.
- Staff felt supported by their line manager and told us an open door policy was ingrained across the service.
- Ward managers sent newsletters to staff to inform them of changes and updates from across the hospital.
- Young people were encouraged to get involved in shaping the provision of services through 'Active', a young person's board at the hospital.
- The workforce within neonatal, children and young people's services was diverse. Data supplied by the trust showed 11% of staff identified themselves from a black or minority ethnic background and 40.7% defined their sexuality as something other than heterosexual. People of all ages made up the workforce, with 75.1% between 19 and 45 years old.

However:

- Addenbrooke's Hospital lacked a formal strategy for children and young people's services though work had commenced on this.
- Integration between adult and children's teams to address concerns around the provision of care and safeguarding of teenage patients in adult areas was lacking.

Leadership of service

- Children's, young people and neonatal service were within the trusts division E, which incorporated all women and children services. A divisional medical director and an associate director of operations led this division.
- A divisional head of nursing managed children's, young people's and neonatal services. Two senior clinical matrons (one for medicine and surgery and a second for children's and neonatal intensive care) supported the divisional head of nursing.
- A band seven sister or charge nurse managed each clinical area on a day-to-day basis.
- All staff we spoke with told us they received support from their ward manager. Ward managers told us they felt supported and respected by the divisional matrons.

Vision and strategy for this service

- The divisional management team told us that children's services did not have a full vision or strategy though work had commenced on this.
- The divisional management team (DMT) told us that young people's services and transition care do not have a strategy to ensure young people receive safe effective transitional care. However, individual areas and specialties had implemented transitional care pathways and these were seen to be effective. The DMT told us no strategy was in place for ensuring the safety and care of young people in adult areas, despite hospital pathways admitting 16 and 17 year old patients directly to adult areas.

Governance, risk management and quality measurement

- The division had a division wide risk register. Each clinical area had a risk register in place containing information on locality specific risks. We reviewed both the divisional and local risk registers.
- The divisional risk register contained 23 risks, with 16 risks over one year old. The risk register contained risk ratings before and after mitigating actions. Local risk registers contained information relating specifically to the areas concerned.
- Children's intensive care had added the storage of the units controlled drugs to the risk register following a change in procedure. The new procedure increased the risk; however, the senior nursing team did not recognise that the increased risk in changing procedure outweighed the perceived benefits.
- Ward F3 had temporarily moved to ward D7. The matron for children's services told us that they had completed a risk assessment for the move to ward D7. We saw copies of risk assessments for D7 during the inspection. On visiting ward D7, we found cleaning cupboards with no door locks containing hazardous substances accessible and at child height; the sluice with no handle on the door and easily accessible rubbish chutes; and unsecure access to a service lift. The children's matron was unaware of the risks we highlighted, despite undertaking the risk assessment. Therefore, we were not assured that senior staff had oversight of the risks to

Services for children and young people

children and young people whilst in a non-children's environment. This increases the risk of harm or injury to patients as mitigating actions cannot be taken to reduce the risks if the risks were not identified initially.

- Following escalation of the concerns, matron asked the estates department to secure the doors to the sluice and cleaning cupboard. Matron assured inspectors that a review of safety on ward D7 would be undertaken.
- The division held regular governance meetings and we reviewed the minutes of these. For example, we reviewed the meeting minutes for the children's trauma governance meeting from May 2016. The minutes show discussions around all trauma patients and incidents involving trauma patients. The minutes also contained actions and delegation of responsibility for completion of the actions.
- We also reviewed governance minutes from haematology and oncology services. The minutes showed discussions around currently identified risks within the services, complaints, incidents and lessons learnt and review of training and competence across the speciality.
- Children's surgical services held monthly audit review meetings. We reviewed the minutes from the June 2016 meeting that showed discussions about ongoing audits and when results should be published. The attendees also discussed relevant cases of mortality and morbidity and related training.

Culture within the service

- We found a culture of openness, transparency and support across all areas inspected. Staff told us managers were supportive and approachable.
- We saw effective team working and dynamics throughout clinical areas. For example, when planning care of patients, staff respected each other's opinions and comments equally.
- We saw cooperation and mutual respect between professionals for areas of expertise across the hospital. For example, the children's intensive care unit (PICU) had employed an operating department practitioner to oversee the running and maintenance of equipment (such as ventilators and medicine pumps). Staff on PICU recognised the expertise that an operating department practitioner could bring to the team and they were now a core part of the PICU clinical team.

Equalities and Diversity – including Workforce Race Equality Standard

- Data given by the trust showed a diverse workforce within children and young people's services. The demographic data showed 92% of the workforce identifying as female with 8% identifying as male. However, the data did not take account of staff that may identify as non-binary.
- The data showed that 11% of the workforce identified as being from a black or minority ethnic background. The departments with the largest diversity of staff were neonatal intensive care, outpatients and the children's diabetes team.
- The majority of the workforce (75.1%) was between 19 and 45 years old.
- The data showed that, of those who answered, 56.4% of the workforce identified themselves as heterosexual, 1.27% as lesbian, gay or bisexual and 39.5% gave their sexuality as undefined.
- The trust had a policy for staff transitioning to a gender other than that assigned at birth. However, the trust did not monitor the number of transgender staff within the workforce.
- We requested information from the trust on the latest Workforce Race Equality Standard. The information provided by the trust was hospital wide and therefore we will report on this within the main provider report. No specific data was received regarding neonatal, children's or young people's services.

Public and staff engagement

- A children's board had been set up at the hospital called 'ACTIVE', which was run and managed by young people aged nine and over. ACTIVE undertook projects and consultations to improve the experiences of young people in hospital. For example, they were involved in patient led assessment of the care environment and produced information on the hospital website. ACTIVE also produced a newsletter containing information about the hospital and articles about projects done within children's services.
- Staff told us they felt able to raise ideas and these would be listened to. Staff were involved in the redesigning of the neonatal unit and had input into the redesign of ward F3.

Services for children and young people

- The hospital undertook a staff survey each year to understand how staff felt about the hospital. CQC will report on the latest staff survey results in the main provider report.

Innovation, improvement and sustainability

- Staff told us they felt expansion and continued development of the services was difficult due to the constraints of the environment at Addenbrooke's Hospital.
- The opening of the redeveloped teenage cancer unit has had a positive impact on the young people that access the service. Separate spaces for older and younger patients, and specifically designed areas to allow for comfort, dignity and relaxation during treatment.
- The redesigning of ward F3, due for completion in November 2016, will give patients a purpose built day surgery unit, with the ability to nurse patients overnight if required. The plans, as seen during the inspection, show a redesigned ward with separate areas for overnight and day patients. A light, bright and open plan design should help ensure the safety of patients, allowing nurses to monitor patients for a distance.
- The children's oncology and haematology clinical nurse specialists were implementing nurse led clinics to ensure patients could be seen quicker. The clinical nurse specialists told us the new nurse led clinics were due to start by the beginning of November 2016.

End of life care

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

Information about the service

The specialist palliative care team supports people affected by life-ending or life-limiting conditions and their families by managing patients' pain and other symptoms. The team supports patients with cancer with managing complex symptoms. It receives referrals from professionals in other hospitals and in the community for other life-threatening or life-limiting conditions from across the Cambridge and East Anglia region. Staff made 1,359 referrals to the specialist palliative care team from April 2015 to March 2016. The majority (58%) of these patients had been living with non-cancer illnesses.

End of life care (all care given to patients approaching the end of their life and following death) and palliative care services at Addenbrooke's Hospital are provided across all wards and departments, as the hospital does not have a dedicated palliative care ward. The palliative care team is supported by the specialist discharge team, the mortuary, bereavement and chaplaincy services. There were 1,483 deaths in the hospital between April 2015 and March 2016.

We visited 16 wards including accident & emergency and intensive care. We visited supporting departments such as the bereavement team, mortuary and chaplaincy. We spoke to 62 members of staff, including doctors, nurses, porters and the mortuary team. We also spoke with seven patients and relatives and looked at 26 patient records. We observed care and attended staff meetings.

Summary of findings

We rated end of life services as good because:

- Patients were well cared for and kept safe from avoidable harm. Staff worked to clear guidelines and policies, and were all up to date with mandatory training, including on how to manage risk and safeguard patients from abuse.
- Staff used good infection control techniques, such as use of personal protective equipment and disposal of waste.
- Staff provided care personalised to each patient and in line with national guidance. , That was reflected in care records that were well organised and accessible.
- The service was responsive to patients' needs. Patients referred to the service were seen promptly and the team was responsive to their individual needs throughout their care, including managing their pain and symptoms with anticipatory medication. The team tried hard to improve discharge times so that patients at the end of their lives could be in the place of their choice.
- Staff were exceptionally caring and compassionate. They treated patients with dignity and respect, and were responsive to the needs of patients and visitors. We saw outstanding examples of how staff had fulfilled patients' dying wishes, including by arranging a wedding in the hospital, moving a patient's wife of 65 years into the bed next to him so they could hold hands, and tracking down a patient's daughter so she could be with him before he died.

End of life care

- The service had good governance arrangements for continually improving the quality of their services and safeguarding high standards of care.

However:

- There were inconsistencies in the types of care plan used by nursing staff.
- The hospital did not meet the staffing levels within the palliative care team, as recommended by the Association for Palliative Medicine in Great Britain and Ireland, and the National Council of Palliative Care.
- Half of DNACPR forms reviewed were completed incorrectly.
- Patient wishing to die at home could go on a fast track discharge. The average time for this was 3.84 days. Although there had been recent improvements this did not meet the recommended time of 2 days.

Are end of life care services safe?

Good



We rated safe as good because:

- There were no serious incidents reported between July 2015 and June 2016.
- Staff were aware of reporting procedures and the importance of thorough analysis of incidents, duty of candour and sharing lessons learnt.
- Clinical areas were visibly clean, personal protective equipment and hand sanitiser was readily available and used.
- Waste was handled and disposed of in accordance to trust policy
- Staff had completed mandatory training with 100% compliance. This included infection control training.
- The mortuary was secured, monitored and accessible only to relevant staff. Mortuary records were complete and accurate.
- All end of life care staff had received training on safeguarding people from abuse and staff knew the process for raising safeguarding concerns. There had been no safeguarding concerns between July 2015 and June 2016.
- Patient records were recorded on an electronic system, allowing notes to be clear, organised and legible.
- Staff assessed and responded to patient risks.
- There were detailed plans for a major incident.

However:

- The mortuary did not have a protocol for the safe storage and disposal of controlled drugs. This was specifically in relation to deceased patients admitted directly to the mortuary from the community.
- There was inconsistency in the type of care plan used, increasing the risk of information being missed.
- The hospital did not meet the staffing levels recommended in The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care guidelines.

Incidents

- There were no never events reported between July 2015 and June 2016. Never events are serious incidents that are wholly preventable as guidance or safety

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recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- There were no serious incidents (those requiring investigation) reported between July 2015 and June 2016 for end of life services.
- Staff were aware of the procedures for reporting an incident using the hospitals electronic system. Staff explained the importance of investigating incidents to learn lessons and improve services. Staff investigated serious incidents using root cause analysis and where necessary further training would be arranged.
- The trust introduced an end of life category on the reporting system in September 2015. This allowed the trust to identify any trends specific to end of life patients. Staff told us there had been too few incidents to identify any areas of concern.
- We spoke to a ward nurse who had used the reporting system to report a non-serious incident. They felt they had good feedback and was notified of the outcome via email.
- Staff were aware of their responsibilities and principles in regard to the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff explained the importance of being open and honest when making mistakes, apologising and notifying all those involved.
- The hospital provided us data regarding non serious incidents. These were recorded in line with NHS England guidelines and included impact result, action taken and lessons learned. We also saw evidence of lessons learned being addressed in ward meetings and use of duty of candour.

Cleanliness, infection control and hygiene

- The wards and departments were visibly clean, bright and well maintained.
- We looked at the August – September 2016 cleaning and disinfection file in the mortuary. This was signed and up to date.

- Hand sanitiser was available at the entrance of each ward and sinks were available for hand washing. We observed staff using hand sanitisers and washing their hands in line with policy and guidance.
- Staff complied with the hospitals infection control policy, including being bare below the elbows in clinical areas. Medical staff used personal protective equipment (PPE) when assessing patients, in line with national institute for health and care excellence guidelines.
- Infection control was part of the hospitals mandatory training. We noted that 100% of mortuary, chaplaincy, bereavement and the palliative care team were compliant with this training. 97.9% of porters were also up to date, exceeding the trusts target of 90%.
- We saw evidence of practices being monitored and improved when required. The hospital infection control team conducted an assessment on the mortuary in January 2016. We reviewed this report and noted the mortuary management team had taken 12 recommendations from it, and produced an action plan. A progress report was produced in July 2016. 11 actions had been completed and one was ongoing. This corroborated our findings during our visit.
- Staff who worked in the mortuary were aware of procedures for the prevention and control of infection, such as the management of clinical waste and environmental cleanliness. Mortuary staff had sufficient access to personal protective equipment (PPE) and there was adequate access to hand washing facilities. We noted these were used by mortuary, porters and funeral staff.
- The mortuary had facilities to store the bodies of deceased patients who were deemed to be at a high risk in relation to infection control and therefore required isolation.
- We saw the trust's guidance for handling and viewing of high infection risk patients. Staff were aware of these procedures and could explain the procedure for protecting, hospital, funeral staff and visitors from risk.
- The Trust porters (trained to deliver patients to the mortuary) we spoke to were aware of the procedures to transfer patients with a risk of infection safely, whilst respecting their cultural and religious needs.

