

Papworth Hospital NHS Foundation Trust

Papworth Hospital NHS Foundation Trust

Quality Report

Papworth Hospital
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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



Medical care

Requires improvement



Surgery

Good



Critical care

Good



End of life care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Papworth Hospital is the UK's largest specialist cardiothoracic hospital and the country's main heart and lung transplant centre. The hospital offers a range of services for outpatients, including cardiac, thoracic, transplant, radiology and pathology services.

We carried out this inspection as part of our comprehensive inspection programme

We carried out an announced inspection of the hospital on 3, and 4 December 2014, and an unannounced inspection on 14 December. We looked at all the inpatient services, including the Progressive Care Unit, and the outpatients department.

Overall we found that the hospital provided highly effective care with outcomes comparable with or above expected standards. The service was delivered by highly skilled, committed, caring staff and patients were overwhelmingly positive about the care they received at the hospital. However, there were areas in which the hospital could improve.

Our key findings were:

Access and flow

- The outpatients department provided 124,066 outpatient appointments during 2013/14, of which 67% were follow-up appointments. The follow-up to new patient ratio was in the highest 25% in the country.
- Meeting the referral-to-treatment time of 18 weeks for cardiology patients in the outpatients department was 98.8% and most other referral-to-treatment times were also meeting the national targets.
- The trust had been failing to meet national referral-to-treatment times for cardiothoracic surgery. This had been rectified at the time of our inspection. There were also a significant number of cancelled operations and high theatre use, and a number of patients had not had their surgery 28 days after their operation was cancelled. This was due to a number of reasons, including late referrals to the hospital from other centres that meant referral-to-treatment time targets could not be met, changes in patients' conditions that meant they were unfit for surgery and capacity issues because of increased demand for some services.
- There were also concerns that the surgical department had no designated emergency theatre, which meant that elective operations were sometimes cancelled or emergency cases waited until a theatre was free.
- There was increasing demand for a number of services provided at the hospital, but service expansion was constrained because of the physical environment and limited building space on the site.

Incident reporting

- There were systems in place for incident reporting, but incident reporting was not consistent across the hospital. There were occasions when incidents were not reported in a timely manner
- In addition, there was limited evidence of shared learning from incidents across some services. As a result there were missed opportunities for learning in relation to avoidable patient harm
- The trust had reported and investigated two Never Events (these are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) over the last 18 months. The quality of the investigation reports for these incidents varied.
- Additional incident investigation reports reviewed also varied in quality, rigour and depth.

Risk management

- The management of risk within individual wards and departments varied. Some local risk registers required review because not all risks were clearly articulated or understood; this was a particular issue in medical services.

Summary of findings

Medicines management

- The hospital used a comprehensive prescription and medication administration record chart for patients that enabled the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- Records confirmed that Pharmacists visited all wards each weekday. Pharmacists and pharmacy technicians completed the medicines management section on the prescription record for every patient to confirm medication reconciliation had occurred. (Medicines reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record with an external list of medications obtained from a patient, or GP).
- The pharmacy department was open six days a week, but with limited hours on Saturday and pharmacists on-call out of hours. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- Medication errors are the highest error group in the trust. Missed doses are counted as an incident; this is considered good practice. Prescribing errors and medication errors are both audited and both show an upwards trend. However, harm rates are well below the national average and indicated good reporting in this area. Action plans were in place and completion timescales identified and monitored. Lessons learnt were shared through the trust's intranet page, junior doctors' newsletter, pharmacy fact sheets and the sisters' network. Plans to set up medication safety champions were in place, with the first meeting scheduled for December 2014.

Safeguarding

- There were systems and processes in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. The safeguarding process was supported by staff training and all relevant staff had received safeguarding training. Staff were confident and competent in raising and escalating safeguarding issues.

Nurse staffing

- Care and treatment were delivered by committed and caring staff who provided patients with good services. Nurse staffing levels had been reviewed throughout the hospital earlier in 2014 and were assessed using a validated acuity tool.
- However, we noted that the Progressive Care Unit did not appear to have selection criteria or pathways for patients admitted to the unit, and there were no regular acuity assessments of patients in the unit at the time of our inspection. Since our inspection the hospital has introduced regular reviews of patient acuity and nurse staffing levels on this unit.

Medical staffing

- Care and treatment were delivered by highly skilled and committed medical staff.
- There was a good consultant presence throughout the wards, providing care to patients seven days a week.
- A 'consultant of the week' system had recently been initiated in medicine and was working well. A comprehensive handover took place from one consultant to another.
- Junior medical staff we spoke with all felt well supported in their roles by senior medical staff and they did not feel their workload was excessive. Findings from the General Medical Council Survey 2014 supported this.
- In terms of the consultant/patient ratio in the Critical Care Area, up to 33 patients were cared for on the unit and one or two consultant intensivists on duty falls below the best current evidence ratios as set out in the Intensive Care Society standards.
- A review of the thoracic service commissioned in May 2014 highlighted that there was poor junior surgical support for the thoracic service and the emergency on-call rota was unsatisfactory because of the limited thoracic experience of some staff on the rota. These matters were being addressed through an action plan developed in response to the review findings.

Summary of findings

Infection prevention and control

- Staff were aware of current infection prevention and control guidelines and we observed good practices such as hand-washing facilities and hand gel available throughout the hospital. Staff observed 'bare below the elbow' guidance and staff wore personal protective equipment, such as gloves and aprons, while delivering care. However, we found that not all staff followed hand hygiene routines consistently.
- Some aspects of infection prevention and control were not being managed effectively, including the routing of some outpatients through thoracic medicine.
- Suitable arrangements were in place for the handling, storage and disposal of clinical waste, including sharps.
- Cleaning schedules were in place and displayed throughout the wards and departments.
- There were clearly defined roles, responsibilities and processes for cleaning the environment and the decontamination of equipment.

Mandatory training

- Mandatory training levels were very good and records demonstrated that overall compliance with mandatory training was 91%.

Outcomes and evidence-based care

- Patients received care and treatment that was evidence-based and in accordance with national guidance.
- Clinical outcomes and mortality rates were comparable with, or better than, other trusts nationally.
- Multidisciplinary team working was well established and used effectively to manage patients' care and treatment needs.
- Staff at the hospital participated in an extensive programme of local, national and internationally recognised research.

Environment and capacity

- The hospital consisted of multiple buildings spread across the site. Many of the outpatient areas had been refurbished but space was limited and the service was physically confined.
- Some of the ward layouts were not appropriate, such as Baron ward, where a corridor in the ward was used as a central thoroughfare for staff and visitors alike.
- The outpatients department had developed many nurse-led clinics with additional clinics being run in the evening and at the weekend. This was recognised as good practice and patients who travelled long distances appreciated this flexibility in their appointment times.

Nutrition and hydration

- Patients had a choice of food and an ample supply of drinks during their stay in hospital. Patients with specialist needs for eating and drinking were supported by dieticians and other professionals
- There was good support for patients who needed assistance with eating and drinking, who were offered appropriate and discreet support.

We saw several areas of outstanding practice including:

- The surgical division's effectiveness and patient outcomes were outstanding and were among the best in the UK.
- The Critical Care Area had recently developed guidelines for the prevention, recognition and management of delirium. This was a multidisciplinary piece of work led by the unit's matrons and also included members of the ALERT team and a consultant intensivist. The guidelines were about to be launched and plans were in place for the work to be shared through conference presentations.
- The hospital had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, such as details of their current medicine.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the hospital must:

Summary of findings

- Stop the practice of routinely preparing the one medicine (GTN) in advance of its immediate use in catheter labs, in contravention of the Nursing and Midwifery Council's standards.
- Ensure that incidents are reported in a timely manner and that learning from incidents takes place.
- Ensure that all fire exits are clear.
- Have an effective system in place to ensure that drugs stored in resuscitation trolleys are in date.
- Address the breach of single-sex accommodation on Duchess ward.
- Improve the way in which risk is managed and reported.
- Develop and implement a strategy for patients with a diagnosis of dementia.

In addition the hospital should:

In the medical division:

- Review the routing of outpatients through Thoracic medicine.
- Review the management of risk within individual wards and departments.
- Ensure the reporting of incidents in a timely manner.
- Develop cross-directorate learning from incidents.
- Review risk assessments for the location of resuscitation trolleys and fire safety exits.
- Improve the audit process for the maintenance of drugs required for the resuscitation trolleys.
- Review the staffing levels for allied health professionals, particularly occupational therapy, to ensure that they are available as part of the multidisciplinary team.
- Review capacity issues in some of the services, particularly in bronchiectasis services.

In the surgical division:

- Address the lack of clarity in selection criteria or pathways for patients admitted to the Progressive Care Unit.
- Review the use of regular acuity assessments of patients in the unit.
- Review and address the reasons for the significant number of cancelled operations and high theatre use.
- Consider the provision of a dedicated emergency theatre.

In the critical care service:

- Review the availability of facilities for relatives in the Critical Care Area.
- Review the medical staffing. In terms of the consultant/patient ratio, with up to 33 patients on the unit and one or two consultant intensivists on duty, this falls below the best current evidence ratios as set out in the Intensive Care Society standards.

End of life care:

- Explore ways to share and highlight the expertise of the end of life team and encourage earlier referral and more open conversations as part of the patients journey, with greater cross-service working.

In outpatients and diagnostic services:

- Improve the contingency plans to respond to the introduction of the new electronic records system at the nearby acute centre that was providing the hospital with pathology services.
- Assess the suitability of the environment to maintain the expansion of outpatient services.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Requires improvement

Rating



Why have we given this rating?

Medical services were delivered by caring and compassionate staff. Staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

Safety within the wards and departments providing care and treatment to medical patients required improvement. There were systems in place for reporting incidents and 'near misses', but not all serious incidents were reported in a timely manner and learning from incidents did not always take place. As a result there were missed opportunities for learning in relation to avoidable patient harm. Three resuscitation trolleys contained out-of-date drugs, and one of them was partially blocking a fire exit with its contents accessible to members of the public. One Medicine (glyceryl trinitrate) was routinely prepared in advance of their immediate use, in contravention of the Nursing and Midwifery Council's standards.

Some aspects of infection prevention and control were not being managed effectively, including the routing of outpatients through thoracic medicine. National guidelines were followed in treating patients and the outcomes for patients were comparable with or better than other trusts nationally. Patient care and treatment were delivered effectively by a multidisciplinary care team seven days a week and out of hours when appropriate.

There were capacity issues in the provision of some services because demand had grown. Increased use of technology and outreach services had enabled staff to meet the needs of more patients in their own homes.

An ongoing breach of the guidance requiring NHS trusts to provide single-sex accommodation was observed on Duchess ward.

The management of risk within individual wards and departments was poor. There was an inward-looking culture within the wards and departments providing care for medical patients, and lead clinicians from

Summary of findings

the cardiac and thoracic teams struggled to think of examples of cross-directorate learning from incidents, or initiatives that worked well that could be shared with other teams.

Staff at the hospital participated in an extensive programme of local, national and internationally recognised research.

Surgery

Good



Care and treatment were delivered in accordance with evidence-based practice and national guidance. Patient outcomes were outstanding and were among the best nationally.

Staff used care pathways effectively. The services participated in national and local clinical audits and results compared favourably with similar trusts. Incidents were reported and investigated and staff were provided with opportunities for learning to prevent reoccurrence. Investigation records were comprehensive and well completed.

There was adequate provision of highly skilled medical and nursing staff throughout the service. Staff were aware of their responsibilities in relation to safeguarding and could identify and escalate issues of abuse or neglect appropriately.

Patients were treated with dignity and respect and were supported through their treatment by compassionate, knowledgeable staff. All the patients we spoke with told us they had received excellent care.

Surgical services were planned to meet the needs of patients both locally and nationally. However, the hospital had been failing to meet its referral-to-treatment time for cardiothoracic surgery. This had been rectified at the time of our inspection. There were a significant number of cancelled operations and high theatre use. In addition there was no identified emergency theatre. Staff spoke highly of their immediate managers. Service quality and patient outcomes were monitored regularly. There was ongoing innovation within the directorate and staff participated in extensive research programmes.

Critical care

Good



We rated the Critical Care Area (CCA) as good, with some areas of outstanding practice. The patients and their relatives that we spoke with told us of the hospital's positive reputation and that they felt very well cared for in the unit. There was evidence of

Summary of findings

strong medical and nursing leadership in the CCA that led to positive outcomes for people. The service submitted regular Intensive Care National Audit and Research Centre data so was able to benchmark its performance and effectiveness alongside other similar specialist trusts.

There was a clear understanding of incident reporting and an embedded culture of audit, learning and development. Staffing levels were continuously monitored in conjunction with the unit's occupancy and patient acuity to ensure that sufficient numbers of suitably skilled staff were on duty. The unit was innovative and had recently developed guidelines for the prevention, recognition and management of delirium, a common condition associated with admission to critical care that affected approximately one in five patients admitted to the CCA.

The environment had a high standard of cleanliness and the hospital's infection control policies were consistently applied. The unit demonstrated safe medicines management and we saw adequate supplies of equipment and devices to meet patients' care needs.

End of life care

Good



The quality of end of life care provided by the hospital was of a good standard. There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for and those close to them were supported sensitively and compassionately. Patients care was highly individualised. Pain relief and aids to comfort were provided in a timely way. There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection. We found that the family viewing area and mortuary were fit for purpose. Records were comprehensive and 'Do not attempt cardio-pulmonary resuscitation' documentation was in place and completed appropriately.

Outpatients and diagnostic imaging

Good



The quality of services in outpatients and diagnostic imaging was good. Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. There were appropriate protocols in place for safeguarding

Summary of findings

vulnerable adults and children. Staffing levels and skill mix were planned to ensure the delivery of outpatient and diagnostic services at all times. Any staff shortage identified was responded to quickly and adequately.

The departments provided an effective service that was based on national good practice guidance and evidence-based treatment regimes. There were good examples of innovation, such as nurse-led clinics to support patients with long-term conditions and fast-track processes to access imaging services that had a positive impact on outcomes for patients. Staff were competent and were supported by their managers to provide a good quality service to patients. At the time of inspection the outpatient service operated six days a week and there were plans to operate seven days a week.

The care provided by staff to patients in the outpatient and diagnostic imaging services was outstanding. All the feedback we received from patients and those close to them was universally positive about the way staff treated and cared for them. People were clear that staff went the extra mile and the care they received exceeded their expectations. The service adopted the 'hello my name is' campaign, which aims to put the patient at the centre of the care received. This demonstrated that people's needs were highly valued by staff and were embedded in their care and treatment.

The service was responsive when planning to meet the needs of local people. Effective consultation encouraged and supported patients and those close to them to influence the design and delivery of the service. However, the physical space available to provide and deliver these services was limited. After targeted and ongoing work, the hospital had a low number of patients who failed to attend their appointments, with a 'Did Not Attend' rate of 3.7%. This was continually monitored to enable adaptations to be made to meet the needs and demand of the population.

Overall, the service was well-led. Staff felt their line managers were approachable, supportive and open to receiving ideas or concerns. Staff knew and

Summary of findings

understood the vision for the hospital, but this was perceived as solely focused on the opening of a new hospital; staff knew little about any other visions for the service.

We found that the local managers demonstrated good leadership within the department and the directorate, but there was a lack of connection between the trust board and the local departments in relation to delivering the vision and strategy for both the service and the trust.

Good 

Papworth Hospital NHS Foundation Trust

Detailed findings

Services we looked at

Medical care; Surgery; Critical care; End of life care; Outpatients & Diagnostic imaging

Contents

Detailed findings from this inspection

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Detailed findings

Background to Papworth Hospital NHS Foundation Trust

Papworth Hospital NHS Foundation Trust is located in Cambridgeshire and accepts patients nationally. The trust gained foundation status in 2004.

The trust has only one location on the Papworth site that is actively registered with the Care Quality Commission. The hospital does not provide a 24-hour emergency department, but patient transfers are accepted 24 hours a day.

Papworth Hospital is the UK's largest specialist cardiothoracic hospital and the country's main heart and lung transplant centre. The trust offers a range of services for outpatients, including cardiac, thoracic, transplant, radiology and pathology services.

Papworth Hospital provides outpatient care to patients from all over the UK. Outpatient care is also provided to paying patients from overseas.

The trust has close working relationships with its partners and to provide care for patients who needed additional support such as rehabilitation or care in their own homes.

We inspected this trust as part of our comprehensive inspection programme.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector of Hospitals

Head of Hospital Inspections: Ann Ford, Care Quality Commission

The team included five CQC inspectors and a variety of specialists including: consultant thoracic surgeon,

consultant cardiologist, consultant anaesthetist, medical devices and decontamination manager, senior physiotherapist, cardiac nurse, cardiothoracic theatre nurse manager, physiologist, nurse and former director of performance and clinical director, cardiac catheterisation laboratory manager, a pharmacist and one expert by experience.

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?

Before our inspection we reviewed a range of information and asked other organisations to share what they knew about the hospital. These included the local clinical

commissioning groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

The announced inspection of the hospital took place on 3 and 4 December 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, student nurses, administrative and other staff, physiotherapists, occupational therapists, pharmacists. We also spoke with staff individually as requested.

Detailed findings

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

We undertook an unannounced inspection on 14 December 2014. We looked at inpatient services, including the Progressive Care Unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experiences of the quality of care and treatment at Papworth Hospital.

Facts and data about Papworth Hospital NHS Foundation Trust

Papworth Hospital is a specialist cardiothoracic hospital and heart and lung transplant centre. The trust offers a range of services for outpatients, including cardiac, thoracic, transplant, radiology and pathology services.

Trust information for 2013/14 listed 255 beds, including 33 critical care beds. There were 23,700 inpatient admissions in 2013/14.

As at December 2014, 1,945 members of staff were employed, including medical, nursing and other staff.

The trust has an annual income of £175 million.

The hospital provides outpatient care to patients from all over the UK. Outpatient care is also provided to paying patients from overseas. The outpatients department provided 124,066 outpatient appointments during 2013/14. Of those appointments, 25% were new referrals, but the majority were follow-up appointments and accounted for 67% of all the appointments provided. The follow-up to new patient ratio (25%) is among the highest in the country.

Surgical services provide heart and thoracic surgery to patients locally and nationally. Last year (2014/15) the hospital carried out over 3,300 operations, including coronary artery bypass grafting, transcatheter aortic valve implantation (TAVI) and thoracic surgery, and it is also a

major national transplant centre. It is the only centre in the UK to provide pulmonary endarterectomy and one of a small number of specialist centres providing extra-corporeal membrane oxygenation (ECMO).

The hospital has five theatres, a small recovery and a main surgical ward, with a number of surgical patients cared for on other wards. Surgical services are known both nationally and internationally for their expertise and positive patient outcomes.

As a tertiary and national referring centre, the Critical Care Area also admits patients who need mechanical support such as ECMO treatment for heart failure and following transplant and pulmonary endarterectomy.

The hospital provides cardiothoracic services and treatments for all patients who are eligible for NHS care. Government policy allows NHS patients to choose which hospital they receive their non-urgent care in. The hospital does not provide an accident and emergency service.

Being a specialist centre, the hospital provides services for many different commissioners.

The hospital site is remote and people without their own transport may find access by public transport difficult.

Detailed findings

Our ratings for this hospital







Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Outstanding	Outstanding	Good	Good	Good
Critical care	Good	Outstanding	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Outstanding	Good	Good	Good
Overall	Good	Outstanding	Outstanding	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Medical care (including older people's care)

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

Information about the service

Medical care and treatment at Papworth Hospital was provided across both the cardiac and thoracic areas. We visited the cardiac day unit, cystic fibrosis unit, the Respiratory Support and Sleep Centre and the thoracic day ward in addition to Hemmingford, Duchess/Baron, Princess and Hugh Fleming wards. We also visited the catheterisation laboratory during our inspection.

We observed care, looked at care and medicines records for 15 people and spoke with 13 patients, six relatives and 37 staff across all disciplines.

Summary of findings

Medical services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

Safety within the wards and departments providing care and treatment to medical patients required improvement. Although there were systems in place for reporting incidents and 'near misses', not all serious incidents were reported in a timely manner and learning from incidents did not always take place. As a result there were missed opportunities for learning in relation to avoidable patient harm.

Three resuscitation trolleys contained out-of-date drugs, and one of them was partially blocking a fire exit with its contents accessible to members of the public. One medicine (GTN) was routinely prepared in advance of its immediate use, in contravention of the Nursing and Midwifery Council's standards.

Some aspects of infection prevention and control were not being managed effectively, including the routing of outpatients through thoracic medicine.

National guidelines were followed in treating patients and the outcomes for patients were comparable with or better than other trusts nationally. Patient care and treatment were delivered effectively by a multidisciplinary care team seven days a week and out of hours when appropriate.

Medical care (including older people's care)

There were capacity issues in the provision of some services because demand had grown. Increased use of technology and outreach services had enabled staff to meet the needs of more patients in their own homes.

An ongoing breach of the guidance requiring NHS trusts to provide single-sex accommodation was observed on Duchess ward.

The management of risk within individual wards and departments was poor. There was an inward-looking culture within the wards and departments providing care for medical patients, and lead clinicians from the cardiac and thoracic teams struggled to think of examples of cross-directorate learning from incidents, or initiatives that worked well that could be shared with other teams.

Staff at Papworth participated in an extensive programme of local, national and internationally recognised research.

Are medical care services safe?

Requires improvement



Safety within the wards and departments providing care and treatment to medical patients requires improvement. Although there were systems in place for reporting incidents and 'near misses', not all serious incidents were reported in a timely manner and learning from incidents did not always take place. As a result there were missed opportunities for learning in relation to avoidable patient harm.

Three resuscitation trolleys contained out-of-date drugs, and one of them was partially blocking a fire exit with its contents accessible to members of the public. One medicine (GTN) was routinely prepared in advance of its immediate use in the catheter laboratory, in contravention of the Nursing and Midwifery Council's standards. Immediate action was taken to cease the practice.

Some aspects of infection prevention and control were not being managed effectively, including the routing of outpatients through thoracic medicine. Medical and nursing staffing levels were satisfactory and staff handovers were good.

Incidents

- There were systems in place for reporting incidents and 'near misses' within wards and departments providing care and treatment to medical patients. Staff were confident in the use of the incident report system but did not always report incidents promptly. During our inspection we were made aware of an incident in the cardiac catheterisation laboratory. The day after the incident, it remained unreported on the incident reporting system and the departmental manager was unaware that the incident had taken place.
- Learning had not taken place from an incident within the same department in May 2014. Additional safeguards were recommended following a root cause analysis of the incident to prevent a recurrence, but these safeguards were not in place at the time of our inspection.
- We found other wards and departments where the dissemination of learning from incidents through staff meetings, ward noticeboards and ward newsletters was good.

Medical care (including older people's care)

- Staff we spoke with were aware of their responsibilities regarding the recently introduced Duty of Candour regulation.
- Incidents reported to the National Reporting and Learning System have not been compared with the England average because this would not give a true reflection considering the specialist nature of the hospital.
- Mortality and morbidity meetings were held monthly and were attended by senior members of the multidisciplinary team. These meetings discussed any deaths that had occurred within the wards and departments providing care and treatment to medical patients and any learning from the deaths. Managers then took the learning points back to their individual teams.
- Staff were aware of current infection prevention and control guidelines. There was a sufficient number of hand wash sinks and hand gels. Hand towel and soap dispensers were adequately stocked.
- We observed staff following hand hygiene practice on most of the wards we visited; however, on three of the wards we found hand hygiene for staff across all disciplines was inconsistent.
- Signage to one department for outpatients directed them through a thoracic medicine ward. We also observed patients and their families being directed through the same ward to X-ray. We discussed this with the ward staff, who informed us that the only other access from the clinic area was outside. Therefore during cold or wet weather patients were frequently directed through the ward. Routing outpatients through an inpatient area increases the risk of infection and compromises the privacy and dignity of inpatients.

Safety thermometer

- The wards and departments providing care and treatment to medical patients were managing patient risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month.
- The trust monitored these indicators and displayed information on the ward performance boards. However, the way the information was presented was not clear to the lay person or the casual observer. An example of this was one ward where tables of scores were all presented in green, indicating at first glance that the ward had reached all targets and was performing well. In reality, almost half of the harms audited were below the target scores.
- The trust in general had performed well against the England average for all the indicators measured for Harm Free Care. The Rate of Harm Free Care was consistently above the national average for the 12 month period.

Cleanliness, infection control and hygiene

- The hospital infection rates for Clostridium difficile and MRSA infections, including the wards and departments providing care for medical patients, were within an acceptable range for a hospital of this size.
- The wards and departments we inspected were clean, but most were cluttered because of their size and layout.

Environment and equipment

- Some wards were not well laid out, particularly Duchess/Baron ward. Some side rooms on this ward opened onto a main thoroughfare within the hospital opposite a busy lift, which meant patients had to keep their doors closed at all times to preserve their dignity and the security of their belongings. Patients were effectively isolated in these side rooms.
- Some side rooms on Baron ward were so small that the bedside locker had to be removed from the rooms to transfer patients from a trolley to the bed. There was insufficient room for staff to pass between the bottom of the bed and the wall without turning sideways, which made it more difficult for staff to undertake routine duties, such as bed making and delivering basic care to patients.
- Staff told us there was sufficient equipment available but that they would occasionally borrow from other wards if necessary. The only shortage of equipment reported to us across all the wards and departments providing care for medical patients was for pulse-oximeters.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- The resuscitation trolley for the cystic fibrosis ward was kept in the main corridor outside the ward because of lack of space on the ward. The position of this trolley partially obstructed a fire exit and the contents of the

Medical care (including older people's care)

trolley were accessible to anyone using this corridor, including members of the public. This represented a risk of the contents being removed or tampered with. We discussed the position of the trolley with the resuscitation lead, who informed us that a risk assessment had been carried out regarding the position of the trolley. We requested a copy of the risk assessment, but did not receive one.