Environment and equipment

- Patients receiving end of life and palliative care were treated on general wards. The wards we visited were

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bright, tidy, spacious and visibly clean. Staff informed us that, where possible, patients would have an option to have a side room, where they had private and quiet surroundings.

- The mortuary was licenced by the Human Tissue Authority to allow post mortem examination and storage of the deceased. The hospital's estates department maintained mortuary equipment. Items of equipment such as fridges and trolleys were visibly clean and had up to date portable appliance testing.
- We saw that mortuary waste was handled and disposed of in accordance to trust policy and in line with national guidance.
- The trust completed a planned maintenance dashboard for equipment relating to end of life services. The latest figures supplied by the hospital were for April to June 2016. We noted that 100% of medium risk equipment and 56% of low risk equipment had been serviced. This exceeded the trust's target of 75% and 50% respectively. There was no high risk equipment listed. This ensured equipment was safe to use.
- Staff felt they had easy access to equipment, such as syringe drivers, bed pans, urinals or pressure relieving mattresses. There were no reported incidents of insufficient or delay in getting specialist equipment such as syringe drivers.
- Access to wards was via a door bell with fitted camera and speakerphone. This helped keep patient's safe, as the ward staff could control who could visit the ward.
- Trust staff had access via swipe cards. We saw signs that stated 'do not allow unknown visitors to follow you through the door'
- The mortuary had a call bell and CCTV in the corridors. All visitors signed a visitor's log book to say their reason for entering the department.

Medicines

- The hospital reported no serious medication errors and 16 minor/no harm medication errors relating to end of life care between October 2015 and June 2016.
- Eight were regarding administration, four prescribing and four storage of medicines. We noted that one was still under investigation and 15 were closed with actions taken and lessons learnt.
- There was only one type of syringe driver in use, minimising the risk of confusion. We received training compliance data for 22 June 2016. 84% (1339) of nursing

staff had been trained to use this syringe driver. Training records indicated that those wards with end of life patients had the highest percentage of syringe driver trained nurses.

Staff we spoke to had received this training, and felt confident in using them effectively.

- We observed two staff nurses entering a patient's side room and immediately checking the syringe driver. We reviewed this patient's notes, and confirmed the checks were documented one hour after commencement on 19 September 2016 and every four hours since (21 September 2016). Regular checking by two members of staff ensured medication was being administered safely and was considered best practice by the Nursing and Midwifery Council (NMC) - Standards for Medicine and Management.
- The trust had a protocol called 'Care in last days of life'. This included anticipatory prescribing to control anticipated pain for patients who were dying within hours or days. Staff used a flowchart document that advised on medication doses to control symptoms (for example breathlessness, pain and nausea). This was considered good practice by the National Institute for Health and Care Excellence (NICE)
- 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.
- The consultant stopped non-palliative medication in the last days and hours of life. This is considered good practice by NICE.
- We observed staff and saw documentation that showed all the records demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS61. This quality standard defines clinical best practice about how people are prescribed antibiotics in accordance with local anti-biotic formularies. We did however note that on one set of notes pain medication was being prescribed, but had not been transferred on to the patient's notes. We escalated this to the ward sister, who said they would address this immediately.
- There were appropriate systems for the safe storage and checking of controlled drugs and syringe drivers. On the

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wards we inspected all medicines were stored safely and the record keeping was in line with the trust's policy. We found controlled drugs were managed in accordance with the Controlled Drugs Regulations 2013.

- The mortuary stored all medications from patients that were transferred deceased from the community. These were kept with the patient in locked fridges. Following a post mortem the medication would then be stored in a container awaiting disposal. Mortuary staff stated they had never received controlled drugs for storage. However there were no mortuary specific protocols should this occur, and this posed a risk of unsafe storage and disposal.

Records

- The hospital used a centralised electronic records management system (Epic). This allowed all nursing and medical staff to access patient records from hand held devices and any computer in the hospital.
- This also allowed patient records to be easily organised and legible. Patient records were secure as each member of staff required a log in username and password.
- We reviewed end of life care patient records. They were organised and under the correct tabs.
- We observed the SPCT reviewing records of patients who were at the end of life.
- Some wards we visited preferred to print out hand over sheets containing clinical information such as Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) status, active treatment, early warning scores (EWS), discharge destination. Staff felt this was easier and more efficient when there were a lower number of patients. We reviewed a set of these notes and saw they matched those on Epic and were updated and reprinted three times in 24 hours.
- We saw evidence that paper handover sheets were signed in and out to ensure correct disposal and protection of patients confidently.
- The trust had yet to implement a unified care plan replacing the Liverpool care pathway, which was withdrawn in July 2014. End of life care plans used were inconsistent across hospital wards.
- Epic had an end of life care flow chart to monitor patient comfort. We saw this documented and used alongside the patients notes.
- We also saw an 'escalation and ceiling of care plan' used in conjunction with the end of life care plan. This

contained resuscitation status, medication, involvement of other teams, nursing plan, and discussion with patients. This was only seen in use on care for the elderly wards.

- Mortuary records, including those for admittance and release of the deceased were accurate.

Safeguarding

- The hospital reported no safeguarding concerns relating to end of life care between July 2015 and June 2016.
- Ward staff were aware of their role in safeguarding. They were able to describe actions and procedures to report a safeguarding concern. We noted that safeguarding was also discussed at ward staff handovers.
- The palliative care, bereavement, chaplaincy and mortuary team had completed safeguarding training for both adults and children. Records submitted by the trust confirmed that all staff were up to date and 100% compliant.

Mandatory training

- Mandatory training included courses to keep staff and patients safe. These included conflict resolution, fire safety, infection control, information governance, moving and handling, resuscitation and safeguarding children and adults.
- End of life care training was part of the trust's induction training.
- Palliative care team were 100% compliant and up to date in all mandatory training, except resuscitation which was 80% (1 member of staff). The trust's target was 90%.
- Mortuary, bereavement and chaplaincy staff were 100% compliant and up to date with all mandatory training.

Assessing and responding to patient risk

- The palliative care team had a daily meeting to discuss patients who were at the end of their life. The team would follow up the care of these patients on the wards.
- Ward staff had two daily clinical meetings, this included updates on patients and their potential risks and safeguarding.
- Patient's notes contained risk assessments for areas such as malnutrition, falls and pressure area damage. We witnessed risks being minimised by completing regular checks in line with national guidelines.

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- We saw examples of these risks being addressed by using mouth care kits to alleviate pain and discomfort and air mattresses to prevent pressure area damage.

Nursing staffing

- There were no dedicated end of life care beds at the trust. Patients receiving end of life care were cared for by nursing staff throughout the trust.
- Each ward had at least one palliative/bereavement care champion who had been trained by the palliative care team to provide end of life support. Ward champions worked closely with the palliative care and bereavement teams. The trust provided us with data that confirmed this; we noted that some wards had up to five champions.
- We spoke to a ward champion, they were passionate about their role and ensured end of life care was a ward priority.
- The palliative care team included 3.65 whole time equivalent (WTE) nurses, 1.8 end of life care facilitators and 0.6 facilitator support. The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative Care recommends there should be a minimum of one specialist palliative care nurse per 250 beds. The trust had 1486 beds. Based on these recommendations the hospital's staffing level for hospital based palliative care nurses was insufficient, as it should have been 5.57 WTE.
- Palliative nurses felt they worked well and safely, but felt understaffed. They understood that they could not provide 7 day face to face care, as recommended by the National Care of the Dying Audits for Hospitals (NCDAH) and NICE guidance for supportive and palliative care CSG4.
- We saw good use of documentation and discussions at handovers with ward staff. This ensured patients receiving end of life care were identified.

Medical staffing

- There were 2.9 WTE palliative care consultants. This was not in line with the Association for Palliative Medicine in Great Britain and Ireland, and the National Council of Palliative Care, which states there should be 5.57 WTE, a minimum of one consultant per 250 beds.
- Palliative care consultants were available Monday to Friday for face to face reviews. However, there was a lack of this face to face support, through the night at weekends and during bank holidays.

- Out of hours advice and guidance about symptom control was provided by doctors on an on call rota.

Major incident awareness and training

- The mortuary had contingency plans for additional storage should it be required. The trust provided us with detailed policies for procedures if the mortuary was full. This took seasonal pressures in to consideration. There was space for approximately 157 deceased patients. At the time of inspection an external body store had just been refurbished, increasing the number of available spaces.
- Mortuary capacity was assessed each week by mortuary staff, during winter months a daily check is completed, staff were aware of their responsibilities in the event of full capacity. Extra planning was performed leading up to a bank holiday weekend to ensure adequate spaces.
- The mortuary also owned a flexible storage facility that would further increase spaces. There were plans to add this to the mortuary major incident plan.
- If required, there was a procedure in place to further increase this capacity, by setting up a cold room.
- The mortuary had a specific major incident response. This had clear guidelines, contact numbers and templates in the event of a major incident. The hospital operated three levels of response, bronze, silver and gold command. The mortuary staff fell under the Bronze category and would work under the Silver Command.
- Mortuary staff understood their responsibility and their role in a major incident and directed us to their 'major incident response kit' this allowed quick access to all the guidance and materials they would require. We saw that this was updated yearly.
- One member of mortuary staff had received additional training in disaster victim identification.

Are end of life care services effective?

Requires improvement



We rated effective as requires improvement because:

- We reviewed twenty Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders, ten were completed correctly (50%).
- Staff were using the trust's end of life-individualised care plans consistently where patients had been identified as

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end of life to ensure they received evidence based end of life care. However, nursing staff were only using the first part of a two part plan. Staff told us they had not yet received training on using the second part.

- The trust did not achieve three out of the four organisational indicators, relating to recommended training in the End of Life Care Audit – Dying in Hospital 2016.
- Do not attempt resuscitation forms and preferred place of death were not routinely audited.
- There was no regular audit of DNACPR forms.

However:

- All of the records we reviewed demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13 with patients being cared for on an individualised care plan.
- The trust had taken part in the National Care of the Dying Audit 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust scored better than the England average on four of the five Clinical KPIs.
- Palliative care team assessed patients within 24 hours in 74% of cases.
- Patient's symptoms including pain were managed and medication was prescribed for anticipatory medicines (medication that patients may need to take to make them more comfortable).
- Patients were properly assessed and supported with their nutritional needs.

Evidence-based care and treatment

- Staff assessed patients' needs and delivered care and treatment in line with National Institute for Health and Care Excellence (NICE) guidance.
- The records we reviewed demonstrated that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard QS13. This guidance defines clinical best practice within end of life care for adults.
- Following the withdrawal of the Liverpool Care Pathway, the trust had developed and implemented individualised care plans for patients approaching the end of their life. The individualised care plans recognised the five priorities for end of life care as set out by the Leadership Alliance for the Care of Dying People (2014).

- Staff were using the trust's end of life-individualised care plans consistently where patients had been identified as end of life to ensure they received evidence based end of life care. However, the individualised care plans were a two part document. Ward staff told us they were only using the first part as they had not received training on how to complete the second part.
- The universal form for treatment options (UFTO) was in use at the trust. 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.
- The Specialist Palliative Care Team were able to tell us about the current guidance relating to end of life care.
- The trust audited some aspects of care including bereavement care. The end of life care strategy for 2016 to 2020 identified a need for an audit plan for end of life care which was not yet in place.

Pain relief

- Patient's symptoms were managed and medication was prescribed for anticipatory medicines (medication that patients may need to take to make them more comfortable). For example we checked three medication administration records on ward D9 and found that all three records demonstrated anticipatory prescribing was undertaken to reduce the risk of escalating symptoms.
- We saw evidence of patients regularly being assessed for pain and given medication in a timely fashion.
- Patients within end of life care services had their pain control reviewed daily. Regular pain medication was prescribed in addition to 'when required medication' (PRN), which was prescribed to manage any breakthrough pain. This pain occurs in between regular, planned pain relief.
- We saw that care followed the National Institute for Health and Care Excellence (NICE) Quality Standard CG140. This quality standard defines clinical best practice in the safe and effective prescribing of strong opioids for pain in palliative care of adults.
- We saw the core standards for pain management services were being met in all of the medical notes we reviewed. The core standards for pain management in England are a comprehensive index of recommendations and standards for pain management.

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- The specialist palliative care team told us they worked closely with the pain team.

Nutrition and hydration

- We reviewed four sets of nursing records relating to patients in the last days of life. We found evidence patients were screened for their risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify patients who are malnourished, at risk of malnutrition and to ensure those who were nutritionally at risk were identified accordingly.
- Where interventions were required, they were documented on the patient's daily record. For example, we saw an entry from the dietician, where a patient required extra nutritional supplements; this was because there was a reduction in the patient's appetite which was a recognised aspect of their illness.
- Patients were encouraged to eat and drink as and when they were able to and for as long as they were able to in their last days of life. For example on one ward we saw a family assisting their relative to eat lunch.
- We looked at the menu on each ward we visited. The menu had a main section and a section for cultural meals which included kosher, halal, vegetarian and vegan options. Staff told us that patients receiving end of life care could also order from the children's menu if they preferred the children's menu choices.
- One end of life care patient told us the food was good and the staff were always willing to help if needed.
- There was a red tray system in use, for patients who needed assistance with their nutrition and hydration.

Patient outcomes

- The trust was contributing data concerning palliative care to the National Minimum Data Set (MDS). The National Council for Palliative Care collects the MDS for specialist palliative care services for palliative care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England.
- The trust had taken part in the End of Life care Audit – Dying in Hospital 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs).

The trust had not achieved all the organisational KPI's because there was a lack of formal training in relation to communication skills for doctors; nurses; health care assistants; (HCAs and allied health professionals).