Medicines

- The service used a comprehensive prescription and medication administration record chart for patients that enabled the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for five patients on one ward. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed.
- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs were stored and managed appropriately.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- Records confirmed that a pharmacist visited all wards each weekday. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date.
- It was normal daily practice within the cardiac catheterisation laboratory for a large amount of a frequently used drug to be prepared in advance and used for five different patients over several hours, decanted from one syringe. All the medical and nursing staff we spoke with confirmed that this was normal practice. This contravenes the Nursing and Midwifery Council Standards for Medicines Management 2010, which states, "Registrants must not prepare substances for injection in advance of their immediate use or administer medication drawn into a syringe or container by another practitioner when not in their presence."
- The trust resuscitation policy required the stock contained within the resuscitation trolleys in clinical

areas to be checked daily. An audit of resuscitation trolleys undertaken in July 2014 found that 29% of the trolleys audited contained out-of-date drugs, despite 100% of daily checks being made on resuscitation trolleys. Feedback was given to wards and departments on the findings of the audit, but no action was taken to establish why nursing staff were signing off the daily checks despite the trolleys containing out-of-date drugs, or to check that this practice was no longer happening.

- During our inspection we found three resuscitation trolleys containing out-of-date drugs. We highlighted this to the ward and departmental managers and these drugs were replaced immediately. One of the replaced drugs was used to resuscitate a patient later the same morning. We found records on all three trolleys, signed by nursing staff and confirming they had been checked daily, but no action had been taken to replace the out-of-date drugs.

Records

- During our inspection we reviewed ten sets of patient records on five wards and departments. In all the records we looked at documentation was accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. Risk assessments for risks such as pressure ulcers and falls were well documented and regularly reviewed. Care plans contained clear accounts of actions in place to reduce and manage risks to patient safety.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training and all of the staff we spoke with about safeguarding had undertaken safeguarding training.

Mandatory training

- Mandatory training was up to date or programmed to take place in all areas we visited. Staff were happy with the access to training within the trust. They were informed in advance of any mandatory training they needed and the training would be scheduled in. The training was competency-based and everyone we spoke with told us the training provided within the trust was of a good standard.

Medical care (including older people's care)

Assessing and responding to patient risk

- Wards and departments providing care for medical patients, with the exception of the Respiratory Support and Sleep Centre, used an electronic version of the National Early Warning Score, which was designed to identify patients whose condition was deteriorating. All staff we spoke with could demonstrate how to use the tool.
- We found that the response provided by the team of highly skilled advanced nurse practitioners, known as the 'ALERT' team, to a patient whose condition was deteriorating was timely and effective.
- Staff we spoke with could describe how they accessed specialist medical help both within and outside of normal working hours. All staff we spoke with told us the response from the medical teams, across all grades, was very good.

Nursing staffing

- Nursing staffing levels had been reviewed throughout the trust earlier in 2014 and were assessed using a validated acuity tool. There were minimum staffing levels set for wards providing care and treatment for medical patients, and required and actual staffing numbers were displayed on every ward we visited.
- Staffing levels on the wards and departments we visited were satisfactory overall. We reviewed copies of duty rotas on four wards over a three-month period and found that the nurse staffing levels and skill mix had been satisfactory during this time.
- Gaps in rotas were usually filled by permanent staff working additional hours or bank/agency workers who were familiar with the hospital and had worked there regularly. This meant continuity of nursing care was good. Patients we spoke with confirmed this.
- Nursing handovers took place at the start of each shift on all the wards providing care for medical patients. Staffing for the shift was discussed as well as any high-risk patients or potential issues. Handovers were detailed and staff members on duty were familiar with the needs of patients under their care.

Medical staffing

- Medical treatment was delivered by highly skilled and committed medical staff.
- There was a good consultant presence throughout the wards, providing care to medical patients seven days a week.

- A 'consultant of the week' system had recently been initiated and was working well. A comprehensive handover took place from one consultant to another. Medical handovers were good.
- Junior medical staff we spoke with all told us they felt well supported in their roles by senior medical staff and told us that they did not feel their workload was excessive. Findings from the General Medical Council Survey 2014 corroborated this.

Major incident awareness and training

- Operational staff we spoke with in all the areas we inspected were unaware of any business continuity planning for their wards and departments.

Are medical care services effective?

Good



National guidelines were followed in treating patients and the outcomes for patients were comparable with or better than other trusts nationally. Patient care and treatment were delivered effectively by a multidisciplinary team seven days a week and out of hours when appropriate.

Evidence-based care and treatment

- Wards and departments caring for medical patients used a combination of National Institute for Health and Care Excellence (NICE) and Royal Colleges' guidelines as a basis for the treatment they provided. Local policies were written in line with these guidelines and had been updated periodically. Some guidelines had been amended to take into account the highly specialised nature of the work undertaken at the hospital.
- There were specific care pathways for certain conditions in order to standardise and improve care for patients.
- Additional audits were undertaken by the wards and departments caring for medical patients. These tended to be very specific to the work undertaken on that particular ward or department, rather than across the wards and departments providing care for medical patients.

Pain relief

- Patients we spoke with told us they received timely and effective pain relief.
- Pain relief was monitored for efficacy and reviewed appropriately.

Medical care (including older people's care)

- There were protocols in place for the safe use of pain-relief medication.

Nutrition and hydration

- Appropriate nutritional assessments had been undertaken and were well documented in all the care records we reviewed.
- People were provided with a choice of suitable and nutritious food and drink, and we observed hot and cold drinks were available throughout the day.
- Staff were able to tell us how they addressed people's religious and cultural needs regarding food.
- We saw that a colour-coded tray system was in place to highlight patient support requirements for eating and drinking.

Patient outcomes

- Because of the highly specialised nature of the work undertaken at Papworth Hospital, participation in some of the national cardiac and thoracic audits was not appropriate.
- The most recent Myocardial Ischaemia National Audit Project (MINAP) data was for 2013 and showed average or above-average performance for those sections of the audit the trust was eligible to participate in, when compared with other trusts nationally.
- Data related to the percentage of deaths following treatment within the primary percutaneous coronary intervention service showed a mortality rate at the hospital that was better than the national average. Between April and July 2014, the mortality rate at the hospital was almost 5% compared with a national mortality rate of over 6%.

Competent staff

- All staff we spoke with across all disciplines had received an appraisal during the last year. Records we viewed supported this. The 2013 NHS staff survey showed that the trust was slightly below the national average for staff reporting that their appraisal was well structured.
- The General Medical Council's decisions regarding the revalidation of doctors at this trust are in line with other trusts throughout England.

Multidisciplinary working

- Multidisciplinary teams worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multidisciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the

team. However, some allied health professionals, particularly those from the physiotherapy team, told us they were not always "listened to". They also expressed concerns that new services were being planned that required additional physiotherapy input without due consideration being given to the resource implications within the physiotherapy department.

- There were four occupational therapists within the hospital, two of whom worked within the wards providing care to medical patients, providing less than one-and-a-half whole time equivalents. This was insufficient to provide an effective occupational therapy service to patients, particularly during times of staff sickness, training or annual leave.
- We saw that teams met regularly throughout the day, both formally and informally, to review patient care and plan for discharge. Multidisciplinary team decisions were recorded and care and treatment plans amended to include changes.

Seven-day services

- There was no pharmacy service at weekends. However, staff told us this did not impact on patients because discharges were usually well planned and patients' medication was ordered in advance. There was access to emergency drugs outside of normal working hours.
- Consultants were very accessible out of hours. Nursing staff told us they would feel comfortable contacting the consultants out of hours if they had any concerns. Consultants we spoke with confirmed this.
- Imaging services were available out of hours.
- Physiotherapy services were available seven days a week and a late shift was undertaken on some wards to provide services to patients who needed physiotherapy services during the evening.

Access to information

- Access to information was good for patients and their families. We saw examples of comprehensive information for patients regarding the management of their health conditions. Although this information was only available in English, alternative language and large print versions were available on request.
- Wards also provided a telephone advice service to patients following discharge.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. The Mental Capacity Act 2005 was adhered to appropriately and Deprivation of Liberty Safeguards were applied when necessary.

Are medical care services caring?

Good



Medical services were delivered by caring and compassionate staff. We observed that staff treated patients with dignity and respect. Care was planned and delivered in a way that took into account the wishes of the patients.

Compassionate care

- We found that, throughout the wards and departments providing care to medical patients, care and treatment were delivered by caring and compassionate staff.
- We spoke with 13 patients and six relatives and everyone spoke very positively about the care that they, or their family member, had received.
- We also saw examples of ways in which people were encouraged to share their impression of the hospital and how improvements could be made.
- The NHS Friends and Family Test showed a high level of satisfaction. All ward areas were above the national average, with an average score of 84% between April and July 2014.

Understanding and involvement of patients and those close to them

- Patients and relatives we spoke with said they felt involved in their care. They had frequent opportunities to speak with the consultant and other members of the multidisciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.

Emotional support

- Staff had built up trusting relationships with patients and their relatives through their interactions, sometimes over many years. Patients and relatives told us that they received considerable emotional support from all members of the multidisciplinary team.

- There were teams of specialist nursing and allied health professional staff throughout the hospital who provided expert emotional support to medical patients and their families.
- There were a range of support groups facilitated by the hospital that were available to patients and their families. People were also encouraged to access the national support groups for many and varied health conditions.

Are medical care services responsive?

Requires improvement



There were capacity issues in the provision of some services because demand had grown. Increased use of technology and outreach services had enabled staff to meet the needs of more patients in their own homes.

There was no strategy in place for addressing the needs of patients with a diagnosis of dementia.

An ongoing breach of the guidance requiring NHS trusts to provide single-sex accommodation was observed on Duchess ward.

Service planning and delivery to meet the needs of local people

- There were capacity issues in the provision of some services. Demand had increased within the bronchiectasis service and staff told us they were finding it a challenge to meet the growth in demand. The lead thoracic clinicians informed us of joint working initiatives and other ways in which the bronchiectasis service had adapted the way care and treatment were provided in order to make best use of the resources available.
- There were some services where the increased use of technology and outreach services were meeting the needs of patients once discharged from hospital. An example of this was the provision of intravenous medicines to some patients at home through an outreach team, avoiding an additional hospital stay.

Medical care (including older people's care)

Access and flow

- Bed occupancy and the flow of medical patients within the wards were well managed. There was clear escalation policies in place and relevant staff met regularly throughout the day to ensure that patients were cared for in a ward that best suited their needs.
- Moving patients during the late evening and night was unusual and generally as a result of clinical need.
- Nursing and medical staff were aware of patients who were being cared for on other wards and these patients' care and treatment had been reviewed appropriately.
- The hospital had an initiative known as 'ticket home' in place. This focused on an expected date of discharge and enabled both staff and patients to work towards the earliest appropriate discharge date for patients.

Meeting people's individual needs

- For patients whose first language was not English, staff could access a language interpreter if required.
- The hospital did not have a strategy for caring for patients with a diagnosis of dementia. With the exception of four questions included as part of the routine admission screening process, screening for dementia did not take place on the wards and departments providing care and treatment to medical patients. Initiatives to alert and inform staff about patients with dementia were not widely used.
- An identified breach of the guidance requiring NHS trusts to provide single sex accommodation was observed on Duchess Ward. Both male and female patients were observed to be able to view patients of the opposite sex while moving around the ward. Also, in order for female patients to enter or leave the ward, they had to pass through a male-only area.

Learning from complaints and concerns

- Staff we spoke with were aware of the trust complaints system and how to advise patients and relatives to make a complaint, should they wish to do so.
- Although the number of formal complaints made to the trust was small, no record was kept of informal verbal complaints that were addressed at ward or departmental level. This meant that any learning from informal complaints could not be shared with other areas, where appropriate, in order to make improvements.

- Information advising people about how to make a complaint was visible within the hospital and signs to the Patient Advice and Liaison Service (PALS) were prominently displayed.

Are medical care services well-led?

Requires improvement



With the exception of the building of a new hospital, none of the staff we spoke with were aware of any strategy for maintaining a high-quality service to medical patients before the anticipated move.

The management of risk within individual wards and departments was poor. There was an inward-looking culture within the wards and departments providing care for medical patients, and lead clinicians from the cardiac and thoracic teams struggled to think of examples of cross-directorate learning from incidents, or initiatives that worked well that could be shared with other teams.

Staff participated in an extensive programme of local, national and internationally recognised research.

Vision and strategy for this service

- The only strategic plans that staff working within the wards and departments providing services for medical patients were aware of was the plans to build a new hospital. This was at least three years in the future, but none of the staff we spoke with were aware of any strategy for the maintenance of a high-quality service to medical patients before the anticipated move.
- None of the staff we spoke with were aware of the vision and values for the hospital and we did not see any evidence of a vision or values for the hospital throughout our inspection.
- Wards providing care and treatment to medical patients had an individual ward vision. Staff working on the wards told us they were aware of the vision and spoke enthusiastically about the vision for their ward.

Governance, risk management and quality measurement

- The management of risk within the wards and departments delivering care to medical patients was poor. None of the ward managers or matrons we spoke with knew how to access their departmental risk

Medical care (including older people's care)

register. They could not tell us what their departmental or organisational risks were and were unclear, when questioned, about how risks could be escalated if necessary.