- The trust scored better than the England average in four of the five clinical KPI's. Where the trust had scored worse than the England average this was because the trust did not perform well against documented evidence at the end of a person's life.
- The specialist palliative care team were engaged with the Outcome Assessment and Complexity Collaborative (OACC) managed by Kings College.
- Ward staff said the specialist palliative care team (SPCT) normally responded within 24 hours to referrals. Data provided by the trust stated that in August 2016 74% of referred patients were seen on the same day.
- The trust did not routinely audit DNACPR forms. We requested this information which was not provided. This meant any errors in completion or training needs were not evidenced or addressed.
- The trust did not participate in the Gold Standards Framework accreditation scheme (GSF). The GSF is a systematic, evidence based approach to improving care for all patients approaching the end of life.

Competent staff

- At the time of our inspection, there were end of life care champion link nurses on the wards across the Hospital who championed end of life care. Link nurses or champions promote good practice for end of life care and have undertaken specific training relevant to their roles.
- The SPCT team were all registered nurses, senior staff had studied to university level had had received degrees in relevant nursing subjects.
- The specialist palliative care team undertook regular teaching every week on a number of subjects for trust staff. An example of this was training undertaken on the 'End of life' education programme for new nurses as part of their induction.
- The specialist palliative care team provided 'shadowing' opportunities for all levels of staff. This allowed more inexperienced staff to work alongside a member of the specialist palliative care team to develop their own skills and knowledge.

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- The trust had taken part in the End of Life Care Audit – Dying in Hospital 2016. This set out organisational key performance indicators (KPIs). KPI8 asked four questions relating to training.
- Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for medical staff? The trust response was no to this KPI against the England average of 63% for other trusts.
- Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for nursing (registered) staff? The trust response was yes to this KPI against the England average of 71% for other trusts.
- Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for nursing (non-registered) staff? The trust response was no to this KPI against an England average of 62% for other trusts.
- Between 1 April 2014 and 31 March 2015, did formal in-house training include/cover specifically communication skills training for care in the last hours or days of life for allied health professional staff? The trust response was no to this KPI against an England average of 49%.
- There was an action plan in place to address the findings of the national audit.

Multidisciplinary working

- Patients receiving end of life care received support from an end of life care multidisciplinary team (MDT). This included the specialist palliative care team consultants, nursing staff, occupational therapists, physiotherapists, dieticians and other relevant professionals. We attended the weekly MDT meeting of the specialist palliative care team and saw that all patients receiving end of life care were discussed in a compassionate and holistic manner.
- Staff on the wards we inspected, told us of the good relationship between themselves and the specialist palliative care team as did staff in accident and emergency.
- The specialist palliative care team worked closely with the patient discharge team to ensure patients nearing end of life could undergo a rapid discharge home or to a 24-hour care facility in the community.

Seven-day services

- The specialist palliative care team worked Monday to Friday 9am to 5pm. A specialist palliative care nurse was on site between 8:30am and 4pm on a Saturday and bank holiday Monday.
- There was a dedicated advice line at a local hospice for professionals and members of the public to call out of hours.
- Rapid discharges could be undertaken seven days a week. The specialist palliative care team worked closely with a local hospice and the hospice at home team to facilitate this.
- The chaplaincy service provided pastoral and spiritual support, and was contactable out of hours on a 24 hour basis.
- The mortuary provided a 24 hour, seven day a week service to both the trust and the community.

Access to information

- There were no paper medical or nursing notes. All patient notes were kept on the trust's computerised record management system (Epic). We saw that staff were able to locate specific information within patient records.
- During our inspection, staff were not able to access Epic for a few hours due to technical issues. Staff showed us, on three different wards, how they gained access to the electronic back-up system, which contained all of the same patient information as Epic.
- One doctor showed us that when end of life care was entered onto Epic for a patient, a list of prompts was shown of anticipatory medication.
- The Specialist Palliative Care Team were notified of palliative or end of life care patients through Epic. We saw an example of this in accident and emergency where a palliative care patient had been seen in the department and was waiting to be admitted to the ward. The nurse in charge showed us how a notification was placed on Epic for the specialist palliative care team.
- Staff working in the community, for example, GPs, district nurses and hospice at home teams could not access Epic, but patient information was available on System 1.
- GP's were informed through an end of life GP referral form by fax if a patient was being rapidly discharged from hospital.

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- Information needed to deliver end of life care was available to staff in a timely and accessible way. There was good access to The Specialist Palliative Care Team and relevant guidance was available on palliative care and end of life care through the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients and relatives told us that staff did not provide any care without first asking their permission
- 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms were recorded on Epic. We spoke with three nurses who showed us the patient list printed off Epic at the beginning of their shift which showed the resuscitation status all of the patients. .
- We looked at 20 'Do not attempt cardiopulmonary resuscitation' (DNACPR) orders and found there were inconsistencies in how these were completed. Out of 20 DNACPR orders, ten were completed correctly (50 %).
- 'Do not attempt cardio pulmonary resuscitation' (DNACPR) orders were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those patients deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and not discussing the DNACPR with the patient, even though it stated they had capacity. We asked the trust for a copy of their Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Policy. The policy stated;
- 'Following the judgment in the case of Tracey vs CUH there is a legal requirement to discuss with a patient when you are considering a DNACPR decision, unless you believe that having this discussion would cause psychological or physiological harm' to the patient. The court ruled that patients have a right to know that a DNACPR decision is being considered'
- This meant the trust's DNACPR policy and the Tracey legislation was not being adhered to. The legal process of the Mental Capacity Act 2005 was also not being followed. An audit of completed DNACPR forms had commenced in June 2016. This data had yet to be analysed at the time of our inspection.

Are end of life care services caring?

Outstanding



We rated caring as outstanding because:

- Staff cared for patients with dignity and respect. Staff were seen to be compassionate.
- Patients we spoke with told us that staff were caring and looked after them well.
- We heard of outstanding examples of fulfilling patient's dying wishes.
- A bereavement service was offered on site, with staff available to support family members with emotional support following bereavement.
- Care and support was clearly a priority for patients and relatives.
- We saw numerous thank you cards of high praise.
- Emotional support was offered in a variety of routes in the hospital
- Staff cared for bereaved relatives weeks after the death had occurred and made it clear emotional support was available.

Compassionate care

- We observed throughout our inspection and in accordance with the National End of Life Care Strategy (Department of Health 2008), that staff spoke about the patients they cared for with compassion, dignity and respect.
- During our inspection, we observed patients being treated with compassion, dignity and respect. This was in accordance with NICE QS15 guidelines. An example of this was a patient's wife told us on one of the wards we inspected, how the ward had arranged their wedding. They showed us the pictures of the wedding that had taken place in the day room by the registrar and the chaplaincy staff
- All of the staff we spoke with showed an awareness of the importance of treating patients and their representatives in a sensitive manner.
- The two porters we spoke to told us the deceased were treated respectfully by ward staff.
- Deceased patient's belongings were handed to the families in a compassionate manner, whilst sitting and offering advice and support.

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- Services provided in the mortuary demonstrated respect and understanding of a patient's cultural or religious needs an example of this was the trust's urgent release policy, this was when the deceased was released within 24 hours of death and was used regularly with regard to cultural and religious beliefs.
- We noted that there were thank you cards in all wards we visited; highly praising the care they had received. One in the Lewin centre said 'we will always remember the kindness you showed us during our father's final days, you always made time for us and delivered amazing care.' One from ward C5 said 'Thank you for making mum so calm and relaxed in her last days' and 'Thank you for providing the family with comfort and sympathy.'
- We read a thank you letter addressed to Ward F4 that read 'care was second to none, the staff from housekeeping to consultants were fabulous.' Another said 'Care cannot be praised more highly'
- One ward nurse on G6 was proud to show us a recent email from a relative who was receiving end of life care. It said 'I was overwhelmed with your kindness and support during this difficult time.'
- A social worker for a recently deceased patient also praised the end of life staff stating 'Care cannot be praised more highly,
- We heard of some outstanding examples of fulfilling patients' dying wishes.
- One patient's wish was to play his guitar. Although not possible the ward organised a side room so the family could play it for him to listen to.
- One patient who was in his last days of life had not been apart from his wife, who was also in hospital, for 65 years, the ward staff organised for two beds to be moved together so they could hold hands.
- One woman's dying wish was to spend her time with her dog. The ward staff facilitated a side room so her dog could stay with her in the afternoons. She also had concerns that the dog was not being walked. Ward staff recorded this in the patient's notes and took turns walking the dog, easing the patient's mind.
- One patient's dying wish was to see the local gardens and die in his own bed. The ward nurse organised for the patient to be taken home on an ambulance with sirens, so he made it back to his own bed in his nursing home. They went past his favourite gardens on the way for him to see them.

- Outstanding, compassionate care was also received by relatives. One woman was thankful that the ward had remembered a conversation with her regarding her occupation. When her father was dying, the ward nurse phoned around places she thought the woman worked. The patient was able to spend his final moments with his daughter.

Understanding and involvement of patients and those close to them

- Staff we observed were compassionate and caring and provided a good standard of treatment and care.
- Positive interactions were observed between staff and patients and their family and relatives.
- We observed multiple discussions between patients and nursing, medical and allied health professionals that were caring and considered the wishes of the patient.
- Patients and family members we spoke with told us they felt involved in the care delivered. We saw that staff discussed care issues with patients and relatives where possible and these were generally clearly documented in patient's notes.
- Patients told us they had been listened to, understood at every stage of their treatment what was happening and were treated with kindness and respect.
- The End of Life Care Audit – Dying in Hospital 2016 clinical key performance indicator (KPI) 3 asked, 'Is there documented evidence that the patient was given an opportunity to have concerns listened to?' The trust scored 82%, which was slightly lower than the England average of 84%.
- The National End of Life Care Audit – Dying in Hospital 2016 clinical KPI asked, 'Is there documented evidence that the needs of the person(s) important to the patient were asked about?' The trust scored 58%, which is higher than the England average of 56%.
- For the organisational KPI 7 which asked, 'Did your trust seek bereaved relatives' or friends' views during the last two financial years (i.e. from 1 April 2013 to 31 March 2015)?' The trust scored 'Yes'. This was in line with 80% of other trusts.

Emotional support

- The chaplaincy service provided a 24 hour seven days a week on call service for patients in the hospital, as well as their relatives, and aimed to see people within the

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hour. The chaplaincy service held communion at the patient's bedside if they were too ill to attend the chapel. The service told us they conducted last rites and blessed the deceased in the mortuary as required.

- The chaplain supported patients, their families and staff. There were a number of thank you cards in the multi-faith chapel.
- The chaplaincy service was not licensed to conduct weddings for end of life care patients. They told us they were able to facilitate this with one of the community registrars who worked three days a week at the hospital. The service employed volunteers who would sit with end of life care patients as required.
- The chaplaincy provided spiritual and non-spiritual support to patients and families regardless of religious beliefs in times of crisis and distress.
- The hospital used a local pet as therapy 'pat' dog which was brought to the hospital to visit patients, staff felt this was beneficial to some end of life patients, and was another way to offer support and comfort.
- The clinical nurse specialists (CNS) from the specialist palliative care team (SPCT) spent time with patients and their families to provide reassurance and support and answer any difficult questions that they may have in relation to the treatment being received.
- The team acknowledged the importance of supporting not only the patient but their relatives and friends throughout the dying process. An example of this was at the multidisciplinary meeting we saw the team approach all of the patients they were discussing in a holistic manner, which means they included the concerns and wishes of the families and loved ones.
- Macmillan volunteers were knowledgeable and proud of the emotional support they offered for dying patients and their families.
- The mortuary team were proud of emotional support they gave to bereaved relatives. We saw a thank you card from a bereaved family member thanking them for their support.
- We also heard of an example of mortuary staff facilitating a lady to visit her deceased husband daily. The mortuary staff made her tea and offered emotional support. The lady described this as invaluable.
- As well as the bereavement follow up scheme, ward staff took pride in writing personalised cards of condolence and making personal phone calls to bereaved relatives two weeks after the death, to see how they were and

offer emotional support. We found this to be fully embedded throughout the trust. Staff told us this had also been adopted by other trusts and was considered best practice.

Are end of life care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Fast track discharge did not meet the NHS England recommended time of 48 hours and on some occasions was much longer than this. The average time to discharge was 3.8 days for patients living in Cambridge and 4.7 days for patients living outside Cambridge.
- Preferred place of care was not routinely audited within the service. Records showed no evidence that this had been considered or discussed with the patient or others.
- End of life care complaints were not audited and delays in investigation and lessons learnt were not documented.

However:

- The palliative care team was available for referrals throughout a patient's treatment and was easily contactable.
- End of life patients had access to side rooms when they were available.
- The bereavement team provided a follow up scheme for additional support for families.
- End of life care patients were identified in a timely manner.
- The hospital had a specialised discharge team who were proactive to discharge patients, who wished to die at home, as quickly as possible.
- The mortuary provided care for the individual needs of the deceased patient and their families.
- Complaints were logged and dealt with in accordance to trust policy.

Service planning and delivery to meet the needs of local people

- There were 1359 referrals to the Specialist Palliative Care Team (SPCT) between April 2015 and March 2016. The SPCT stated that 42% of referrals were for patients with a cancer diagnosis and 58% with non-cancer diagnosis.

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- Referrals to the SPCT could be made any time during a patient's treatment. This allowed early involvement of the SPCT and time to facilitate the most appropriate care and treatment. The SPCT encouraged referrals from nursing, medical and allied health professional staff from across the trust.
- Referrals to SPCT were done via the Epic system. Staff informed us they could also contact SPCT by bleep, telephone or through switchboard.
- The palliative care team worked closely with neighbouring trusts and hospitals to provide an on call rota for out of hours advice. One nurse had used this advice line and said staff who answered were always pleasant.' a junior doctor said ' It is a good service and very helpful'
- The trust did not have a specific end of life care ward or beds. Patients requiring palliative care were cared for across all clinical wards. We saw end of life care patients being cared for in side rooms wherever possible. One nurse told us that side rooms were not always available, but management would do their best to find one on another ward.
- We did see two incidents where end of life patients were moved back on to the bays as side rooms were required for infection isolation cases. Staff were aware that clinical needs and safety of bay patients was paramount. We reviewed these incidents and noted EOLC patients were moved back to side rooms as soon as one become free.
- Ward R2 Side rooms were purposely located to overlook Kae's garden, a courtyard area especially designed to be a relaxing environment. We saw end of life care patients helped out to the courtyard.
- Referrals to the SPCT were prioritised and discussed at clinical meeting each morning. This was attended by a SPC nurse for pain control, an EOL nurse, for stopped treatments, and consultant for high dependency cases.
- The hospital had a discharge team that facilitated fast track discharge and end of life care planning for those patients wishing to die at home.
- Relatives had the option of reduced cost parking when visiting. Staff offered relatives hot drinks throughout the day. We also noted that wards allowed open visiting times for relatives of end of life care patients. Pull out beds and comfortable chairs were available for visitors to stay the night. This ensured family and friends could spend unlimited time with the patient.
- The hospital could provide temporary, on-site accommodation for families of patients or those who were awaiting treatment and needed to be closer to the hospital.
- The bereavement team offered a follow up service. One week following a patient death they would send a condolence card to the families personally signed by the ward sister and their team.
- Four to six weeks after every death in the hospital, the patient's family were invited to attend a meeting to discuss the circumstances of death. The meeting is chaired by the bereavement manager and attended by the consultant and SPC nurse. Bereavement staff felt this had improved working relationships with the palliative care team, and had a response rate of 25%

Meeting people's individual needs

- The hospital had a Macmillan information pod that was staffed by trust staff as well as volunteers located in the oncology outpatients area., providing advice and support for patients, including end of life and the bereaved.
- Learning disability patients are flagged on the Epic system and visited by a learning disability specialist nurse. We saw the patient had a 'My Passport' form that contained likes and dislikes and any special issues.
- Care workers were encouraged to assist in the hospital setting, such as feeding the patient. This ensured continuity of care.
- We saw specialised call bells used for patients with motor neurone disease, or those with difficulty moving. These were more sensitive and could be placed in the best position for the patient.
- We spoke to a patient who was at the end of their life and being nursed in a side room. We asked if they were comfortable and they indicated they were. They were on an air mattress, with framed pictures and teddy bears from home around the bed. We reviewed the patients notes. We found that their care was tailored towards their preferences and took into account their coexisting conditions such as pressure sore assessments. This was in accordance with The National Institute for Health and Care Excellence standards QS15.

End of life care

- The End of Life Care Audit – Dying in Hospital 2016 demonstrated that 69% of dying patients had their individual care needs assessed in the last 24 hours of their life. This was higher than the England average of 66%.
- Staff allowed patients in side rooms to have their own pillows and duvets from home,
- We saw various quiet rooms throughout the hospital with access to drinks, sofas and soft furnishings. Staff told us these were often used for families of end of life patients, for quiet time or breaking bad news.
- The hospital had access to a translation service, British Sign Language, Deaf/Blind Manual, Visual Frame Signing and a Visual Impairment Assistance Service. Staff we spoke to had not yet needed to use these services.
- Guidance literature was available for patients and their relatives. This included information about what to expect at the end of life, and. There were also patient and relative information leaflets around the last days of life the processes involved in caring for patients at the end of life. These were also available in different languages, larger print and audio versions. This was considered good practice and in line with the national accessible information standards.
- We saw bereavement booklets were given out by the bereavement service and on the wards. The booklet was called “after bereavement.” The booklet contained a number of different sections with information to assist people with the bereavement process.
- We saw a ‘wedding box’ on the oncology ward. This was used to fulfil dying wishes of getting married. It included items such as confetti and photo frames and was replenished by a local department store.
- The mortuary had a viewing suite where families could visit their relatives and loved ones. We visited the area and saw the viewing suite was divided into a waiting room and a viewing room. The suite was neutral with no religious symbols which allowed it to accommodate people of all religions.
- Windows in the waiting area allowed viewing of the deceased without entering the viewing room. Curtains were used to protect privacy if required.
- The mortuary waiting room was clean, and provided facilities for relatives such as comfortable seating, tissues and information leaflets.
- Visitors to the mortuary were collected from the hospital reception and escorted to the mortuary. A call bell was used if visitors required assistance from staff. This allowed staff to respond quickly, whilst allowing privacy and dignity to the deceased and their family.
- Deceased patients were on a portable trolley with a pillow and cover. Mortuary staff used different sized trays to accommodate different sized patients.
- The mortuary staff said they could accommodate all faiths, they would allow family washing of the deceased if requested. They worked closely with faith leaders and undertakers to ensure deceased patients were cared for following their cultural and religious requirements.
- There was no evidence of preferred place of care documented in the patient’s notes.

Access and flow

- Face to face palliative care was available Monday to Saturday 9am to 5pm including bank holiday Mondays. At other times consultant telephone advice was provided on an on call basis.
- The SPCT worked closely with the specialist discharge team to discharge people to their preferred place of dying if they were not on the rapid discharge plan.
- The SPCT had a dedicated discharge sister who was able to fast track discharges for patients who wanted to return home or to other places of care in the community.
- The August point of referral to discharge averaged at 3.84 days for those living in Cambridge and 4.75 days for those living outside of Cambridge. This was running data and was not audited.
- Ward staff spoke highly of fast track discharge and felt delays were due to getting external care in place, rather than any trust procedures. One nurse said if all external care was in place, discharge could be very fast. Another ward nurse stated they had seen fast track discharge within 24 hours, but also up to two weeks. They felt all blockages in the system were not related to the trust.
- The discharge team was proud of the service they provided, however were aware that they were not reaching their target of fast track discharge within 48 hours. They had been proactive in reducing this time, working alongside the volunteer sector and the ‘self-funder scheme’. This supported self-funders with nursing home choice. Funding had also been made

End of life care

available for extra care. This was used to provide more nursing home beds and live in carers. The palliative care team felt this had made improvements but stated it was still about 'getting everything in the right place'

- Preferred place of death was not audited and the trust unable to provide this information when requested.
- Patients were identified as requiring end of life care in a timely manner. We noted that this was discussed at both ward hand over meetings and the daily multidisciplinary palliative care meetings.
- During our inspection, the Epic computer system was unavailable due to technical problems; all clinical notes were on the backup system. All staff we spoke to said it was not a problem and were aware of patients DNACPR status and were able to undertake ward rounds as normal.
- Porters made patient transfers to the mortuary a priority. These times were not audited but staff felt they were always transferred in a timely manner and in accordance to trust policy. Wards were sometimes flexible on these times if the families wished to remain and spend time with the deceased. We observed porters being called for a mortuary transfer, from one of the wards we visited, and confirmed it was in a timely manner and within one hour. This is considered best practice by the National End of Life Care Programme and National Nurse Consultant Group.
- We also noted that the mortuary transfer was sensitive and discrete, porters used a concealment trolley, the lights were dimmed and part of the ward was temporarily closed.
- The bereavement team was available Monday to Friday 8am to 4pm. The chaplaincy team was also trained to carry out bereavement team duties. This enabled families to organise funerals within 24 hours, should it be required.
- The hospital had an on-site registrar three days a week. This allowed families to complete all paperwork at once rather than travel to the registry office.
- We heard of an example of a family being out of the country when a family member died in the hospital. They were able to arrive in the country and have a registrars appointment as soon as they reached the hospital.

- The mortuary had an appointment system for families wishing to view deceased relatives. Viewings were generally within day time hours, although we heard examples of viewings taking place out of hours to meet the family's needs.

Learning from complaints and concerns

- The trust submitted data showing it had received nine complaints relating to end of life care between June 2015 and June 2016.
- These complaints were logged in a response data base, with descriptions of complaints and actions taken. We noted that all the complaints were dealt with in a timely manner.
- We reviewed the complaints and noted that outcomes had been explained to individuals in an open and honest way.
- However, prior to our inspection we spoke to one family member who had made one of the complaints. Their concerns matched that on the data base, and it stated the complaint was under investigation. This was the only end of life care complaint that had a delay. The data base stated investigation was 'extended' but did not give further explanation. The family did not feel the hospital had dealt with their complaint promptly.
- The SPCT told us they did not audit complaints and there was no evidence of lessons learnt being documented from these particular complaints.
- Staff we spoke with told us that if a patient or relative had concerns about care being delivered they would try and address the issue at the time in order to resolve the concerns as quickly as possible.
- We were told complaints would be handled in line with trust policy. Staff told us they would advise patients to go to PALS (Patient Advice and Liaison Service) if they were unable to deal with concerns directly. Patients would be advised to make a formal complaint if their concerns remained. Staff we spoke with knew how to raise concerns or make a complaint on behalf of a patient or their relatives.

Are end of life care services well-led?

Good



We rated well-led as good because:

End of life care

- Staff were aware of the trust vision and committed to its purpose.
- There was a detailed, formal strategy in place for end of life services which noted a lack of audit plan for this service
- Regular meetings ensured good management overview of the service.
- There was an effective governance framework within the palliative care team.
- Risks and quality of service were monitored and the risk register was up to date and risks clearly mitigated
- The hospital were engaged with both end of life staff and patients.
- The end of life care strategy was still in draft form, the clinical lead told us it was important to gather all available resources. Four local hospices had been involved in its production. The hospital was also awaiting the National Council for Palliative Care (NCPC) project to be completed so they could combine it with the hospitals strategy.
- The end of life care strategy was discussed, and its progress monitored in the End of Life Operational group meeting June 2016.

Leadership of service

- The service was led by a consultant and senior palliative care nurse with executive level responsibility held by the chief nurse.
- Leaders of the service had relevant end of life care experience. We found them to be knowledgeable and have the skills to fulfil their role.
- End of life staff felt management was supportive. A member of mortuary staff said 'The manager is approachable and their door was always open for support'.
- Most of the staff we spoke with on the wards were aware of the SPCT. They could name the SPCT nurses and could give us examples of cases where they had felt involved with improving care for patients who were at the end of life.

Vision and strategy for this service

- The trust wide values were "Together - Safe, Kind, Excellent"
- We saw Posters throughout the trust titled 'Our Values' outlining these values and visions.
- All the staff we spoke with were proud to work to the hospital values and felt they were realistic. Staff felt that end of life care was provided in line with these values and were proud of the safe, caring service they provided.
- The philosophy for delivering specialist palliative care at Addenbrooke's Hospital was that care is patient centred, whilst encompassing as far as possible the needs of family/ carers and other healthcare professionals. Their goal was to enable the provision of excellent palliative care throughout the Trust.

Governance, risk management and quality measurement

- End of life care was part of the acute medicine directorate.
- There was an effective governance framework to support the delivery of the end of life strategy at this trust.
- There was an end of life care executive and clinical lead. We found they had an active role in end of life care and its plans and improvements.
- The trust had appointed a non-executive director for end of life care since our last inspection. We were told this was likely to change as they had recently also been appointed as trust chair.
- According to the End of Life Care Audit – Dying in Hospital 2016, the trust did not have a lay member on the trust board with a responsibility or role for end of life care. The trust was below the England average of 49%.
- We found the specialist palliative care team (SPCT) had regular team meetings in which issues and general communications were discussed.
- There was an end of life care operational group that met monthly and was chaired by associate director of nursing. We were told that they were chair because of their palliative care background. We reviewed three meeting minutes and noted that there was good overview of the service, with improvements, strategy and action plans discussed.
- There was an end of life care steering group every six months. Chaired by the Director of nursing, including representatives from stakeholders, such as local hospices.
- The trust did not produce a board report for end of life or palliative care. We were told that this was recognised as a gap and would commence in December 2016.

End of life care

- We reviewed the end of life care risk register. We noted there were three risks listed. These were all regarding lack of palliative care service seven days a week. We saw actions required and review dates.
- The risks on the register matched what we were told by staff and what we found during our inspection.
- The mortuary manager had overview of the service. We were told of the recent risk on the register concerning capacity when the mortuary merges with another. We saw evidence of meetings to identify and reduce the risk, resulting in the risk being resolved.
- Quality was measured using a matrix system on the Epic system. It recorded data such as where people die by ward, and time between admission and death. This was used to target education to the wards and areas that required it most.

Culture within the service

- End of life care staff were passionate and keen to improve.
- Staff felt respected, valued and encouraged to progress in their careers by their managers and department leads. In a recent staff survey 72% of staff would recommend the hospital as a place to work.
- Staff were open and honest and admitted when things went wrong, in line with duty of candour regulations.
- We saw emails off different departments sending thank you notes to each other on the service they provided.

Public engagement

- The hospital carried out a Bereavement Care Questionnaire in November 2015. This was an adapted version of the national survey (VOICES). This gave the

public an opportunity to suggest improvements. The survey was sent out to bereaved relatives by post and had a 46.7% response rate. Results showed a high level of satisfaction.

- The bereavement follow up service also gives the opportunity for bereaved families to talk to hospital staff for advice and support, in the weeks following a death.