Leadership of service

- We saw some examples of good leadership by individual members of medical and nursing staff throughout the wards and departments providing care and treatment for medical patients that were positive role models for staff.
- Staff told us they attended regular staff meetings and that their immediate line managers were accessible and approachable.
- The results of the NHS Staff Survey 2013 indicated that the trust was better than expected for the percentage of staff reporting good communication between senior management and staff; 35% of staff reported that communication was good, compared with the national average of 29%.
- There was a nursing leadership programme in place within the trust that had been attended by some of the managers we spoke with, who had found it valuable.

Culture within the service

- Many staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the hospital.
- There was an inward-looking culture within the wards and departments providing care for medical patients. We found staff from across all disciplines were very focused on their own specific areas of work.
- Lead clinicians we spoke with from both the cardiac and thoracic teams could not provide us with any examples of cross-directorate learning from incidents, or initiatives that worked well that could be shared with other teams.







Public and staff engagement

- Staff we spoke with from all disciplines were excited about the planned new hospital and most were looking forward to the move to the new building, although sad to be leaving the hospital they were fond of.

Innovation, improvement and sustainability

- Staff at the hospital participated in an extensive programme of local, national and internationally recognised research.
- Staff were piloting the use of electronic video communication with patients within their own homes.

Surgery

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

Information about the service

The surgical services at Papworth Hospital provide heart and thoracic surgery to patients locally and nationally. Last year the hospital carried out over 3,300 operations, including coronary artery bypass grafting, transcatheter aortic valve implantation and thoracic surgery, and it is also a major national transplant centre. It is the only centre in the UK to provide pulmonary endarterectomy and one of a small number of specialist centres providing extra-corporeal membrane oxygenation (ECMO).

The service has five theatres, a small recovery and a main surgical ward, with a number of surgical patients cared for on other wards. The surgical services provided at the hospital are known both nationally and internationally for their expertise and positive patient outcomes.

Summary of findings

Care and treatment were delivered in accordance with evidence-based practice and national guidance. Patient outcomes were outstanding and were among the best nationally.

Staff used care pathways effectively. The services participated in national and local clinical audits and results compared favourably with similar trusts.

Incidents were reported and investigated and staff were provided with opportunities for learning to prevent reoccurrence. Investigation records were comprehensive and well completed.

There was adequate provision of highly skilled medical and nursing staff throughout the service.

Staff were aware of their responsibilities in relation to safeguarding and could identify and escalate issues of abuse or neglect appropriately.

Patients were treated with dignity and respect and were supported through their treatment by compassionate, knowledgeable staff. All the patients we spoke with told us they had received excellent care.

Surgical services were planned to meet the needs of patients both locally and nationally. However, the hospital had been failing to meet its referral-to-treatment time for cardiothoracic surgery.

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This had been addressed at the time of our inspection. There were a significant number of cancelled operations and high theatre use. In addition, there was no identified emergency theatre.

Staff spoke highly of their immediate managers. Service quality and patient outcomes were monitored regularly. There was ongoing innovation within the directorate and staff participated in extensive research programmes.

Are surgery services safe?

Good



There were systems in place to report incidents and feedback from incidents was provided to staff to aid learning and prevent reoccurrence.

The wards were clean and well maintained. Staff followed good practice guidance in relation to the control and prevention of infection. However, we did identify that on the Progressive Care Unit (PCU) not all staff maintained good hand hygiene practice. Medicines were stored and administered safely and correctly. Records were comprehensive and contained relevant information and risk assessments that were accurately completed.

Staff were aware of their responsibilities in relation to safeguarding. Mandatory training rates were good.

An early warning system was used to alert staff to patients whose condition was deteriorating, or was at risk of deterioration, so that medical intervention could be provided promptly.

In the PCU there were no clear selection criteria or pathways for patients admitted to the unit. In addition, there were no regular acuity assessments of patient needs. We were concerned that the acuity and dependency of patients in the unit was not monitored and raised this at the time of our inspection. The management team took immediate action to address this issue.

Nursing staffing was suitable to meet patients' needs and patients were regularly reviewed by highly skilled medical staff, though transplant and ventricular assist device patients received more consultant-led reviews than surgical patients.

Incidents

- There were 16 serious incidents reported for the surgical directorate in the previous twelve months before the inspection.
- Staff were aware of the incident reporting system and were confident in reporting incidents or concerns.

Surgery

- Meeting minutes showed that incidents were investigated and outcomes were fed back to staff to highlight learning opportunities. Staff confirmed that incidents were discussed with them individually and at staff meetings to aid learning and prevent reoccurrence.
- Mortality and morbidity meetings were held within the surgical directorate. Medical staff attended these meetings. Ward nursing staff attended only if it related to care on their ward. Minutes we reviewed showed that at times there was a lack of detail in the records and learning points were not clearly noted.

Safety thermometer

- The safety thermometer was clearly displayed in the ward area. (The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care.)
- When the safety thermometer indicated a concern, trends in results were identified and practice changed. For example, a cluster of infections was identified, an investigation and root cause analysis was completed and changes to practice initiated to reduce infection rates.
- The thermometer showed that Braden score (pressure ulcer risk score), falls and malnutrition risk assessments completion rates were 95%.
- There were consistently low numbers of patient pressure ulcers, falls and catheter-associated urinary tract infections within the service.

Cleanliness, infection control and hygiene

- Ward, theatres and related clinical areas were clean and well maintained.
- There were publically displayed cleaning rotas for each area. The most recent cleanliness audits demonstrated 95% compliance with standards of cleanliness. However, they were some months old at the time of our inspection.
- There had been one case of MRSA bacteraemia since May 2013 and a low number of Clostridium difficile infections.
- There had been a number of cases of MSSA bacteraemia between August and October 2014. A root cause analysis had been completed, procedures had been externally benchmarked and changes made to practice as a result.
- There was adequate personal protective equipment for staff and visitors to use and hand sanitizers were available.

- While most staff washed their hands appropriately, we saw a number of instances on the PCU when staff did not wash their hands appropriately, including after emptying a catheter bag and when assisting a patient to move in bed and then attending to another patient.
- The wards displayed 100% compliance with hand hygiene audits.
- Data from Public Health England showed that for surgical sites that were audited, the service had lower than the England average for post-operative wound infections at 2.85%, against an England average of 4.07%.
- Isolation rooms were used in line with trust policy.

Environment and equipment

- Equipment was maintained and serviced in line with manufacturers' and national guidance.
- Resuscitation equipment was in place and was checked daily.
- In theatres, the difficult airway management equipment was readily available in an emergency, with clear guidance for staff.
- While we were inspecting the theatres, the ventilation system failed. Staff told us that this had happened on a number of occasions over the year.
- Because of a lack of storage space, some equipment such as trolleys and hoists were stored in corridors, leading to a cluttered environment.
- Staff had received relevant training on the use of medical devices within theatres and ward areas.

Medicines

- The hospital used a comprehensive prescription and medication administration record chart for patients that enabled the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for nine patients on two wards. We found appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. Patients' allergies were recorded on their prescription chart.
- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature.
- Controlled drugs were stored and managed appropriately.

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- Emergency medicines were available for use and there was evidence that these were regularly checked and ready for use.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- Records confirmed that a pharmacist visited all wards each weekday. Pharmacy staff checked that the medicines patients were taking on admission were correct and that their records were current and accurate.

Records

- Records were stored securely and were accessible for staff.
- Records contained appropriate risk assessments, including pressure area care, nutritional and pain assessments. All were accurately completed and mitigating actions implemented.
- There were comprehensive pre-operative assessments completed in the pre-operative clinics that were continued and reviewed on admission to the ward.
- Records were comprehensive and contained the information required to safely care for patients. Patient pathways were completed appropriately.
- In theatres there was a paperless electronic anaesthesia record that maintained records for any events or medicines given to the patient in the department.

Safeguarding

- Safeguarding formed part of mandatory training and we saw that over 90% of staff had completed appropriate training.
- Staff could describe their responsibilities regarding safeguarding and were able to report and escalate issues of abuse or neglect through a recognised pathway.

Mandatory training

- Mandatory training included infection control, basic life support and moving handling among others. Training was tailored to specific areas so that staff in theatres received updates relating to their specific area of work.
- Records indicated that over 90% of staff were up to date with mandatory training requirements.

Assessing and responding to patient risk

- The service had implemented the 'Five steps to safer surgery' in the operating theatres.

- The WHO checklist was used appropriately, with good communication and briefing sessions embedded in the service.
- The wards used the modified early warning system (MEWS) to identify patients whose condition was deteriorating or was at risk of deteriorating. Records we reviewed demonstrated that the MEWS score was consistently and appropriately applied.
- Staff were supported by the ALERT team in caring for deteriorating patients. If a MEWS score was high, it automatically triggered the ALERT team to review the patient. Staff felt the system worked well and the ALERT team were prompt to review patients at risk.
- Mallard ward had a five-bed PCU. We were told this was for patients who needed additional care or monitoring and was used as a 'step down' from the Critical Care Area (CCA). The unit had previously had nine beds, but four had been closed because of insufficient substantive staff.
- The PCU opened in September 2013 and was originally supported by medical intensivists; however, this arrangement had lasted only a few months. Patients in the PCU were now reviewed four times a day by surgeons and the ALERT team. We asked staff if the change to medical staffing in the area had been explained or risk assessed before the change, but staff were unsure of the decision-making process in this regard.
- We asked to view the agreed admission criteria for the PCU and we were provided with an 'operational document' that was under review. We found that before a patient was transferred to the PCU, a ward nurse would assess them for suitability to determine if their needs could be met. However, admission and discharge criteria were not clear and we were concerned that transfers to the unit may have been driven by the need for critical care beds.
- Between January and December 2014, 105 patients who had been discharged from the CCA were readmitted because of deterioration of their condition.
- Mortality and morbidity meeting minutes we reviewed indicated that a patient had been admitted to a ward bed rather than a PCU bed and was subsequently readmitted to critical care. Actions indicated that patients should remain on critical care if no PCU bed was available, though there was a lack of detail in the minutes of these meetings.

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Nursing staffing

- The operating theatres were fully staffed with some new staff remaining supernumerary because they were still receiving induction.
- Mallard ward had vacancies for just over six whole time equivalent nurses and also had several staff on maternity leave. The ward was covering these shortfalls by offering overtime to permanent staff and utilising bank workers. There was little use of agency workers. Last year, 2013/14 nursing staff turnover on Mallard ward was 16%, with 12 members of staff leaving. The service was recruiting nurses at the time of our inspection.
- Staffing levels for each shift were displayed clearly on the wards (safer staffing).
- Because of insufficient staffing levels, four beds in the PCU had been closed and were now used for patients who did not require PCU care.
- During our announced inspection, the acuity of patients in the PCU increased. Staff we spoke with on the unit confirmed this and told us they were increasing staffing to manage patient needs.
- We asked if a formal acuity tool had been used to determine the acuity of patients and nurse staffing requirements. Staff told us an acuity tool had been used in early November, but not on the day in question.
- We were concerned that the lack of regular use of an acuity tool meant staff were (potentially) unaware of the dependency and needs of patients and that appropriate staffing levels could not be identified.
- During our unannounced inspection on Sunday 14 December, we saw that the acuity of patients in the unit had changed again. We asked if patient acuity had been assessed and we were informed that it had not. We remained concerned that the acuity of patients was not considered when determining staffing for the unit and there was no way to audit the acuity of patients being transferred to the PCU from critical care over time.
- This matter was raised with the management team, who took action to address this issue.

Surgical staffing

- Surgical treatment was delivered by highly skilled and committed medical staff.
- Surgical services had higher numbers of consultant surgeons and registrars than the England average.
- There were clear on-call arrangements, both out of hours and at weekends.

- Transplant surgeons worked a one-in-seven rota and because there was a first and second surgeon on-call, this effectively meant a one-in-three rota. Specialist advice we received indicated this may be necessary to keep transplant skills up to date, but would require ongoing monitoring. This was a busy rota, particularly for ventricular assist device patients who would require two surgeons for transplant.
- Patients who had transplant surgery or had a ventricular assist device implanted were medically reviewed twice daily and seen by a consultant at least once a day. There were also consultant-led ward rounds at weekends.
- Surgical patients were seen daily by the registrar, though staff told us that surgical consultants were less visible in the ward areas.
- A review of the thoracic service commissioned by the trust in May 2014 highlighted that there was poor junior surgical support for the thoracic service and the emergency on-call rota was unsatisfactory because of the limited thoracic experience of some staff on the rota. There was also a lack of ownership of patients being cared for within the service who required further investigation. Senior directorate staff informed us that following a meeting in October 2014 (to discuss and agree action points); the findings of the review were now being addressed.

Major incident awareness and training

- Senior staff we spoke with seemed unclear about the major incident or business continuity plans for the service, though information received following the inspection indicated that there was a business continuity plan in place.
- The Risk Management Group meeting minutes from August 2014 indicated that a major incident plan/mutual aid agreement with a neighbouring trust for 2014/15 was still being discussed and was not yet implemented. The Risk Management Group meeting minutes from August 2014 indicated that a major incident plan/mutual aid agreement with a neighbouring trust for 2014/15 was still being discussed and was not yet implemented. However, the Mutual Aid Agreement was implemented in September 2014 after The Risk Management Group meeting of that month.
- A contingency plan for theatres indicated that there were insufficient critical care beds to admit in an

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emergency; the plan was to open additional capacity, though no mention was made of retaining the patient in theatre in the interim, or if additional capacity could not be found.