Staff engagement

- The hospital had an awards system for staff. The 'You made a difference' award aims to reward and recognise both teams and individual staff members who have 'made a difference' to patients, visitors or colleagues. All winners of the You Made a Difference individual awards made throughout the year would automatically be entered into the annual 'employee of the year' award, with winners being announced at the "Our Way" Annual Awards in December.
- We saw that both the palliative care team and specialist discharge team had been nominated.
- Ward L4 was awarded the best performing ward in 2016, part of which was due to their end of life care.
- Staff were encouraged to use a 'Care First' counselling service if they required. We saw posters advertising the advice lines.
- The mortuary had regular debriefs; staff felt this reduced stress after upsetting cases.

Innovation, improvement and sustainability

- All staff we spoke to were passionate to do their best for patients and continuously improve.
- The hospital had developed a rota watch system on the intranet. This enabled staff to contact on call staff more efficiently.
- The bereavement follow up scheme saw a reduction in complaints of approximately 50%.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients department (OPD) at Addenbrooke's Hospital offers a wide range of clinics to both adults and children. The specialities covered include dermatology, orthopaedics, ophthalmology, pain and respiratory. The diagnostic imaging (DI) department performs routine x-rays as well as more complex diagnostic techniques such as magnetic-resonance imaging (MRI) and computerised tomography (CT) scanning. There are separate areas for children within the department.

Between January 2014 and July 2015 there were 1,336,900 total attendances at outpatients and 326,400 attendances at diagnostic imaging.

We used a variety of methods to gather evidence in order to assess and rate the OPD and DI services at Addenbrooke's hospital.

During our inspection we visited the outpatients department (OPD) and diagnostic imaging department (DI) and their associated waiting areas. We spoke with 44 members of staff including 19 nurses, three consultants, eight radiographers, 10 administration staff, two allied health care professionals, one equipment maintenance technician and one health care assistant. We interviewed the acting associate director of operations, the outpatient services operations manager, the Imaging Operations Manager, the divisional director and the divisional head of nursing. We observed patients receiving care, reviewed electronic patient medical records and spoke with 32 patients and their relatives.

We observed the care environment and looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments and audit findings.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatient and diagnostic imaging service as good. We rated outpatient and diagnostic imaging as good for safe, caring and well led. We rated responsiveness as requires improvement and although effectiveness of the service was inspected, we did not rate it. We found:

- The trust had taken action to ensure that patients awaiting appointments were being risk assessed to enable appointments to be booked in order of clinical priority.
- There had been improvements with appointment slot issues (ASIs) and did not attend (DNA) rates since our inspection in February 2016.
- Staff received feedback about incidents that happened in their area and there was evidence of learning.
- Staff received appraisals and there was effective multidisciplinary working within the department.
- Staff were caring and patients and carers spoke positively about the care and compassion shown by all clinic staff. Friends and family test (FFT) data showed 93.8% of patients would recommend the service although this was based on a low response rate.
- Medical staff planned and delivered patient care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
- The board and other levels of governance within the trust worked effectively together and interacted with each other regularly. Structures, processes and systems of accountability were clearly set out, understood and effective.
- Staff gave us numerous examples of innovations and improvements which had been introduced across OPD and DI as well as plans to improve sustainability.

However, we found:

- There were still appointment backlogs in some specialties.
- The trust was failing to meet referral to treatment time in six of the 18 specialties. However, this was an improving performance since our last inspection.

- There were waits of longer than six weeks for some diagnostic tests.
- FFT response rates were low.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents.
- There was good evidence of feedback and learning from internal and external incidents.
- All the staff we spoke with were aware of their responsibilities under the Duty of Candour requirement.
- The trust had taken action to ensure that patients awaiting appointments were being risk assessed to enable appointments to be booked in order of clinical priority.
- There were systems and processes in place to keep patients safe and safeguarded from abuse and staff knew how to respond in suspected abuse situations.
- Staffing levels and skill mix was planned and reviewed in order to keep people safe at all times. Senior staff responded to staff shortages quickly and effectively.
- Management assessed, monitored and managed the risks to patients who used the service including for deteriorating health.
- Management had identified risks to patient safety from service developments, changes in demand and disruption to services. There was a plan of action in case of emergency or major incident.
- All the clinic areas we visited were visibly clean and well maintained.
- All the nursing and medical staff we saw were abiding by the “bare below the elbow” policy.

However, we also found:

- Poor medicine management in the magnetic-resonance imaging suite and (MRIS), CT and the eye clinic.
- There were some gaps in staffing in a number of clinic areas for nursing and medical staff.
- Only 61% of medium risk medical equipment had been serviced, this did not meet the hospital target of 75%.
- Decontamination of reusable medical devices within the maxillofacial and oral clinic was not in accordance with best practice guidelines.

Incidents

- The OPD and DI department reported four serious incidents between August 2015 and July 2016. Two were confidential information leak incidents, one was a delay in treatment and one was a never event relating to a surgical procedure. A never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The imaging manager described how the incident had been investigated through interviews with staff and the patient and root cause analysis (RCA). Changes to the procedure of removing surgical devices had been implemented which evidenced learning from incidents.
- Between August 2015 and July 2016 the OPD and DI department reported 536 incidents to the national reporting and learning scheme (NRLS). Of these, 534 (99%) were classified as low or no harm. This was comparable to the England average.
- We reviewed the hospital Incident reporting and investigation policy. We found it was in date and detailed all aspects of incident reporting and investigation. Staff were able to show us how to access the policy and the incident reporting form on the trust computer system.
- All the nursing staff we spoke with knew their responsibility to raise concerns and report incidents. Staff gave examples of what incidents they would report and how they would do this using the electronic incident reporting system.
- All the nursing staff we spoke to understood their responsibility with regard to the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Posters promoting the duty of candour were displayed throughout the OPD and on patient information screens.
- Nursing staff discussed Incidents at staff daily “huddle boards” and learnings and outcomes were shared. Staff gave us examples of learnings from incidents. The diagnostic imaging manager described how the never event had been investigated and what action had been taken to prevent the incident occurring again.

Outpatients and diagnostic imaging

- We saw the minutes August 2016 speech and language therapy team meeting. Patient safety issues and incidents were discussed. There was evidence of learning from an incident which had been identified at another trust.
- The diagnostic imaging manager was aware of their responsibility regarding Ionising radiation (medical exposure) regulations IR(ME)R and there were policies and guidelines for the diagnostic imaging department developed in line with IR(ME)R. Each radiology department had a named radiation protection supervisor (RPS) who was accountable to the onsite radiation protection advisor (RPA). Incidents involving radiation were reported on the electronic incident reporting system and to the RPS who would escalate them to the RPA if appropriate. The RPA would then inform any relevant outside organisations such as East Anglian Region Radiation Protection Service (EARRPS) and CQC if required.
- Nursing staff were able to describe the procedure they would follow for treating patients believed to have infectious diseases. Staff explained how patients would be given the last appointment of the day where possible so the room could be deep cleaned overnight. Infectious patients would be given a room away from other patients to wait for their appointment.
- Decontamination of reusable medical devices within the maxillofacial and oral clinic was not best practice. There were no separate clean and dirty areas for contaminated dental equipment which posed a risk of cross contamination. We reviewed the risk register and saw that the risk was being managed with use of colour coded boxes to separate dirty and clean equipment. This risk had been ongoing for over six years however, the trust had begun to take steps to rectify although the clinic manager was not aware of any time frames for implementation.
- Waste management procedures were in place for the disposal of radioactive waste. These complied with the Environment Agency's Environmental Permitting Regulations (2010).

Cleanliness, infection control and hygiene

- All the clinic and waiting areas we visited were visibly clean and well maintained.
- Red "I am clean" tags were seen on equipment throughout the OPD and DI department.
- Staff carried out hand hygiene audits twice per month throughout the OPD and diagnostic imaging. We saw the hand hygiene audits for April, May and June 2016, which showed the clinics, were all 100% compliant, which exceeded the trust target of 95%.
- We observed sanitiser hand gel dispensers located throughout the department. There were posters displayed and a screen on the patient information display was dedicated to encouraging staff and visitors to use the gels.
- All the staff we observed in clinical areas were abiding by the "bare below the elbow" national institute for clinical excellence (NICE) guidance and we witnessed staff using the hand gels and demonstrating good hand hygiene. Staff were compliant with the trust policy on hand hygiene and personal protective equipment (PPE).
- The hospital employed external cleaners to clean the outpatients department each evening. We saw cleaning schedules displayed on doors throughout OPD. We reviewed the cleaning records and saw all the clinics had contractual cleaning scores of 95% to 100%. This was in line with national cleaning scores.

Environment and equipment

- Electrical testing had been carried out on all the portable electrical equipment we saw (PAT) in line with legislation. We saw labels on equipment to demonstrate that testing had been completed and on which date.
- Signs warning of the presence of strong magnets and radiation were clearly displayed on doors in the magnetic resonance imaging (MRI) department and the radiology department.
- We reviewed seven resuscitation equipment trolleys and seven resuscitation equipment boxes across OPD and DI. We found all the equipment to be in date and stored correctly. Records of daily and weekly checks were complete with no omissions for July and August 2016.
- Specialised personal protective equipment (PPE) such as lead aprons for staff and patients were available in the radiology department. We saw records to confirm radiographers checked aprons for wear and tear on a daily basis and screened them annually for damage.
- In diagnostic imaging, quality assurance checks were in place for equipment. These were mandatory checks

Outpatients and diagnostic imaging

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.

- The imaging department had a radiation protection advisor (RPA) who carried out equipment checks on a six monthly basis or when required to do so.
- We reviewed the radiation protection advisor's (RPA) six monthly report (September 2015 to April 2016) detailing the inspection and testing of diagnostic radiology imaging equipment. The report showed all the equipment reviewed was satisfactory. Staff radiation dose monitoring badges were also tested and results were found to be satisfactory overall.
- We saw comprehensive risk assessments for radiology. These were carried out and reviewed by each radiology department RPS and stored on the electronic records system.
- Data provided by the hospital prior to our inspection showed 100% of high risk equipment within the OPD and DI department had been routinely serviced. This exceeded the hospital target of 98%. 75% of low risk equipment had been serviced, this also exceeded the hospital target (50%). However, only 61% of medium risk equipment had been serviced, this did not meet the hospital target of 75%.
- Maintenance and repair of diagnostic imaging equipment was performed by the manufacturer. The hospital clinical engineering team were introducing an electronic asset register which would enable audits of equipment to be undertaken easily and the tracking of medical equipment by radio frequency identification (RFID)
- We saw good waste segregation with domestic waste in black bags, infectious waste in orange bags and sharps into yellow sharps bins as per hospital policy. Confidential waste was disposed of into sealed bins.
- The hospital executive team had identified a suitable area for the installation of an additional MRI scanner which could be used in the event of another MRI scanner breaking down.

Medicines

- The hospital had a policy for the safe management of medicines. Staff were able to view the policy on the

hospital intranet. We reviewed the trust storage of medicine policy and found it was in date. The policy stated all medicines must be stored in locked cupboards or fridges.

- We reviewed medicine storage and security in seven areas where medicines were stored. Medicines were stored in locked cupboards and the nurse in charge held the keys. We found good stock control and medicine rotation in all areas. All the medicines we saw were in date and records of daily room and fridge temperature monitoring were complete. However, in three areas medicines were not secure. In CT a medicine was being stored without records and checks being carried out, in MRIS the drug cupboard was not locked and in the eye clinic all the nursing staff had keys to the drug cupboards and these were taken home with them at the end of shift. We raised these issues at the time of our inspection. At our follow up inspection we found the medicine in CT had been returned to pharmacy and were no longer being stored, the eye clinic had submitted an urgent request to the executives for the installation of a key code safe so that staff no longer took keys to the drug cupboard off site. In MRIs the drug cupboard was found to be locked however, the department manager said that staff left the door open when they were busy. We reminded them that the cupboard should be locked at all times in line with CUH Ordering and Storage of Medicines Policy.
- We saw prescription forms (FP10s) were stored securely in locked cupboards and staff recorded prescription numbers on the electronic record system when prescriptions were issued. However, in the eye clinic, nursing staff did not keep records of any FP10s issued to patients and had no way of knowing if any had been removed from the pad inappropriately.
- Radiographers could prescribe and administer contrast for radiological procedures according to patient group directions (PGD). We reviewed the PGDs for a number of medicines; they were in date, relevant and signed appropriately.

Records

- The hospital used an electronic records management system called Epic. The electronic patient record included care plans, case notes and test results as well as records of consent and patient outcomes.

Outpatients and diagnostic imaging

- The electronic patient record meant that patient notes were always available to nursing and medical staff at clinics. Nursing and medical staff spoke positively about EPIC.
- The OPD and DI department were not 100% paperless, some documents, for example the contrast questionnaire, were completed by hand and scanned into the patient record by administration staff.
- We saw Epic in use. There were specific “tabs” within each patient record for the inclusion of results, diagnostic images, correspondence, referrals, alerts and orders. Medical staff showed us how tests and prescriptions could be ordered.
- The business continuity plan detailed the action to take if Epic failed. A backup computer system could be accessed to print patient lists and patient notes could be requested from onsite medical records. Nursing staff told us that since the introduction of Epic in 2014 they had never had to request paper records.