Are surgery services effective?

Outstanding



We found that patient clinical outcomes for complex surgery, including cardiac, thoracic and transplant surgery, were outstanding and among the very best in the UK. Evidence-based care and treatment were embedded throughout the directorate for all members of staff.

Patients received pain relief in a timely way and medication was monitored for efficacy. Patients were well supported in meeting their nutrition and hydration needs.

There were competency frameworks in place for staff in theatres and ward environment, but there were no specific frameworks in place for staff working on the Progressive Care Unit (PCU) that looked after patients with a higher level of acuity than the ward. There was effective collaboration and multidisciplinary working with colleagues internally and externally and seven-day services included elective theatre lists on a Saturday and Sunday. While consent processes were in place, staff had a limited understanding of the Mental Capacity Act.

Evidence-based care and treatment

- We saw that there was frequent local audit activity such as a post-operative handover audit completed in September 2014. Audit results were visible in the ward area, highlighting a different audit each month.
- We saw that guidance from Royal Colleges was in place, including Royal College of Anaesthetists guidance on difficult airway management.
- Care was provided in line with National Institute for Health and Care Excellence (NICE) guidance; for example, for off-pump coronary artery bypass graft and transcatheter aortic valve implantation. There were a small number of procedures that were highly specialised and had limited national guidance.
- There were pathways in place for patients undergoing surgery that were underpinned by NICE guidance, including for transcatheter aortic valve implantation.
- The hospital participated in national audits, including the Myocardial Ischemia National Audit Project (MINAP).

- Though not a regulated profession, the perfusionists followed guidance from the Society of Clinical Perfusion Scientists.
- Local policies and procedures were followed in relation to care of patients pre-, peri- and post-operatively.
- The service actively engaged with the research networks and recruited well to national and international research studies through surgical-led research in thoracic surgery.

Pain relief

- Patients' initial pain assessments and pain relief requirements were discussed at pre-operative assessment clinics.
- Records indicated that regular pain assessments were completed and analgesics were monitored for efficacy.
- Acute pain following surgery was managed by the ALERT team with recourse to anaesthetists if required. Staff on the wards were well supported in managing patients' pain.
- Pain relief was administered in a number of ways, including patient-controlled analgesia, epidural and oral pain relief. Patients we spoke with told us they received effective pain relief in a timely way.
- Medicines records indicated that pain relief was administered as prescribed.

Nutrition and hydration

- Patient records included an assessment of patients' nutritional requirements.
- When patients were identified as at risk, there were fluid and food charts in place and these were reviewed and updated by staff.
- When patients had a poor uptake of food, this was addressed by the medical staff, who prescribed appropriate dietary supplements.
- Patient records also showed that there was regular dietician involvement when patients were identified as being at risk.
- Patients' hydration requirements were supported by intravenous fluids if required pre- and post-operatively.
- Documentation reviewed showed that fluid charts were accurately completed and totalled so that patients' hydration status could be accurately monitored.
- Audits showed that 82.5% of fluid balance charts were completed in November 2014.
- Patients who required help with eating and drinking were supported sensitively.

Surgery

Patient outcomes

- Readmission rates for elective procedures were better than the England average, with the exception of cardiothoracic transplantation, which was worse than the England average.
- Readmission rates for non-elective procedures were better than the England average.
- Individual surgeons' performance data provided by the Society for Cardiothoracic Surgery showed that they consistently performed better than the England average. Most recent audit data from November 2013 to October 2014 showed that all surgeons at the hospital had a lower level mortality than would be predicted for the procedures, with most having a significantly lower mortality rate.
- National transplant and ventricular assist device audit results are among the best in the UK.
- Data between 2009 and 2012 showed that the hospital had the lowest 30-day mortality after heart transplant in the UK and carried out the largest number of operations. The same was true for data at 90 days following heart transplant. One-year and three-year survival following transplant were among the best in the UK.
- When patient risk is considered, the service has among the lowest mortality for these procedures and best long-term survival rates nationally.
- Data between 2009 and 2012 showed that the hospital had the highest survival rates following ventricular assist device implantation.
- Patient outcomes with short-term ventricular assist device before progressing to transplant were among the best in the UK.
- Data showed that primary percutaneous coronary intervention 30-day mortality was within expected limits, with a low overall trust mortality rate.
- The most recent data from the Adult Cardiac Surgery Audit showed that the hospital had a low mortality of 10% for emergency and salvage cardiac surgery, which was among the lowest in the country.
- Most recent audit data from October 2013 to November 2014.
- Mortality rates are consistently lower than England average and significantly lower than the Euroscore predicted mortality. Euroscore predicts outcomes based on key data and is an internationally recognised tool.
- Data by type of procedure.

- Mortality rates are consistently lower than Euroscore predicted mortality.

Competent staff

- Data reviewed showed that most staff had received appraisal and supervisions. Staff we spoke with confirmed that they had received appraisals in 2013/14.
- Nursing and Operating department practitioner staff had a comprehensive supernumerary induction period with regular meetings with a mentor before they worked unsupervised. A new member of staff told us they had felt supported when starting work at the hospital.
- Staff were actively supported to undertake additional training and education to enhance their skills.
- Audit days were undertaken in theatres monthly to share knowledge and for teaching purposes.
- We saw that there were competency frameworks in place for theatres and ward areas, including for the ventricular assist device which applies to PCU and are completed at induction. The only exception is the CPAP medical device competency where training and practice is covered during the Mallard/PCU study day. However sign off can only be achieved when there are patients in PCU requiring the device for a period of time, which until recently has been very few patients.
- Medical staff received adequate support to maintain their registration/revalidation.
- A number of consultant medical staff provided specialist training to medical staff from other hospitals, nationally and internationally.

Multidisciplinary working

- There was effective multidisciplinary team working between medical, nursing and allied health professionals.
- Patient pathways had clear input from members of the multidisciplinary team, including physiotherapists, occupational therapists and dieticians.
- We observed an internal multidisciplinary team meeting and found there was effective information sharing and planning of care between the specialties with a clear identification of roles and responsibilities for each discipline involved.
- Multidisciplinary team meetings were set up for referring clinicians to discuss the patients' ongoing needs before transfer and, if necessary before their discharge back to their referring hospital.
- Patients were referred to community services if they required ongoing aftercare.

Surgery

- There was good communication between surgeons and anaesthetists before, during and after surgery.
- The perfusion service was supplied by a contracted organisation. There was good multidisciplinary working between perfusionists and the department as a whole. Senior staff had frequent contact with the contractor to ensure adequate staffing for the multidisciplinary team.
- Patients were seen in the pre-op admission clinic one week before a formal multidisciplinary team meeting to ensure the multidisciplinary team had the most up-to-date information to support decision-making.
- When other clinical support was required (such as upper gastrointestinal surgeons), medical staff attended from a nearby trust. Senior staff told us that how quickly the support was provided depended on the clinician on-call. We were told that they were frustrated by this and it was a key motivator for the move to another site.
- Patients confirmed their consent for surgery as well as for tissue sampling in line with national standards. Patients who were recruited into research studies were properly consented and received the required information in line with guidance from the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use and “Good clinical practice” Guidelines (ICH/GCP).
- Some staff had training in the Mental Capacity Act and it was also covered within safeguarding training. This was important as if patients lacked the capacity to make their own decisions; staff should make decisions about care and treatment in the best interests of the patient and involve the patient’s representatives and other healthcare professionals, in accordance with the trust’s safeguarding vulnerable adult’s policy. However, we spoke with five staff who had a poor understanding of the act and could not describe their responsibilities in this regard.

Seven-day services

- There were elective operations carried out on Saturdays and Sundays. Transplant surgeons operated an on-call system to cover these periods, as did the transplant coordinators.
- Ward rounds from surgical staff and/or the ALERT team took place at weekends.
- There was access to radiology services over weekends and out of hours, with an on-call rota in place. Staff were able to access these services when required and most services were available out of hours.
- Allied health professionals such as physiotherapists were available at weekends and staff reported easy access to them out of hours.

Access to information

- Medical records and other information were available when required, including notes transferred from other hospitals.
- Because of problems at a neighbouring trust, there had been delays in getting MRSA swab results. This had been mitigated by regarding patients with delayed results as potential carriers and treating them as such. This matter was now resolved.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek consent from patients. The staff we spoke with were clear on how they sought verbal informed consent and written consent before providing care or treatment.

Are surgery services caring?

Outstanding



Patients were treated with dignity and respect at all times. Patients spoke positively about their care and treatment. Staff ensured patients and their relatives were involved in their care. Patients and their relatives were supported with their emotional needs and there were services in place to provide support for patients, relatives and staff. The Friends and Family Test was positive for the surgical wards. Patients and their relatives/carers confirmed that they were kept informed of their treatment plans and were given information to support decision-making. Emotional wellbeing was supported by staff with support from specialist practitioners who were able to convey complex information. Patients could be referred to external counselling services if they required ongoing support.

Compassionate care

- The Friends and Family Test was overwhelmingly positive for the surgical wards. Mallard ward had an average response rate of 46% and had scored 90% for July 2014. Scores had been higher than 85% since February 2014. The response rate and scores for ward areas were better than the England average.

Surgery

- Patient-led assessments of the care environment (PLACE) were in line with or better than the England average.
- We observed numerous examples of compassionate care provided to patients.
- Patients' privacy and dignity were maintained.
- There was an obvious positive rapport between patients and staff.
- Eleven patients we spoke with told us that they were always treated with care and respect by staff.
- Patient names were recorded on a whiteboard by the nurses' station. We saw a privacy blind was used to ensure patient details remained confidential, but we saw a number of occasions when staff failed to use the blind after viewing the board.

Understanding and involvement of patients and those close to them

- For some procedures, such as transarterial aortic valve implant, patients were awake. Throughout the procedure staff communicated well with the patient, informing them of what was happening and how things were progressing. Staff worked hard to rapidly develop a rapport with the patient that put them at their ease.
- Patients we talked with told us that they had been kept fully informed of their treatment plans and any changes that were proposed.
- A relative we spoke with told us they lived a considerable distance from the hospital but they had received a regular daily telephone call updating them of their relative's progress.

Emotional support

- There were a number of clinical nurse specialists who supported patients before, during and after treatment.
- Transplant coordinators supported patients after discharge for follow-up care and regular monitoring.
- While no counselling services were provided on site, patients were referred to counselling services in the community if required.
- Patients' anxieties and questions were openly discussed and patients spoke positively of the emotional support they received and the DVD available about the patient's journey.
- Clinical nurse specialists were available to discuss specific concerns about procedures and act as a point

of contact for patients during their treatment. One patient we spoke with told us they had been guided through initial diagnosis to treatment and felt well supported.

- All patients we talked with spoke very highly of the service and the care they received while at the hospital.

Are surgery services responsive?

Good



Service planning was carried out to meet the needs of patients in the local commissioning area. The service also treated patients who were referred from other services nationally. As a result, services were also planned in accordance with national commissioning requirements.

There was a high theatre utilisation rate and frequent cancellations of operations because of overrunning theatre lists, emergency or urgent cases, or because some patients were unfit for surgery. Senior medical staff were concerned about the access and flow through theatres because there was no designated emergency/urgent theatre and this had implications for urgent and unpredictable care.

The trust had been failing to meet its referral-to-treatment target for cardiothoracic surgery. This had been improved to within the national tolerance of a minimum of 90 percent for admitted patients at the time of the inspection.

We saw that the service was responsive to patients' individual needs, and translation services or specialist equipment were available if required.

Staff were aware of how to manage complaints and we saw that learning from complaints was shared with staff.

Service planning and delivery to meet the needs of local people

- The hospital provides services to patients from the local area but is also a national and international referral centre for some specialties.
- The surgical directorate engaged with local commissioners and the wider health economy to plan services to meet patient needs.
- The pulmonary endarterectomy service was a national service providing highly specialised treatment to patients from all over the UK and the unit was one of small number of specialised units offering ECMO.

Surgery

Access and flow

- Surgical admissions to the hospital were 84% for elective surgery, 8% for emergency surgery and 8% for day-case surgery.
- Bed occupancy was 79% between April and June 2014.
- Information reviewed before our inspection showed that the number of patients who had their operation cancelled and were not rebooked for surgery within 28 days was rising. The most recent data showed 28 patients were affected between April and June 2014. Improvements had been made and the following 6 months (July to December 2014) there were 5 surgical patients who were not rebooked within 28 days.
- Length of stay for elective cardiac surgery patients was shorter than the England average, but was longer than the England average for elective thoracic surgery and transplant surgery.
- Length of stay for non-elective patients was slightly longer than the England average for transplant patients but shorter than the England average for cardiac and thoracic surgery.
- A pilot of a ward-based advanced nurse practitioner had begun. The purpose of this role was to support ward staff, undertake some tasks previously done by a doctor and manage the patient journey to facilitate timely discharge and reduce length of stay.
- Theatre utilisation for June 2014 was 90% and was not below 85% during July, August and September 2014. If emergencies were included, this rose to 101% in May and September 2014, with other months noted in excess of 95%. High theatre utilisation can make scheduling unplanned work difficult and was compounded by the service not having a designated emergency theatre. We were told “We do not have empty theatres. If there is a cancellation, we fill it.”
- Senior medical staff told us that they were concerned about the flow of patients through theatre. During our announced inspection we saw preparations for a transplant being made. As all five theatres had full operating lists, staff had to consider how they would manage the patients and determine those operations that might be cancelled. Shortly after our inspection we received information that five operations had been cancelled because of a transplant patient requiring treatment. It is acknowledged that the timing of transplant surgery can be unpredictable; however, it was an important part of surgical care provided at the hospital and should be included in service planning.
- There was a peak of 73 operations cancelled in March 2014 (against approximately 300 procedures completed). Cancellations dropped after March, but had increased again to 54 in September 2014 with an average of 20 patients per month cancelled for non-clinical reasons. Senior staff told us that the unit “had a large number of cancellations”.
- We reviewed information that showed the In House Urgent method of admitting patients for urgent procedures sometimes meant a lack of ownership of these patients and a failure to prepare them adequately for surgery resulting in cancellation. Senior directorate staff we spoke with were aware of these issues and putting actions in place to address them. Changes to the system took place from 03 November 2014.
- For the year to September 2014, 29% of operations were cancelled because of transplant and emergency cases taking theatre time, 20% because of lack of critical care beds or staff and 18% because planned cases overran; 17% of patients were considered unfit for surgery.
- Out-of-hours surgery had increased compared with the previous year.
- The trust was failing to reach its referral-to-treatment time target for cardiothoracic surgery. In October 2014, the trust was at 83.5% against a target of 90%. This had been improved to within the national tolerance of a minimum of 90 percent for admitted patients at the time of the inspection.
- Two senior staff told us that there were also delays in getting patients who required emergency surgery into theatre because of the amount of work carried out. There was a Regulation 28 letter to the trust from the coroner in December 2013 highlighting concerns about delays in getting emergency cases into theatre.
- We saw four incident forms from October 2014 that showed four patients had waited for an extended period (up to four hours) in theatre following surgery and were cared for by an anaesthetist and operating department staff because no critical care bed was available.
- We saw that patients’ discharge date was first discussed at the pre-operative admission clinic. The ‘ticket home’ system was used to ensure all patients had a discharge date to work towards.

Meeting people’s individual needs

- Translation services were available for people whose first language was not English; though staff told us they were seldom required.

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- Specialist equipment was ordered as required, such as for bariatric patients.
- A dementia pathway and assessment plan was in place for patients requiring this support.
- Some patients lived a considerable distance from the hospital and were unable to attend for pre-admission assessment. In these instances, patients were admitted the day before for full assessment to eliminate the need for multiple journeys.
- Staff told us that they used different communication methods to support people following discharge, including email and Skype.
- One patient told us that they lived a long way from the hospital. They told us a clear plan for discharge to their referring hospital had been well communicated so that they were reassured they would be transferred nearer home as soon as possible.
- The hospital had a 'you said, we did' initiative; positive responses included improvements had been made to the wireless network so that patients could communicate better with those people they were close to.

Learning from complaints and concerns

- Complaints were responded to and lessons learnt.
- There was a complaints policy in place and staff and patients knew how to access it.
- Staff were aware of how to manage complaints locally and who to refer to for resolution or escalation.
- Meeting minutes indicated that complaints were discussed with staff. We saw one example of a complaint that had been investigated and changes to practice made in response.

Are surgery services well-led?

Good



Staff had a vision for their area of work but were unclear of the vision for the service as a whole other than the proposed move to a new hospital. One member of staff told us that the vision was to “grow the business”; while senior staff told us that the resources and facilities were very stretched so there were limited options for service expansion. It was not clear how these views were reconciled.

There were regular governance meetings and quality measurement within the service. Staff were positive and spoke highly of the local leadership. Staff felt their line managers were visible and accessible and they felt well supported.

Two senior medical staff felt under pressure to meet targets and senior managers acknowledged that a lot was asked of surgeons.

There were plans ongoing to improve the thoracic service in response to a review completed in May 2014 and there was an extensive programme of innovation and research within the surgical service.

Vision and strategy for this service

- Staff had a vision for their service and one senior member of staff said the vision was to “grow the business”. Mallard ward had its local vision clearly displayed on the ward.
- A number of staff referred to the proposed move of the hospital to a new site in Cambridge and considered this the vision for the future.
- Senior staff we spoke with told us of the business plan in place to facilitate the move to a new hospital and plans to develop the thoracic service in response to a review of the service carried out in May 2014.
- The review indicated that the provision of thoracic services was not effectively managed. There was also criticism of how the thoracic service functioned as a team. Senior staff told us that the future appointment of a third consultant would address some of these concerns and we were made aware of an action plan to address the wider findings of the review.
- Other than the move to a new hospital, junior and middle-grade medical staff were unclear about the vision and strategy for the future provision of surgical services.

Governance, risk management and quality measurement

- Local governance meetings were held monthly and quality and patient outcomes were discussed as part of this meeting. Minutes from the meetings were brief and identified learning points from patient experiences were not always clearly articulated.

Surgery

- Clinical outcomes were monitored frequently as part of national and local audit. Audit findings were used to support ongoing service improvement. The service performed exceptionally well in relation to patient outcomes.
- There was a local risk register for theatres that was shared with staff. We noted that the risk regarding the theatre ventilation system failing had been removed from the register even though the system failed again during our inspection. Senior staff we spoke with confirmed that the system failing had been an ongoing problem.

Leadership of service

- There was defined and visible leadership within the service. Staff felt that their line managers were visible and supportive.
- Staff spoke highly of local leadership both in theatres and the surgical wards. Staff were proud of the work they did and proud of the service they delivered to patients.
- On Mallard ward we were concerned by the lack of senior nursing clinical leadership, given its size and the inclusion of the Progressive Care Unit (PCU) caring for high-dependency patients. Senior staff voiced the same concerns about nurse leadership in this area. We were informed that a business case for a band 7 nurse for the PCU had gone to the executive board; however, the outcome was not determined at the time of our inspection, although staff were confident that the case would be approved.
- Senior staff told us that they were not always involved in the wider decision-making about their clinical area and sometimes felt disconnected from the senior team in this regard.
- Senior staff acknowledged that there had been instability in the senior management team because of staff moves and secondments, but felt that this was improving and they were taking more decisions within the service rather than corporately.

Culture within the service

- There was an open culture within the service. Staff they felt able to raise concerns and secure support from local leadership and able to challenge nurse/ODP leadership within the department.
- Staff told us they felt positive for the future of the service and many referred to the planned move to a new site in Cambridge.
- Staff spoke with us openly and shared information throughout the inspection.
- We had received information before the inspection that the culture in the service was one of meeting targets rather than patient-focused. We reviewed information from a survey carried out before our inspection that highlighted a number of consultants had complained of bullying within the organisation, that their views were not considered, some reported being subject to intimidating behaviour and that there was additional pressure to work on weekends. There had been a response from the medical director and a number of meetings to discuss and address these concerns. The discussions were ongoing at the time of our inspection.

Public and staff engagement

- The views and experiences of patients and relatives were actively sought. This was achieved through the Friends and Family Test and other surveys such as informal feedback and the 'you said, we did' initiative.
- Staff told us they had regular staff meetings locally within each unit, but there were limited fora for staff to engage with other services and directorates.

Innovation, improvement and sustainability.

- There were ongoing examples of clinical innovation and research around the use of ECMO, pulmonary endarterectomy, ventricular assist device, transplantation and cardiac surgery.

Critical care

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

Information about the service

For the purpose of management and governance, the Critical Care Area (CCA) at Papworth Hospital was part of the Theatres, Critical Care and Anaesthetic Services directorate. The 33-bedded CCA comprised six cardiac recovery beds (CRU) dedicated to the care and treatment of patients for the first 24 hours after open heart surgery. The remaining 27 intensive care beds provided a flexible level of care for patients who required ongoing complex treatment and support. As a tertiary and national referring centre, the unit also admitted patients who needed mechanical support such as extra-corporeal membrane oxygenation (ECMO), treatment for heart failure and after transplant, and pulmonary endarterectomy. In addition, the unit treated patients with cardiothoracic emergencies such as chest trauma and aortic dissection. The aforementioned sources of referral contributed to more than 2,500 annual admissions to the CCA.

The unit was staffed by over 200 nurses led by two matrons and augmented by a range of nurses and critical care practitioners who provided continuous specialist nursing care.

The medical care was led by dedicated medical intensivists supported by a multidisciplinary team that included referring and specialist consultants, specialist nurses, physiotherapists, pharmacists, dieticians and speech and language therapists.

At the time of the inspection all 33 beds were in use, including the side rooms, specifically used for isolation purposes, and the unit was staffed to provide one-to-one nursing care with additional supernumerary senior nurse support.

Critical care

Summary of findings

Overall we rated the critical care services as good, with some areas of outstanding practice. The patients and their relatives who we spoke with told us of the hospital's positive reputation and that they felt safe when being cared for there. There was evidence of strong medical and nursing leadership in the CCA that led to positive outcomes for people. The service submitted regular Intensive Care National Audit and Research Centre (ICNARC) data so was able to benchmark its performance and effectiveness alongside other similar specialist trusts.

There was a clear understanding of incident reporting and an embedded culture of audit, learning and development. Staffing levels were continuously monitored in conjunction with the unit's occupancy and patient acuity to ensure that sufficient numbers of suitably skilled staff were on duty. The unit was innovative and had recently developed guidelines for the prevention, recognition and management of delirium, a common condition associated with admission to critical care that affected approximately one in five patients admitted to the CCA.

The environment had a high standard of cleanliness and the hospital's infection control policies were consistently applied. The unit demonstrated safe medicines management and we saw adequate supplies of equipment and devices to meet patients' care needs.

Are critical care services safe?

Good



The service demonstrated effective systems and a transparent culture for reporting, investigating and learning from incidents. Patients benefited from good quality care, treatment and support. We saw that people's care needs were assessed, planned and delivered in a way that promoted and supported the prevention of avoidable harm and infection.

Incidents

- The hospital had an overarching and updated procedure covering the reporting of accidents, adverse events, incidents and defects. We reviewed evidence that confirmed incidents were reported and investigated, and that learning was applied in the Critical Care Area (CCA).
- All the staff we spoke with were familiar with the incident reporting process. The CCA used the trust-wide system for reporting incidents, although some staff told us that depending on the nature of the concern sometimes reports were made anonymously through the electronic patient information system. Some staff told us that the computerised information system was used to report "smaller" incidents such as maintenance issues and when using the computerised information system it prompted and reminded staff to report incidents on the trust system. It was clear that this parallel reporting method required careful scrutiny to ensure that it was being appropriately used.
- We asked staff to tell us about the most recent serious incidents in the CCA and they were able to describe two relating to the development of grade 3 pressure ulcers.
- There had also been an incident during the night shift before our first visit to the CCA and this had resulted in an urgent meeting being called. The meeting was attended by the consultant intensivist and senior nursing and medical staff, which included executive team representation. The incident, which was a recognised complication of the procedure, was discussed and independent suitably qualified staff were identified and appointed to conduct an investigation.
- We saw that incidents were reported and reviewed in a number of different meetings. We attended the weekly multidisciplinary team meeting for the CCA at which the

Critical care

incidents that had arisen during the previous week were discussed. At this specific meeting 17 incidents were reviewed. They were predominantly rated as green and caused no harm to patients. We also saw that incidents were reported regularly in detail through the Quality, Safety and Risk Meeting report that then reported to the directorate business meeting. For example, in the minutes of the Quality, Safety and Risk meeting minutes dated 25 November 2014, 33 incidents were reported from October 2014. Of these, 30 were rated green and had resulted in no harm, with three being rated as yellow and requiring professional intervention. These related to skin damage from the positioning of cannulae and tape along with the failure to re-suture a repositioned central venous catheter. It was noted that the report showed the incidents had been discussed with the patient and/or the patient's family. This demonstrated an understanding of the duty of candour required of the hospital.

- In terms of learning from incidents we saw that in addition to review at the weekly multidisciplinary team meeting, learning was also shared at the shift handovers and a 'spotlight of the week' was displayed within the unit itself. This highlighted a particular learning event arising from a previously reported and investigated incident.
- We also saw evidence of shared learning from elsewhere in the hospital, with the revision of an insertion of central venous catheter checklist. This had been revised to include a tick box to report that the guide wire had been accounted for. This had been as a consequence of a previous incidence of guide wire retention elsewhere in the hospital.
- The weekly multidisciplinary team meeting also included a morbidity and mortality section where any patient deaths in the unit were presented for discussion by the unit's matron.

Safety thermometer

- There were clear Safety Thermometer performance boards displayed in the corridor outside critical care, which showed performance for October 2014. These provided a quick and simple method for surveying patient safety and analysing results in order to measure and monitor improvement.
- We saw that for each shift the numbers of nursing staff on duty each shift were displayed in accordance with the safer staffing initiative put in place as part of the

NHS response to the Francis enquiry. On the days of our visit, the actual numbers of registered and unregistered nurses either met or exceeded the expected numbers of staff on duty.