Safeguarding

- The hospital had policies and procedures in place to ensure vulnerable patients were safeguarded and staff received mandatory training in safeguarding children and safeguarding adults.
- We reviewed the hospital’s Safeguarding Policy and found it was comprehensive and in date although female genital mutilation (FGM) was not covered. The policy detailed who staff should contact if a safeguarding issue was suspected. The trust chief nurse was executive lead for safeguarding.
- All the staff we spoke with knew their responsibilities regarding safeguarding. Staff could describe how to raise a safeguarding concern and knew how to contact the hospital safeguarding lead. Posters about safeguarding and a flow chart of steps staff should follow were displayed on notice boards around the OPD.
- We saw posters displayed throughout the OPD advising patients on the use of chaperones. Nursing staff explained that two nursing professionals were always present during intimate examinations, if the patient was vulnerable or if the patient was a child.
- The diagnostic imaging department used the PAUSED checklist to ensure the right person received the right scan at the right time. The PAUSED checklist includes, checking with the patient details verbally, confirming the correct site to be x-rayed/scanned, confirming the examination is on the right date and the right time,

selecting the correct imaging protocol, recording the dose of exposure, ensuring images are stored correctly and informing the patient on how they can get the results.

- We saw World Health Organisation (WHO) surgical safety checklists being used throughout the DI department and dermatology.
- An internal audit of 37 patient records for WHO checklist completion showed only 20 (54%) contained completed WHO checklists. This was well below hospital target of 100%. The audit lead recommended WHO checklist completion tips were sent to all staff groups concerned. We saw a consultant completing a “WHO style” checklist on Epic before beginning a procedure. A re-audit had not yet been undertaken.

Mandatory training

- We reviewed the hospital’s mandatory training policy. The policy was in date and applied to permanent, bank and agency staff.
- Staff received mandatory training in conflict resolution, health, safety and welfare, equality and diversity, safeguarding children, safeguarding adults, fire safety, moving and handling, resuscitation, Information governance and Infection prevention and control
- Mandatory training was delivered at induction and by face-to-face or e-learning. Management monitored staff compliance at the monthly divisional performance meetings.
- For the reporting period February 2016 to July 2016, data provided by the hospital showed 94% of staff, trust wide, were compliant with their mandatory training against a trust target of 90%.
- For the reporting period February 2016 to July 2016, data provided by the hospital showed only 66% of outpatient staff were compliant with their safeguarding level 2 mandatory training against a trust target of 90%.

Assessing and responding to patient risk

- All patients who were waiting for follow up appointments had been risk assessed by consultants and were being booked into appointment slots based on their clinical priority. At the time of our inspection, 80% of patients in the backlog had an appointment booked.

Outpatients and diagnostic imaging

- There were systems in place to contact an emergency response team if a patient deteriorated within the outpatients or diagnostic imaging department. Resuscitation trolleys were available to staff within outpatients in emergencies.
- Deteriorating patients within the OPD and DI department were monitored by the national early warning score (NEWS). Nursing staff had access to the resuscitation equipment and escalated to medical staff if required.
- Women between 12 and 55 were asked if there was a possibility they could be pregnant prior to any radiological procedures. We saw this on the MRI patient safety questionnaire and the contrast consent form.
- The diagnostic imaging department had nominated radiation protection supervisors for all areas of radiology. Local rules, displayed on the doors throughout radiology, detailed who was the RPS for the area and who to contact in the event of an over exposure incident. The radiation protection advisor (RPA) was based on site and was easy to contact.
- All medical qualified professionals were able to request diagnostic imaging along with a list of acceptable non-medical requestors and those staff who had “on behalf of” requestor’s rights, such as specialist nurses who were following up from multidisciplinary team (MDT) meetings. The RPS screened all requests for suitability of referrer and justification of the exposure before booking any appointments.
- All areas of radiology followed the ionising radiation (medical exposure) regulations IR(ME)R guidelines. Prevention of contrast induced nephropathy was based on the NICE guidelines along with numerous other policies used throughout radiology.

Nursing staffing

- Clinic leads planned nursing staff levels and skill mix based on experience and professional judgement. Clinics staffing was according to the number of patients attending, procedures booked and the skill mix required. There are no guidelines for the staffing requirement of outpatient departments.
- Data provided by the hospital prior to inspection showed there were 28 nursing vacancies across outpatients and diagnostic imaging which was a

vacancy rate of 19%. The nursing staff turnover rate was 19% and sickness was 6%. The vacancy, turnover and sickness rates were all above the trust average of 11%, 11% and 3% respectively.

- During our inspection, clinic 1, clinic 8, clinic 12, the pain clinic and the dermatology clinic staffing levels fell below planned requirements by one or two staff. Clinic managers told us that they were covering the staff absences using bank nurses and staff flexibility and that there was no impact on patients. The call centre, CT and MRIS were also operating with reduced staff.
- There was a trust wide ongoing recruitment campaign for registered nurses (RN). The trust held a dedicated nurse recruitment day once a month.
- We saw records of local induction for bank staff. The bank staff had signed the checklist to confirm they had completed each task before being eligible to work on the ward or department.
- The percentage of work hours filled by agency and bank nursing staff between March 2016 and August 2016 ranged from 0% in x-ray to 33% in ENT. The rehabilitation clinic also had a consistently high percentage of working hours filled by bank and agency nursing staff (27% - 43%).

Medical staffing

- In the diagnostic imaging department, three radiologists provided out of hours cover during weekends.
- From April 2015 to March 2016 the use of medical locums within the OPD and DI department was low at 3%. This was lower than the trust average.
- The trust had recruited consultants from a number of specialties with commitments to outpatient clinics. This had reduced the need for locum cover and helped the trust address the backlog of patients as identified at previous inspections.
- The manager of clinic 12 explained, if the clinic was running late staff could contact another doctor who would come to the clinic to help alleviate the backlog of patients. Staff told us this had happened during our inspection.

Major incident awareness and training

- There was an internal major incident policy in place. The policy, which was hospital wide, detailed how staff should deal with circumstances such as loss of staff, loss of information technology or data, loss of utilities, fire and terrorism.

Outpatients and diagnostic imaging

- The hospital executive team had identified a suitable area for the installation of an additional MRI scanner. The scanner could be used to prevent any impact on the patients waiting for MRI in the event of another MRI scanner breaking down.
- In the event of a radiation incident, each radiology department had a named radiation protection supervisor (RPS) who was accountable to the onsite radiation protection advisor (RPA). Incidents involving radiation were reported on the electronic incident reporting system and to the RPS who would escalate them to the RPA if appropriate. The RPA would then inform any relevant outside organisations such as East Anglian Region Radiation Protection Service (EARRPS) and CQC if required.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not rate the effectiveness of outpatients and diagnostic imaging services although we found:

- Medical staff planned and delivered patient care and treatment in line with current evidence-based guidance, standards, best practice and legislation.
 - Where people were subject to the Mental Health Act (MHA), their rights were protected and staff had regard for the MHA Code of Practice.
 - There was participation in relevant local and national audits, including clinical audits and other monitoring activities such as reviews of services. The diagnostic imaging department was part of the Imaging Services Accreditation Scheme.
 - Nursing staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was provided to meet these learning needs. Staff were supported to maintain and further develop their professional skills and experience.
 - There was evidence of good multidisciplinary working when patients received care from a range of different staff, teams or services. All relevant staff, teams and services were involved in assessing, planning and delivering patient care and treatment.
- One hundred percent of outpatient and diagnostic imaging services staff had received an appraisal in the past year.
 - Some outpatient services were being made available in the evenings and on Saturdays and Sundays in order to deal with appointment backlogs.
 - Staff could access the information they needed to assess, plan and deliver care to people in a timely way. Patient notes were always available for outpatient clinics.

Evidence-based care and treatment

- The hospital had a named radiation protection advisor (RPA) whose role was to lead on the development, implementation, monitoring and review of the policy and procedures to comply with IR(ME)R regulations. The hospital had a radiation protection adviser (RPA) who was based on site at the hospital.
- All areas of radiology followed the ionising radiation (medical exposure) regulations IR(ME)R guidelines. Prevention of contrast induced nephropathy was based on the NICE guidelines along with multiple policies used throughout radiology.
- The radiology department used diagnostic reference levels (DRLs) to optimise patient exposure to radiation. We saw local and national DRLs were in use throughout radiology.
- The radiology department had a comprehensive audit plan based on issues identified through the risk register and NICE guidance amongst others. Each audit had a named lead auditor and an estimated completion date.
- Policies and procedures throughout OPD and diagnostic imaging were based on National Institute for Health and Care Excellence (NICE) guidelines. We saw staff adhered to them.

Nutrition and Hydration

- The Women's Royal Voluntary Service (WRVS) brought a trolley of food and drink around the clinics which were a distance from the coffee shop so that patients could have something to eat and drink. Water dispensers were available in all clinics for patients and visitors to use freely.

Pain relief

- The pain clinic used policies based on the Faculty of Pain Medicine's Core Standards for Pain Management (2015) and the National Institute for Health and Care

Outpatients and diagnostic imaging

Excellence (NICE) guidelines. Patients followed a specific pain management pathway. Consultants discussed patients at weekly multidisciplinary team meetings (MDT) in the presence of occupational therapists, physiotherapists, pain nurse specialists and psychologists.

- The hospital offered two nurse led pain clinics daily. Patients were enrolled onto a pain management pathway which involved educational sessions and transcutaneous electrical nerve stimulation (TENS) machine trials as well as three monthly follow up appointments.
- The hospital conducted an audit of outpatient attendance at pain clinics between March 2015 and August 2015. This showed some patient attendance at some clinics was good and other clinics had high numbers of patients who do not attend (DNA). The hospital audit lead made recommendations to improve the pain clinic and an action plan was developed to address them. Actions included, increasing capacity at those clinics which were well attended, and releasing nurses from clinics which were less well supported. We saw that these actions had been implemented.

Patient outcomes

- The diagnostic imaging service was part of the Imaging Services Accreditation Scheme (ISAS). ISAS is a patient-focused assessment and accreditation scheme designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments. At this inspection we saw that ISAS accreditation had again been awarded for the fourth consecutive year.
- The OPD had enrolled in the NHS benchmarking scheme. The scheme looked at how the service compared to other similar services regarding equipment and equipment utilisation and hours of service. Participation enabled the identification and sharing of good practice. Feedback had not been received at the time of inspection.
- The OPD performance in the national cancer audits showed better than average positive outcomes.
- Breast cancer five and ten year survival rates were among the best in England. The audit of survival rates demonstrated that patients with metastatic disease were receiving chemotherapy up to one month prior to

death. The audit led to changes in treatment for patients with terminal cancer such as increased access to palliative care and chemotherapy being withdrawn earlier. This evidenced learning from audits.

Competent staff

- Staff had the right skills and qualifications to do their jobs. Nursing staff were trained so that they were competent to cover in a variety of clinics if the need arose.
- Three nursing staff in clinic 12 were undergoing additional training to enable them to take blood samples and perform electrocardiograms (ECGs).
- Staff had access to training and development through external and internal courses. We were shown a staff resource room where staff could access books and the internet during study periods.
- We spoke with a trainee radiographer. They told us they were very well supported, they had a named mentor, attended weekly tutorials and always worked under supervision. We saw signed records of the training they had received.
- Data supplied by the trust showed that for the reporting period, April 2015 to March 2016, 100% of outpatient and diagnostic imaging services staff had received an appraisal. This met the trust target.
- Three radiographers had received training to read plain film x-ray and two more radiographers were just starting the training at the time of our inspection.

Multidisciplinary working

- There was good internal MDT working between specialities and with allied health professionals (AHP's). Nursing staff gave examples of how the speech therapy clinic worked with the dietician and the audiology clinic worked with the ENT clinic. The ENT clinic often cleaned out patients' ears to ensure their hearing test could be carried out. There were weekly pain MDT meetings attended by pain nurse specialists, occupational therapists, psychologists and physiotherapists.
- The outpatient and diagnostic imaging department took part in multidisciplinary (MDT) meetings. There were 45 MDT meetings each week with attendance from specialist nurses, consultants, radiologists and from local trusts and social services. Staff used video link to enable MDT meetings with regional and national teams for liver transplant, and advanced testicular cancer among others.

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- Radiographers told us that if patients had recently undergone a radiology procedure at another hospital then the images could be obtained from picture archiving communication system (PACS) if they were relevant. This would save the patient from additional exposure to radiation.
- One stop clinics were available for breast care, head and neck lumps, haematuria and renal colic patients.
- Specialist nurses were available to support patients with respiratory disorders, breast care, dementia, Parkinson's, heart failure and MS.

Seven-day services

- Outpatient services were not routinely available seven days a week. Clinics were Monday to Friday from 8am until 5pm or 8.30am until 5.30pm depending on the clinic. Some outpatient services were being made available in the evenings and on Saturdays and Sundays in order to deal with appointment backlogs.
- Diagnostic Imaging ran a routine six day service with extended days of 07:00 – 20:00 in CT, MRI and US. MRI was available on Sundays to reduce waiting lists.

Access to information

- The electronic reporting system (Epic) ensured that all the information required to deliver effective patient care, such as test results, care plans and diagnostic images were available to the relevant staff. Patient notes were always available for outpatient clinics.
- Diagnostic images were available to consultants via the picture archiving communication system (PACS) within five minutes of the procedure being completed. Radiographers told us that if patients had recently undergone a relevant radiology procedure at another hospital then the images could be obtained from PACS to prevent the patient having additional exposure to radiation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a policy for obtaining patient consent. We reviewed the policy and saw it was in date and referenced the mental capacity act (MCA). Nursing staff could explain the procedure for obtaining patient consent and what to do regarding making a "best interests" decision.