- Patients had appropriate risk assessments in place for pressure ulcers, falls and malnutrition. These assessments were carried out using the electronic patient information system and were regularly reviewed as appropriate.
- Staff were able to tell us the rationale and importance of data collection for the safety thermometer and how it could be used to improve the service delivered.

Cleanliness, infection control and hygiene

- Our observations of the clinical areas during the inspection showed a clean if cluttered environment. There was clear signage on entry to the unit, indicating who was responsible for cleaning what.
- We saw that staff adhered to good practice guidance for the control and prevention of infection. For example, the unit had adopted a 'bare below the elbows' policy in clinical areas, which was adhered to. We saw that wall-mounted antiseptic gel dispensers were appropriately sited around the unit and were used. Staff washed their hands appropriately and used personal protective equipment such as gloves and aprons.
- We saw that an infection control report was included in the monthly directorate business meeting. The papers for the November meeting reported that there had been no incidence of MRSA in 2013/14 and one case so far in 2014/15. There had been an increase in the incidence of MSSA across the hospital in September and October 2014, which had resulted in the following actions for CCA. (1) A review of compliance with central venous catheter bundles; (2) a review of all central venous catheter dressing and means of securing lines; and (3) a continued review on a daily basis of the ongoing need for a central venous catheter. The CCA contributed data in accordance with the Matching Michigan programme, which also showed an increase from 1.3 to 3.7 regarding the incidence of intensive care-acquired central venous catheter-related blood stream infections per 1,000 patient days, which is above the national standard.
- Following an increase on positive cultures of pseudomonas earlier in the year, mainly in urine

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samples, a new policy had been introduced for sampling from urinary catheters. Compliance with the urinary catheter care bundle was monitored monthly and demonstrated good levels of compliance.

- The unit had an infection control lead and five link nurses who were responsible for auditing compliance with a range of high-impact interventions. Most of the audits demonstrated a high level of compliance, though the high-impact interventions for central venous catheter insertion and care showed only 80% compliance, with the shortfalls being related to dressings either being inappropriate, incorrectly applied or not changed on time. The hand hygiene audit results were in excess of the 95% target figure for compliance. However, we noted that while the September hand hygiene audit result indicated 98% compliance, the infection prevention and control lead had recorded instances of noncompliance that had resulted in specific staff being spoken to and their practice challenged.
- All patients in the unit had their MRSA status checked. We saw appropriate use of isolation cubicles for patients who required isolation for an identified infection risk.
- Records of cubicle or bed space curtain changes were displayed.
- There were appropriate arrangements in place for the safe disposal of sharps and contaminated items.

Environment and equipment

- The CCA was identified as a high-risk area and the quality of its cleaning was audited weekly. If the score fell below 95%, an action plan was put in place. We saw that the reported score for October was 98%. The CCA also aims to clean every bed space monthly, with October scores reported as 100%. We saw that weekly audit checks also took place on any empty beds to establish their cleanliness and readiness for admission. The October score for this measure was 96%.
- The unit itself was not purpose built by today's standards and very few bed spaces enjoyed natural light.
- We were told that the unit was able to get the equipment it needed. It had access to capital funds, charitable sources and local directorate funding. We saw a report on the current 'wish list' for equipment and were told that while the idea was to proactively identify

equipment needs annually, it was also usually possible to flexibly respond to equipment needs. An example of this had been the purchase of additional pumps for patient-controlled analgesia.

- There was a rolling replacement programme for equipment ensuring that the unit had an ample supply of equipment to meet patient needs.
- Storage was an issue, especially for bariatric equipment, which we were told would be hired on an as-required basis.
- Resuscitation and emergency/difficult intubation equipment was readily available and checked on each shift by suitably competent staff.
- Regular staff and temporary workers all received the necessary training to ensure that they were able to use the different types of equipment available to them.
- There were suitable arrangements in place for the management of waste and clinical specimens.

Medicines

- The service had systems in place that demonstrated compliance with the Medicines Act 1968 and the Misuse of Drugs Act 1971.
- We observed staff administering medication in a person-centred way and saw that the appropriate checks were being carried out. However, medication errors did occur and six were reported in the Quality, Safety and Risk meeting as having occurred during October 2014. These included the use of an incorrect flush bag on a transduced arterial line. More specifically, dextrose saline was used instead of saline, with the risk being that abnormal blood sugar readings could occur if the sample was taken from that arterial line. This issue, which we note had occurred before, had resulted in a number of actions including (1) awareness raised with staff at CCA handover times and (2) separate storage area for 500-ml bags of saline. An article had also been written for circulation in the CCA newsletter.
- Controlled drugs were managed appropriately and stored securely. The six-bedded cardiac recovery (CRU) had its own stock of controlled drugs that were managed and stored safely.
- The unit used an e-prescribing system, which clearly documented allergies, but it did not prevent the prescribing of medicines to which the patient was allergic.
- When the patient was discharged to the ward, a hand-written medication chart was transcribed.

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- We were told that there was microbiologist attendance at ward rounds three times a week. We noted that there were times when there was a delay in receiving microbiology reports electronically. It was explained that this was related to the contract for microbiology, which was provided off-site by the nearby trust in Cambridge.

Records

- All the care records on the CCA were electronic. The computerised information system included a comprehensive suite of risk assessments including falls, mental capacity and deprivation of liberty, pressure ulcers, manual handling and end of life/do not resuscitate. The system included a number of alerts and triggers to assist staff and act as an additional safety feature, for example when recording pulmonary artery catheter readings.
- All the electronic records that we looked at had been appropriately and accurately completed. It was also possible to search within the computerised information system for archived patient records so that their stay within the CCA could be analysed.
- On discharge, the patient's care and treatment were documented again in a hand-written medical record. A written summary document detailing the care on the CCA was prepared for the receiving ward. We saw that this summary was used as the basis for the handover to the ward nurse.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training and all of the staff we spoke with about safeguarding had undertaken safeguarding training.

Mandatory training

- Mandatory training was up to date or programmed to take place in all areas we visited. The training was competency based and everyone we spoke with told us the training provided within the trust was of a good standard.

Assessing and responding to patient risk

- The ALERT service was implemented at the beginning of September 2009 in order to provide experienced interventional support to patients who are at risk of deterioration. The service provides support to the whole

trust, identifying patients within inpatient ward areas who are at greatest risk of deterioration. The ALERT team routinely follows up patients who are discharged from the CCA and who are deemed high risk, to ensure their postoperative recovery is monitored and any signs of deterioration are picked up in a timely manner. They also respond to calls from ward nurses concerned about a patient's clinical condition. A major part of the team's role is to provide support and education to all ward staff and junior medical staff in order to improve levels of care and patient safety.

- The team consisted of nine advanced nurse practitioners who were able to provide a 24/7 service.
- We noted from the 2013/14 ALERT team's annual report that 17% of the patients seen by the ALERT team were routine follow-ups from CCA discharge.
- The wards in the hospital used a modified early warning score system (MEWS), which is a system that scores vital signs and is used as a tool for identifying patients who are deteriorating clinically.
- The ALERT team collected a range of data regarding their performance, which included breakdown of referrals by ward and speciality, MEWS scores on referral or discharge from the CCA, numbers of visits to patients, readmissions and an analysis of cardiac arrest calls.
- In addition the ALERT team provided an acute pain management service to the cardiac directorate.

Nursing staffing

- The hospital acknowledged that the recruitment and retention of nurses is one of its biggest challenges and there are many contributing factors, including that Papworth Hospital is situated in a rural village area.
- From our observations, the rotas we viewed and the staff we spoke with on the days of our inspection, the CCA was staffed safely and appropriately and in accordance with the Intensive Care Society standards for nurse staffing. The unit was able to provide nurse staffing levels that met the needs of its patients. The coordinating nurse for the shift would aim to staff the unit with one nurse per patient even if some patients were assessed as being level 2 patients. In addition, there were senior nurses in supernumerary supporting, coordinating and educational roles.
- On the first day of our inspection there were 37 registered nurses on duty and five unregistered (healthcare assistants). The staff were allocated to two teams. Each team was further subdivided into bays.

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Each team had senior nurses in supernumerary supporting roles. There were two matrons on duty as well as a supernumerary coordinating senior nurse, ensuring sufficient numbers of suitably qualified and experienced staff on duty throughout the 24 hours.

- The Intensive Care Society 'Levels of Intensive Care' document was used to determine the acuity of the patients in the unit. This document sets out the criteria for patients being assessed at Level 0 (patients whose needs can be met through routine care) through to Level 3 (patients requiring advanced respiratory and organ support).
- The unit did use agency nursing staff and at the time of our inspection there were four agency nurses on the shift. Having spoken to those staff, we noted that the agency staff used on the unit were predominantly long-term agency nurses. Before the unit agreed to use an agency nurse they had to attend in-house training and work a supernumerary shift to establish their competency. The constant flow of patients in and out of the unit meant that patient acuity and staffing requirements were continuously being assessed. If it was judged that agency staff were not required, for example if the occupancy on the unit fell, then agency nurses were cancelled.
- The hospital had embarked on a number of initiatives to try and address the interlinked issues of recruitment and retention and spend on agency staff. For example, permanent staff were offered overtime shifts, enhanced supernumerary support had been introduced, the unit had introduced competency-based career pay progressions and accelerated pathways for band 5 to band 6 and relocation packages were being considered for new staff. Progress against both recruitment and retention plans and the agency spend were robustly monitored and reported on monthly to the division. The most recent reports available to us showed that nurse staffing and staff turnover was now below the planned average per month. For the month of October 2014 the planned staff turnover was 2.1%, with the actual being 1.4%.
- The overall hospital sickness target was 3% and the current levels in the CCA were at 5.5%, though this represented an improvement on the levels experienced throughout 2013.
- We saw that there was a structured nursing handover between shifts that included a handover between supernumerary senior nursing staff and a bedside

handover between hands-on nursing staff. We noted that 'huddles' had been introduced for each bay at approximately 11am and after the afternoon ward round to help keep all staff in a bay informed of what was going on in their wider teams.

Medical staffing

- The medical care on the CCA was led by a consultant intensivist and the CCA had a designated clinical director.
- In terms of the consultant/patient ratio, with up to 33 patients on the unit and one or two consultant intensivists on duty, this falls below the best current evidence ratios as set out in the Intensive Care Society standards. However, the intensivists were supported by registrars and the consultants from the parent teams such as the transplant and cardiothoracic teams.
- From February 2015, following the anticipated addition of another consultant intensivist, this will mean that all Intensive Care Society standards for patient ratios, out of hours and training will be met with two consultant intensivist-led teams on the CCA.
- We were informed that all consultant anaesthetists, when allocated to the CCA, worked solely in the CCA, although many did three-month blocks in the CCA alternating with a similar block in anaesthesia.
- There were two consultant intensivist-led multidisciplinary ward rounds each day with additional ward rounds being undertaken by the respective parent teams.
- At night there was a consultant on duty at least until 10pm and then on-call. In most cases the consultant on-call chose to stay overnight in the hospital but were always available to attend within 30 minutes.
- There was always an anaesthetist on the unit who was skilled in airway management.
- Medical staff handovers were staggered with those of the nursing teams to ensure that there was always appropriate expertise on the unit.
- Locum doctors were rarely used and if so were closely supervised.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place, though we were told that they hadn't been tested in the CCA since a desktop exercise some three years ago.

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Are critical care services effective?

Outstanding



The Critical Care Area (CCA) used a combination of national guidelines to inform the care and treatment that they provided. These included guidance from the National Institute for Health and Care Excellence (NICE) and the Intensive Care Society.

There was evidence of a comprehensive local audit programme on the Unit. This helped to ensure the ongoing clinical effectiveness of practice. The progress and results of all audit activity was reported and monitored through the Quality, Safety and Risk report, which in turn was presented at the CCA business meetings monthly.

All staff were provided with a comprehensive induction programme, allocated a mentor and underwent competency-based assessments to ensure that they had the skills required to do their jobs.

There was strong evidence of multidisciplinary and multi-professional working in critical care. Allied professional support was available 24 hours a day.

Evidence-based care and treatment

- The CCA used a combination of national guidelines to inform the care and treatment that they provided. These included guidance from NICE and the Intensive Care Society.
- We saw evidence of a comprehensive local audit programme on the CCA. This helped to ensure the ongoing clinical effectiveness of practice. Examples of current audit activity were glove use in the CCA and a review of central venous lines. In addition a series of environmental and facilities audits were undertaken such as a bed cleaning audit and deep cleaning audit. The progress and results of all audit activity was reported and monitored through the Quality, Safety and Risk report, which in turn was presented at the CCA business meetings monthly.
- We saw evidence that patient pathways reflected national guidance and were continuously audited.
- The CCA had started a review of document control procedures to include indexing the main documents used, establishing an agreed house style and a review of the computerised information system. New and revised

policy documents were reviewed, revised and subsequently approved at the monthly CCA business meetings. Examples of recently approved policies were the guidance for home discharge from critical care and a procedure to cover the photographing and sending of patient-sensitive information to other hospitals for specialist review.