- Nursing staff told us patients were asked for consent before any examination or procedure was carried out. We saw staff doing this prior to giving care. Patients we spoke with told us staff always asked for their consent before they received treatment.
- A consultant explained the procedure for obtaining consent to us. Consent forms for procedures were given to the patient at consultation to take home to read and sign. At the appointment the consultant talked through the consent form with the patient and confirmed verbally that they wished to proceed with the procedure.
- We heard staff interacting with a patient who was asked for verbal consent before a minor procedure was carried out. The member of staff clearly explained what they were doing and kept the patient informed at all times.
- The trust had introduced Mental Capacity Act and Deprivation of Liberty training. Trust wide, 96% of staff had completed this training against a trust target of 90%.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- Patients were consistently positive about the treatment they received from the staff in OPD and DI.
- Nursing staff maintained patient privacy, dignity and confidentiality and treated patients kindly.
- FFT data showed 93.8% of patients would recommend the service although this figure was based on a low number of patients responding.
- Patients were involved in their care and in making decisions. Patients understood their care, treatment and condition and were well informed.
- The OPD had clinical nurse specialists who were available to support patients living with pain, dementia and breast cancer among other things.

Compassionate care

- Throughout our inspection we saw staff were friendly, approachable and professional towards patients and their carers. We saw patients were spoken to courteously and respectfully at all times.

Outpatients and diagnostic imaging

- All the patients we spoke with were consistently positive about the treatment they received in OPD and DI. Patients told us the staff were professional and caring.
- In May 2016, Friends and Family Test (FFT) data showed 88.5% of patients would recommend the service based on 349 patient responses. This is below the national average score of 92%. All the patients we spoke with said they would recommend the department. At the time of our inspection, the FFT data showed 93.8% of patients would recommend the service based on an unknown number of patient responses.
- In May 2016, Friends and Family Test (FFT) data showed 93% of patients said they were made to feel welcome in the clinic based on a relatively low number (349) patient responses. We observed nursing and administration staff were friendly and courteous towards patients.
- We observed nursing staff interacting with a young child in the plaster clinic. The child was anxious about the procedure. The nurse was reassuring and spoke to the child using language they could understand and repeatedly asked the child “is this ok” as the plaster cast was being removed. The nurse explained that the child had been visiting the department frequently during recent months and that nursing staff ensured the patient always saw the same nurse. The child’s mother said “she (the nurse) is excellent”.
- We observed nursing staff caring for an elderly patient who was a regular visitor to the department. The staff were welcoming and friendly and demonstrated a good knowledge of the patients’ personal situation. The patient said “(this is) a wonderful hospital, very caring staff”
- Nursing staff maintained patient privacy and dignity by closing doors and curtains around patient bays before beginning procedures. Staff knocked and introduced themselves and asked permission to enter before going in to assist with care.
- We saw staff maintained patient confidentiality by locking computer screens when they moved away from them so that patient information was not visible.
- Chaperones were provided according to hospital policy when patients were having intimate procedures or if a patient requested one.
- In diagnostic imaging, staff showed patients who needed to undress for their procedures to individual single sex cubicles. In x-ray, once patients were changed into gowns they waited in the main waiting area. In MRI,

once patients were changed they could wait in the changing room until they were called for their procedure. In CT, patients changed behind a curtain once they were in the room.

Understanding and involvement of patients and those close to them

- The May 2016 outpatient experience survey showed that 86% of patients felt involved in the decision making around their care based on 349 patient responses.
- In general, the patients we spoke with felt involved in their care plans. All the patients we spoke with said they had received explanations about their treatments and been well informed about their conditions.
- Patients told us that reception staff informed them of clinic delays at the time of arrival and an explanation for the delay was usually given. We saw information such as whether the clinic was on time or not displayed on patient information screens throughout the OPD.
- We saw a wide range of information leaflets throughout the OPD. Leaflets related to medical conditions seen within the specific clinic area such as “tonsillectomy for adults” and “living with tinnitus” in ENT.

Emotional support

- The hospital Chaplaincy service provided emotional and spiritual support to patients and their families hospital wide.
- The OPD had clinical nurse specialists who were available to support patients living with pain, dementia and breast cancer among other things.
- The clinic manager in clinic 12 told us that nursing staff were encouraged to give out the clinic phone number to patients who seemed distressed so patients could talk to someone at a later date if they wished to.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires improvement because:

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- The trust was failing to meet referral to treatment times (RTT) for 6 out of 18 specialties. At the time of our inspection there were approximately 1000 patients waiting longer than 18 weeks though this represented an improving performance.
- There were waits longer than 6 weeks for some diagnostic imaging, particularly MRI.
- The follow up to new appointment ratio was below the England average.
- In June 2016, there were 15,148 patients overdue their follow up appointment.
- The trust was failing to meet the two-week England cancer wait.
- A large number of complaints were open more than the trust's 25 day target.
- General hospital signage throughout the OPD and DI was clear and easy to follow. Signs to the eye clinic were in line with the Royal National Institute for the Blind (RNIB) guidance for colour and font.
- Volunteers were available in the OPD entrance to help patients and visitors as they arrived in the OPD. Staff told us they could telephone the volunteer station and a volunteer would come to the clinic to help patients to their next destination.
- Staff 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.
- The hospital offered rapid access and one stop clinics for some specialties including breast, urology, prostate, deep vein thrombosis (DVT) and respiratory among others.
- Private funding had enabled the clinic manager to purchase a new electrocardiogram (ECG) machine for clinic 12. Nursing staff were undergoing additional training so that they could perform ECGs when the ECG department was closed. This would mean patients would not need a repeat visit.
- The fracture clinic held virtual clinics where consultants reviewed patient x-rays and decided on treatment plans without the patient needing to be present. Patients could be offered an appointment or discharged depending on the outcome. Nursing staff contacted the patient to inform them of the plan for their care.
- Additional clinics were being held in evenings and at weekends throughout the DI and OPD to address the patient backlogs.
- There were a number of disabled parking spaces at the entrance to the OPD. The park and ride bus stopped very near to the entrance and the hospital courtesy bus picked patients up and dropped them off from the OPD as well as oncology, eye clinic and the main hospital car park.
- The ear nose and throat clinic (ENT) took patients' mobile phone numbers so that patients could leave the department if their appointment was delayed and be called back at the right time.
- The Women's Royal Voluntary Service (WRVS) brought a trolley of food and drink around the clinics which were a distance from the coffee shop so that patients could have something to eat and drink. Water dispensers were available in all clinics for patients and visitors to use freely.

However, we also found,

- All the patients waiting follow up appointments had been risk assessed by a consultant and appointments were being booked according to clinical risk and 80% of patients now had an appointment booked.
- OPD and DI services were planned and delivered in a way that met the needs of the local population.
- Staff monitored appointment slot issues (ASIs) and referred any concerns to the appropriate specialty. At the time of our inspection we saw ASIs had been reduced to 35 from 270 in April 2016.
- Did not attend (DNA) rates had fallen and were now in line with the trust target.
- There was evidence of learning and sharing from complaints.
- Appointment booking centre staff offered patients a choice of time and date to attend for their appointment.
- At the time of our inspection the number of patients overdue their follow up appointment had reduced to approximately 13 000 patients which represented an improving performance.

Service planning and delivery to meet the needs of local people

- All the waiting areas we visited had enough seating for patients and their relatives. Bariatric chairs could be brought from the stores if a larger patient was expected in clinic.
- In a number of outpatient clinic waiting rooms there was priority seating identified as "calling spots". These chairs were for patients who were hearing impaired.

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- A dispensing pharmacy was available in the outpatient department foyer for patients to collect medications. The pharmacy was available from 8.30am until 6pm daily.

Access and flow

- Between January 2016 and April 2016, the number of appointment slot issues (ASI) increased from approximately 30 at any one time to approximately 270. Minutes from the operational taskforce meeting showed that staff monitored ASI and referred any concerns to the appropriate specialty. At the time of our inspection we saw ASIs had been reduced to 35 from 50 and more.
- The hospital was meeting the required target of 92% of patients waiting no more than 18 weeks from referral to treatment time (RTT) in 12 out of 18 specialties. The hospital was achieving 90.8% of patients achieving the 18 week RTT in the remaining six specialties. In May 2016, there were 2968 patients waiting more than 18 weeks. At the time of our inspection we saw the number of patients waiting had reduced to approximately 1000 patients.
- The ophthalmology department was achieving 96.4% of patients meeting the RTT. In June 2015 there were approximately 6000 patients overdue their follow up appointment, at the time of our inspection this had reduced to 2000 patients. All the patients in the backlog had been triaged and 97% of these patients had appointments scheduled based on their clinical risk.
- Hospital data showed that between January 2016 to June 2016 the waiting time for a first appointment reduced in 18 speciality clinics; however, it had increased for 18 clinics and remained the same for 45 clinics.
- In June 2016, there was a 29 week wait for a first appointment with an optometrist, this was more than double the waiting time from the previous month. The average waiting time for a first appointment was seven weeks. The operations manager explained that backlogs were due to capacity issues, a lack of space to see the patients in clinics and a lack of medical staff to see the patients.
- The trust was not meeting its six week diagnostic performance target. From June 2015 to May 2016, the diagnostic waiting times were consistently longer than the England average. The trust had arranged additional diagnostic imaging clinics at weekends and some evenings to address the issue.
- In May 2016, there were 2,225 patients waiting for magnetic resonance imaging (MRI), 311 (14%) had waited longer than six weeks. Since January 2016, the number of patients breaching the six week waiting time had been increasing, despite the trust having an action plan in place to address this. At the time of our inspection there were 100 patients waiting more than six weeks for their MRI appointment. The operations manager told us this was being addressed by the use of an additional MRI scanner and by additional clinics at weekends.
- There were 1,637 patients waiting for ultrasound and 16 of them (1%) had waited longer than six weeks. There were no breaches for the patients waiting for computerised tomography (CT).
- The trust was failing to meet the two-week England average cancer wait. Between February 2016 and June 2016 the average number of patients receiving treatment within 62 days from urgent GP referral for all cancers was 81.6%, less than the England average of 85%.
- Data supplied by the trust showed the follow up to new appointment ratio was below the England average between March 2015 and February 2016. The trust was performing in line with the worse 25% of hospitals nationally with a trust wide average ratio of 1.65 follow up to new appointments. The lower the 'new to follow-up ratio', the more likely a significant proportion of a clinician's time is being taken up with follow up appointments at the expense of seeing new patients. At the time of our inspection, all patients waiting follow up appointment had been risk assessed by a consultant and appointments were being booked according to clinical risk. The trust told us that 80% of patients now had an appointment booked.
- Data provided by the hospital showed that in July 2015, 23,182 patients were overdue their follow up appointment by more than one month. However, in June 2016, this number had reduced by 35% to 15,148. At the time of our inspection the number of patients had reduced further to approximately 13,000 patients.
- The trust cancelled 5% of clinics within six weeks during March and April 2016. This had improved slightly to 4% of clinics for May 2016 and June 2016. In March 2016, the

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trust cancelled 5% of clinics over six weeks, this improved slightly to 4% and 3% in April and May respectively but worsened again to 5% in June 2016. The hospital told us the main reason for clinic cancellations was due to medical staffing issues.

- The trust was addressing the radiology reporting backlogs. All images were reported in-house 24 hours per day and seven days per week. At the time of our inspection three radiographers had been trained to report plain film images and two more radiographers were beginning the training. This enabled radiologists to report the more complex images and reduced image reporting backlogs. Images were reported based on clinical priority, emergency department (ED) patient images were reported first, followed by inpatients, then cancer patients then routine or follow up patients.
- The hospital surveyed 349 patients in relation to waiting times in the OPD. Two-hundred and fifty-eight patients (74%) said their appointments were within 30 minutes of the original appointment time. Reception staff told patients about clinic delays at the time of arrival and updates were available on patient information display screens.
- We spoke with 32 patients during our inspection. Of these, six complained about long waits due to clinics running behind schedule.
- Data provided by the hospital showed that in May 2016, the percentage of patients who did not attend (DNA) their appointment was 6%. However, in May 2016, this had reduced to 4.8% meeting the trust target.
- Data provided by the hospital showed, on average, staff answered 76% of inbound calls to the outpatient department appointment-booking centre. This was an improvement on previous data, which showed only 50% of calls were being answered.
- We listened to four booking centre co-ordinators making appointments for patients on the telephone. On all four calls patients were offered a choice of time and date to attend for their appointment.
- The radiology day unit (RDU) had opened another bed and now had eight beds and a reclining chair. The unit was nurse led and patients who would previously have required an inpatient stay were treated here. The unit was open until 8pm and had two separate bays to accommodate for male and female patients.
- Patients who had special needs or were being monitored for safeguarding issues could be identified on Epic by an “alert”. This enabled nursing staff to prepare for the patients arrival at the clinic in advance.
- There was a chaperone policy in place. This information was displayed throughout the outpatient and diagnostic imaging department.
- The OPD had access to a learning disability nurse specialist. In audiology, clinics for patients with learning disabilities were held on Tuesdays, this allowed for the presence of a second audiologist.
- Hearing loops were available in some clinics to assist patients who were hearing impaired.
- Posters were displayed throughout OPD and DI informing staff and patients about dementia champions who could be contacted for advice and support regarding patients living with dementia.
- A telephone based translation service called Language line was available for patients who did not speak English as a first language. Face to face translators could be booked in advance. Staff told us patients usually brought friends or family who could translate for them. In CT we saw a patient who spoke Portuguese, her relative who was translating did not want to enter the scanner room, the HCA said “I speak Portuguese, I can translate for you”.
- The trust had play specialists, a radiographer told us the play specialists could come to x-ray to support children who were anxious during their x-ray.
- The MRI department had a scanner which was able to accommodate bariatric patients and special equipment such as hoists and bariatric chairs could be brought to the OPD and DI department from the facilities team.
- A MRI safe wheelchair was available for use by disabled patients in MRIS.
- Radiographers offered eye masks to patients who were anxious or suffered from claustrophobia. The radiographer told us that patients who wore the eye masks during their MRI scan consistently reported that the procedure was less stressful.
- Lifts and ramps enabled easy access throughout the OPD and DI department for people who had mobility issues. Patients and visitors could access wheel chairs free of charge at the entrance to the OPD.

Meeting people’s individual needs

Learning from complaints and concerns

Outpatients and diagnostic imaging

- We reviewed the trust policy on the management of complaints and concerns. The policy detailed how to make a complaint and the procedure the hospital would follow to respond to it. The policy stated all responses would be within 25 days unless an extension was sought.
- We reviewed the hospital complaints register for April 2016 to June 2016. There were 28 complaints against OPD and DI. The top three causes for complaint were communication issues, six complaints, delays at clinics and staff attitudes, five complaints each. Six of the complaints had been closed, two had breached accepted timeframes for closure and the remainder were still open and under investigation. A large number of the open complaints had their timescales for closure extended to more than 25 days. At the time of our inspection the oldest open complaint was regarding access to services and was from 1 April 2016.
- Information was available on the Trust web site detailing how to make a complaint and included the hospital's complaints policy. We saw information about making complaints displayed on patient information screens in numerous locations across the departments. Leaflets were also available called "Tell us what you think".
- Patients gave mixed feedback regarding making a complaint. Fourteen of the patients we spoke with knew how to make a complaint and were aware of the patient advice and liaison service (PALs) and 16 patients said they did not know how to go about making a complaint.
- Staff told us of a change made to a seating area as a result of a patient complaint. In the ear nose and throat (ENT) clinic patients had complained they could not hear their names being called, staff had rearranged the seating to improve the situation. This evidenced learning from complaints
- We reviewed two sets of Outpatient Patient Safety and Governance meeting minutes. "Improving Patient Experience" was a standing agenda item complaints were routinely discussed.
- There was a clear statement of vision and values and all the staff knew and understood them.
- The board and other levels of management within the OPD and DI service functioned effectively and interacted with each other regularly. Reporting structures, processes and systems of accountability were clearly set out, understood and effective.
- Quality received significant attention in board meetings and other relevant meetings below board level.
- OPD centralisation was well underway with expected completion in March 2017 for those services being included.
- The SAFER bundle model had been introduced into OPD.
- All the staff we asked said they felt valued and well supported by local managers.
- Staff gave us numerous examples of innovations and improvements which had been introduced across OPD and DI as well as plans to improve sustainability.
- The trust proactively engaged and involved all staff by the listening learning and acting together group.

Leadership of service

- At the time of our inspection, outpatients and diagnostic imaging services were led by the divisional director, the associate director of operations and acting head of nursing.
- We spoke with the Divisional Director, Operations Manager and the Assistant Director of Operations (ADO) for outpatients. It was clear from our discussions that the trust board had continued to focus on improving out-patient services.
- Nursing and administration staff gave a mixed response regarding the visibility of the senior leadership team (SLT) and the executive team in the outpatient and diagnostic imaging department. In three areas we visited staff said they felt well supported and in two areas staff said they did not feel well supported. However, staff in all areas spoke very highly of the matron, the Operations Manager and the ADO.

Vision and strategy for this service

- The outpatient department mission statement was "to provide high quality and responsive care to our patients, in a safe, caring and compassionate environment."

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

Outpatients and diagnostic imaging

Ensuring that the right patient is seen, at the right time, by the right clinician, on the correct pathway in order to deliver excellent care, safe services and a positive experience every time”.

- The trust wide values were “Together – Safe, Kind, Excellent” All the staff we spoke with knew the hospital values and felt staff lived by them. We saw the values displayed on posters and patient information screens throughout the OPD and DI department.
- We saw a strategy document for the “centralisation” of the OPD. Centralisation involved combining selected outpatient clinics and processes under one management structure. The operations manager told us that they expected centralisation to be complete by April 2017 for all the OPD clinics which were being included.
- The operations manager had adapted the “safer bundle” and introduced it into the OPD. The OPD bundle is similar to a clinical care bundle. It is a set of simple actions for nursing and administration staff to complete to improve patient flow and prevent unnecessary waiting for patients. We saw the safer bundle displayed throughout OPD and DI.
- The operations manager had implemented “operational grip” which was a process for managing OPD completely by considering safety, quality, capacity and financial sustainability in all management processes.

Governance, risk management and quality measurement

- The OPD had a clear governance structure in place and regular meetings were being held. We reviewed the minutes of two governance meetings, two outpatient board meeting minutes together with two sets of quality committee meeting minutes. These demonstrated that there was oversight of the outpatient departments’ performance, risks, quality and key milestones. Actions were distributed and closed once they had been completed. Governance meetings were held quarterly and the quality committee and outpatient board both met monthly.
- The management of the OPD was such that each clinic had a clinic lead who was responsible for the day to day organisation of the clinic. The clinic lead reported to the head of department who in turn reported to the divisional lead and ultimately the out patients operations manager.

- Clinic managers met on a daily basis and received the briefing from the daily 8.27 meeting.. We saw records of attendance and minutes from an “8:27” meeting. There was evidence that outpatient services, operational capacity, risk management, finance, information governance, infection prevention and control along with key topics and policies and incidents, complaints, issues arising and feedback from the daily huddles were discussed.
- Team meetings were held weekly to share information from the “8:27” meeting. We saw minutes of the team meeting where an incident had been discussed. This assured us there was feedback and sharing of incidents.
- Clinic managers, the operations manager and the deputy operations manager met every other week.
- The operations manager met with the senior leadership team and the executive team every other week. The divisional lead told us that risk assessments and safety incidents were always discussed at the meeting.
- “Daily huddles” were held in four of the outpatient clinics we visited. The clinic lead, nursing and administration staff gathered around a white board and discussed the previous day and the day ahead. The briefing looked at incidents, complaints, staffing levels, and issues arising such as patients with complex needs attending the clinic that day. A record of the “huddle” was kept in the clinic diary.
- We attended a “daily huddle” in the appointment-booking centre. The appointment booking centre lead and four team leaders gathered around a white board. Numbers of patients awaiting appointments, cancer two week waits, urgent referrals, appointment slot issues (ASIs) and patients about to breach their 18 week RTT were discussed along with successes, incidents and feedback. Figures were updated based on the previous day activity. Team leads then relayed the information to their team of booking coordinators. Booking coordinators told us they “really like the daily huddles as it keeps morale up and you can see where you are up to (with patient numbers)”
- We reviewed the OPD specific risk register prior to our inspection. There were 63 risks identified, eight were scored as high risk, 35 as medium risk and 20 as low risk. All risks had actions and review dates in place to reduce and mitigate the risks.
- Open high risks included the back log of patients in ear nose and throat (ENT), the obstructed fire escape off clinic 8, lack of compliance with the chaperone policy

Outpatients and diagnostic imaging

due to not enough HCAs, cancellation of routine surgery due to prioritising urgent patients and the lack of clean and dirty areas for instrument decontamination in clinic 8. The clinic managers were all aware of the risks which had been identified and we saw the risk assessments for managing the risks.

- There were well established governance systems for diagnostic and imaging services. A radiation committee was in place and governance meetings took place regularly as well as regular reports from the Radiation Protection Adviser (RPA). Any incidents involving radiation were reported to the radiation safety committee and the East Anglian Regional Radiation Protection Service (EARRPS).

Culture within the service

- The operations manager told us that all staff were actively encouraged to raise concerns and risks which they felt needed to be addressed. All the staff we spoke with said they felt they would be happy to raise concerns.
- All the staff we asked said they felt valued and well supported by local managers.
- Nursing, medical, administration staff and volunteers were welcoming and helpful towards us throughout our inspection. All the staff we spoke with were open and honest. Staff told us they were proud of their departments and managers told us they were proud of their staff.

Public engagement

- The operations manager told us that the aim was for each clinic to obtain friends and family (FFT) data from 100 patients and visitors per clinic per month. We saw the FFT questionnaire on reception desks throughout the OPD and DI department.
- Patient feedback was collected via electronic kiosks and comment cards.
- The hospital wide patient experience group met quarterly to discuss hospital wide issues.

Staff engagement

- The trust wide staff satisfaction survey showed that 93% of staff would recommend the hospital as a place to receive care and 72% of the staff would recommend the hospital as a place to work.

- Trust wide reception forum provided support, guidance and shared learning to front line receptionists across the trust
- The Listening, Learning and Acting Together group focused on sharing learnings from incidents with outpatient nursing and administrative staff.
- We saw the monthly outpatients newsletter which staff received electronically and staff told us about the “you made a difference award” which staff could be nominated for by patients and colleagues.

Innovation, improvement and sustainability

- During our inspection staff gave us numerous examples of innovations and improvements which had been introduced across OPD and DI as well as plans to improve sustainability.
- The OPD was implementing self check in kiosks to reduce waiting times at reception areas within clinics and assist with improved information governance as patients will not be required to provide their personal information at reception desks. The kiosks will also provide directions to the patients’ clinic, enable the collection of Friends and Family data and capture pre-appointment information where required.
- Clinic 12 had purchased an ECG machine and trained three HCAs to perform ECG. This enabled patients to have their ECG performed even when the ECG department was closed and meant they did not have to have a return visit to the OPD.
- Clinic 12 had purchased a reclining chair so patients who were waiting for admission to hospital could be more comfortable.
- The radiology day unit (RDU) had introduced an additional bed. This helped reduce the number of patients who needed to be admitted to the hospital for their radiology procedure.
- The trust had introduced pets as therapy (PAT) dogs to visit outpatient department waiting areas to help reduce patient anxiety and frustration while waiting for their appointments. The dogs attended the OPD on alternate Thursday mornings.
- The clinical equipment maintenance team were introducing an electronic system for the management of equipment across the hospital. The portable equipment would have a tracker installed so that nursing staff were able to locate equipment which had been moved or borrowed by other departments.

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- The OPD operations manager was looking at introducing outpatients performance boards. This would enable staff across OPD to compare their clinics' performance against other clinics with regard to waiting times, FFT data and DNAs among others things.
- The hospital executive team had identified a suitable area for the installation of an additional MRI scanner which could be used to maintain capacity in the event of an MRI scanner breaking down.

Outstanding practice and areas for improvement

Outstanding practice

- Ward J2 ran weekly 'music and movement' classes to help meet the holistic needs of patients during their long-term recovery. A volunteer specialising in music and movement ran the classes and staff encouraged patients and their relatives to attend. This had received excellent feedback from patients and relatives.
- The teenage cancer unit provided outstanding facilities for young people diagnosed with cancer and receiving treatment for cancer. The teenage cancer unit provided a welcoming, age appropriate environment for young people to receive treatment, but also meet other young people and relax and socialise.
- The ED team had developed a mobile phone application called "Choose Well." The application offered guidance on waiting times and hospital services across Cambridge in order to improve the patient experience and offer choices in health care.
- The emergency department had secured £100,000 of funding from the Small Business Research Initiative (SBRI) to support the development of a crowd prediction modelling tool to enable the trust to understand and map patient flow through the department.
- The charitable trust was in the process of setting up a trauma ICU centre in Burma in which a number of the ICU/NCCU staff were involved, as well as the Burma nurse specialist visiting later on in the year.
- The initiative for 'Family Facetime' proposed the purchase of two technology tablets to enable mums on the Obstetric Close Observation Area (OCoA) who are too unwell to visit their baby on the neonatal intensive care unit to receive a video link via Facetime with their baby.
- The bereavement follow up scheme saw a reduction in complaints of approximately 50%.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure medicines including controlled medicines are securely stored at all times.
- Ensure that end of life care is properly audited (such as preferred place of death and DNACPR) and actions taken in response to those audits.
- Ensure that complaints are responded to in a timely way wherever possible.
- Ensure resuscitation decisions are always documented legibly and completed fully in accordance with the trusts own policy and the legal framework of the Mental Capacity Act 2005.

Action the hospital **SHOULD** take to improve

- Ensure it improves the environment for children in the ED to ensure children's safety at all times.
- Review staffing in the emergency department with respect registered nurses (child branch) to ensure children's needs and national guidance are met.
- Review staffing of the specialist palliative care team against national guidance.
- The trust should ensure that all staff complete mandatory training and safeguarding training to ensure it complies with the 90% compliance target.
- Continue to work to improve delayed discharges and discharges that occur between the hours of 10pm and 7am in the critical care and intensive care units.
- The trust should ensure the actions from the safeguarding review they have conducted for level three training for staff in adult areas caring for patients under the age of 18 years are implemented.
- The trust should review the level of children's safeguarding training healthcare assistants undertake to ensure it is in line with the Intercollegiate Role Framework for Looked After Children and the trusts own Safeguarding Children's Policy.
- Review consultant hours in maternity in line with national guidance.

Outstanding practice and areas for improvement

- Continue to improve referral to treatment time performance including for cancer services and reduce the number of cancelled operations.
- Consider improvements to the response rate for the Friends and Family Test which are poor across the trust.
- Ensure that systems are in place to reduce the risk of confidential information leaks.
- Work to reduce the number of diversions of high risk deliveries in maternity services.
- Continue to reduce the time for end of life patients to be discharged to their preferred place of care.
- Ensure that all equipment is appropriately checked and safety tested where required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the fundamental standards that were not being met. The provider must send CQC a report that says what action they are going to take to meet these fundamental standards.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider failed to ensure the monitoring of end of life care through local audit.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

The provider failed to ensure that the Mental Capacity Act 2005 was consistently applied when a DNACPR decision was made.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider had failed to ensure that all medicines were stored securely and in line with local policy.