- There was also evidence to show that the unit took part in a number of national and international research studies. For example, the LIFEGUARDS study sponsored by Monash University in Melbourne, Australia. This is a study involving the ventilator management of patients undergoing extra-corporeal membrane oxygenation (ECMO).
- The CCA contributed data to the Intensive Care National Audit and Research Centre (ICNARC), which was set up to collate what we know about critical care in the UK and try to evaluate its impact and effects. As a consequence of its specialist function there are only a few other hospitals nationally that Papworth as a critical care unit can be benchmarked against. In addition, the ICNARC data available was some 18 months old (April to June 2013).

Pain relief

- As part of their individual care plan all patients in the CCA were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool.
- We saw that epidurals and patient-controlled analgesia systems were used in accordance with trust guidelines.
- The ALERT team of advanced nurse practitioners also provided an acute pain management service to the cardiac directorate.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission, to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission.
- Nutritional risk scores were updated and recorded appropriately on the computerised patient record.
- Two dieticians were available for patients on the unit.
- We were told that the unit did not have a dedicated specialist nurse for total parenteral nutrition.

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Patient outcomes

- The unit demonstrated submission of continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes were being monitored against the performance of similar units nationally. Given the specialist nature of the hospital there were limited comparator specialist trusts in the UK. However, the contributions we observed that had been verified by ICNARC indicated that the hospital was performing better or comparably with similar trusts. For example, the hospital was the best performing for hospital mortality among its comparators.
- We saw that the hospital also submitted data to the national cardiac arrest audit. The ALERT team based at Papworth had also done some early analysis of the cardiac arrest calls to which they are called. They had analysed data from April 2013 to March 2014, which showed a reduction in the number of cardiac arrest calls being made now that the VitalPAC monitoring system had been installed on the wards. The figures indicated a reduction in the number of cardiac arrests from 1.1% to 0.1% of the patients seen by the ALERT team. (The ALERT team saw all patients on discharge from the CCA). This early analysis also indicated that the readmission rate to the CCA had slightly increased from 4.7% to 5.8% over the same period. This suggested that the introduction of VitalPAC, along with the standardisation of observation recording, including MEWS scoring, and the timely actions of the ALERT team were having a positive outcome for patients.

Competent staff

- All nursing staff had been subject to an annual registration check and were encouraged and supported to maintain their professional development.
- The CCA employed nurses in a practice educator role to work with and support staff to develop their skills and competencies.
- All new trained nurses to the unit completed an induction pack that had been produced jointly by the unit's clinical educators. New staff were assigned a mentor and during their induction period were introduced to the competencies required to work in a critical care environment. Staff completed a training passport document that recorded their signed-off competencies.

- Agency nurses were used, although only after they had demonstrated their competency. They remained under supervision by permanent senior unit staff. When agency nurses were used, we saw that they tended to be 'regular' agency workers who had worked on the unit before.
- All trained nurses in the CCA had received life support training to at least intermediate level and more than 50% had a recognised postgraduate qualification in critical care.
- Data reviewed showed that most staff had received appraisal and supervisions. All staff we spoke with had received an appraisal during the last year.
- We saw evidence to support the fact that all consultants working in the CCA had achieved both Step 1 and Step 2 competencies and equivalent.

Multidisciplinary working

- Multidisciplinary ward rounds took place each day that involved nursing, pharmacy, physiotherapy and others relevant personnel.
- In addition to the consultant intensivist-led ward rounds; there were also ward rounds every day from the other specialities, including surgery, transplant, cardiology and respiratory medicine.
- There was a daily bed management meeting held in the hospital to discuss site activity that the supernumerary nurse coordinator for the CCA attended.
- A weekly multidisciplinary meeting was held for the CCA. This meeting was led by the consultant clinical lead and matrons and discussed in detail the current condition and plan of care for each patient on the unit. This included input from the medical and nursing teams alongside physiotherapy, microbiology and other allied healthcare professionals as availability allowed.
- There was evidence of team working with bed managers, wards and other hospitals to assess and plan ongoing care and treatment when patients were ready for step down, discharge or repatriation.
- There was a service level agreement in place with the local trust that covered a number of areas of service and support. Being a specialist service, an area of importance to patients was the provision of non-cardiothoracic input. While we considered that this might pose a risk to patients in that they would have to wait for support, no one we spoke with during the inspection could recall a delay in care and treatment following referral to the neighbouring service that had

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resulted in an incident or subsequent harm to a patient. Indeed, we saw one example of how swift a response could be provided, with a CCA patient receiving an endoscopic investigation at the hospital by a colorectal team from the neighbouring trust just 90 minutes after the telephone referral had been made. It was clear that consultants had developed positive relations with their peers at the neighbouring hospital and a telephone call often expedited the required support.

- While some aspects of a critical care outreach function were undertaken by the hospital ALERT team, the CCA did not have a formal outreach team.

Seven-day services

- Consultant cover was available at weekends, with one consultant working on the unit on Saturday for a full day and then a half day on Sunday. Outside this timeframe there was always a consultant on-call.
- Pharmacy, physiotherapy and imaging services were available during the daytime at weekends. Out-of-hours support was provided via an on call system.
- A full service was provided by the ALERT team 24/7.
- We were told that weekend access to psychiatric support was available but rarely used.

Access to information

- The CCA used a computerised patient information and record system that was accessible at the patient's bedside by those staff with the relevant permissions. This enabled consistency and continuity of record keeping while the patient was in the CCA, supporting staff to deliver effective care.
- When a patient was discharged to the ward, a paper-based transfer document was printed, which formed the basis for the nurse-to-nurse handover. The handover was undertaken face-to-face once the patient had been settled into their ward bed space.
- The patient's prescription chart was also hand written in the CCA before transfer to the ward.
- The electronic patient record was used to collect and analyse data about patient stays, care and treatment on the CCA.

Consent and Mental Capacity Act

- The staff we spoke with were able to demonstrate understanding of the issues of consent and capacity for patients in critical care, although there was some

uncertainty regarding the role of the family in patients assessed as having a lack of capacity. Staff did articulate that in such circumstances they would seek guidance from senior staff or from the safeguarding lead.

- There was an assessment of mental capacity recorded in the electronic patient record.

Are critical care services caring?

Good



People and their relatives were treated with understanding, compassion, dignity and respect. The evidence demonstrated that the unit was good at involving patients, family and friends in all aspects of their care and treatment. The October patient experience feedback questionnaire indicated that all the six patients interviewed either agreed or strongly agreed that they knew what was happening to them and thought that the care was as good as it could be. One person told us that "the teamwork and standard of care is absolutely brilliant".

Compassionate care

- The relatives that we spoke with told us that their loved ones were cared for in a kind, respectful and compassionate manner by staff. Our own observations supported this.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate manner.
- Conversations regarding a patient's condition, prognosis, care and treatment options were sensitively managed.
- We noted that curtains were pulled around patients' bed spaces for the delivery of personal care and during ward rounds regardless of the conscious state of the patient.

Understanding and involvement of patients and those close to them

- We saw evidence in the clinical notes that patients and their relatives were involved in making decisions about their care and treatment.
- The latest patient experience feedback questionnaires reported positive comments about information sharing with patients and their relatives. This was backed up by our observations on the visit.

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- The most common issues generally reported by patients during and following their stay on the CCA were disturbed sleeping and being woken too early. We saw that care was planned on an individual basis to limit this whenever possible, such as by reviewing preferences for wash times and more generally keeping the lights down after 11pm and trying to reduce noise.
- Patients were allocated a named nurse for a span of duty on either a 1:1 or 1:2 basis, depending on their acuity. This helped to ensure continuity of care and support the establishment of good nurse–patient interactions.

Emotional support

- We saw that, when necessary, additional face-to-face meetings were organised with nursing and medical staff to ensure family members were kept informed and had the opportunity to have their questions answered.
- Staff supported patients and those close to them sensitively and were skilled in allaying fears and anxieties.
- The hospital made a document titled ‘Quality of Care and Service’ readily available, which was designed to assist patients or relatives in securing on-the-spot help, advice and support. This document recognised the anxieties people feel when contemplating making a complaint and gave assurances about how any complaint would be managed.
- A number of specialist carer support groups were available, such as the Norfolk Zipper Club, which provides support for cardiac surgery patients. We spoke with a member of the transplant patient support group, who was visiting the unit while in the hospital for a support group meeting.
- Relatives had access to a 24/7 chaplaincy service.

Are critical care services responsive?

Good



Patient care and treatment were delivered in a personalised way. Patients and those close to them were positive about the way their needs were met and managed.

We found low levels of complaints and evidence that the service responded appropriately to people’s comments and concerns.

The Critical Care Area (CCA) had two small adjoining relatives rooms on the corridor outside the main unit and adjacent to the nearby surgical ward. However, considering the size of the CCA (33 beds) and the acuity of its patients, we did not feel that this provision met the needs of visiting relatives and families.

Service planning and delivery to meet the needs of local people

- The hospital provides cardiothoracic services and treatments for all patients who are eligible for NHS care. Government policy allows NHS patients to choose which hospital they receive their non-urgent care in. The hospital does not provide an accident and emergency service.
- The site is remote and difficult to access by public transport.
- Accommodation for relatives was limited. There were no overnight facilities on the CCA other than the two small relative’s rooms. There was a hostel on site for the use of transplant patients’ relatives and bed and breakfast was available within the local community of Papworth Everard. In addition, two houses were available in Papworth Everard for the benefit of patients relatives.
- The small relative’s rooms did not afford any degree of privacy for difficult conversations with families and relatives. We were told that on occasions, if available, an alternative office was found for a confidential talk with relatives. Clearly space was of a premium on such an ageing site and although some staff did say that the relatives’ facilities were to be extended, they were unsure of how and when.
- Drinks were made available in the two relatives rooms and food was available until 7pm in the hospital restaurant. After that relatives and staff were reliant on the nearby vending machines. One relative did tell us that they had raised the issue of food and its quality using a feedback questionnaire. We were told that the facilities for relatives were the most common source of complaints.

Meeting people’s individual needs

- The CCA used a computerised information system that brought consistency in record keeping.
- The electronic care records that we reviewed demonstrated that people’s individual needs were taken into consideration before delivering care.

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- The most recently published (November 2014) Friends and Family national survey reported that 97% of hospital staff would recommend the hospital to their friends and family for care. This was the second highest score in the region.
- The unit was situated on the first floor of the Christopher Parish building. Lift access was available.
- There was adequate car parking available on site and this was free.
- We were told that interpreting services were available through the switchboard, though in practice there was little need for formal interpreters on the CCA as often the staff on duty were able to provide support.
- There was awareness among the staff of the delirium that patients can experience as a consequence of being cared for and treated in a critical care environment. This is especially common in patients having cardiac surgery and the unit had developed new guidelines for the early detection and management of delirium. The guidance promoted the appointment of delirium champions on the wards so that ward staff were much more confident in managing these challenges on discharge from CCA.
- The latest available figures for cancellations showed that there had been 37 theatre cancellations for the month of October 2014; the monthly average number of cancellations for 2014 was 35, which was similar to 2013/14. In October there had been no cancellations as a consequence of CCA staffing. This represented a significant improvement over quarters three and four of last year. Eight cancellations were because of capacity issues in the CCA, with all 33 beds being in use. The year to date figures show that there have been 62 cancellations because of capacity, which reflects an 8% reduction over the same period in 2013.
- For non-clinical transfers out of the unit, out-of-hours discharges to the ward and unplanned readmissions to the unit within 48 hours are comparable with similar specialist trust critical care units. For example, there had been just one out-of-hours (between 10pm and 7am) discharge in October 2014. This had been to accommodate an emergency admission to the CCA when the unit was otherwise full.
- The bed occupancy figures reported by the hospital for October were 88%, with occupancy for the six CRU beds being 92%. The occupancy figures comprise 64% cardiac surgery, 17% transplant and ventricular assist devices, 6% respiratory ECMO, 7% pulmonary endarterectomy and 7% other. The figures indicate that there has been no limiting of specialities in October 2014 as a consequence of bed occupancy.
- The most recent figures show that there were 248 admissions in October 2014. This reflects an increase in the ICU admissions and a decrease in CRU admissions. The mean length of stay in the unit is 3.96 days.
- The repatriation of patients is reviewed and discussed at the CCA weekly multidisciplinary meeting. There were 10 repatriations in October 2014 and the numbers were closely monitored as one of the unit's service improvement targets. The East of England Operational Delivery Network has produced a repatriation policy and has started an audit of delays.

Access and flow

- Some hospital staff suggested that critical care created a bottle neck in the flow of patients through the hospital, as a lack of available critical care beds could lead to the cancellation of theatre cases. This required balanced management dependent on the availability of not just CCA beds but also beds on the wards for patients who were ready and able leave the unit. Patient acuity was also a factor. For example the wards might find a patient with delirium more challenging to manage.
- A hospital bed status and management meeting was held at 8.15am each morning and this was attended by the CCA coordinating senior nurse who had details of the patients on critical care, which patients were likely to be ready to go to the ward and what numbers of beds would be needed for the planned theatre cases for that day. There was always the unknown factor of beds that might be needed during the course of the day for emergencies or transplants becoming available. There had been 37 emergency admissions in October 2014, accounting for 15% of all admissions to the CCA.
- Patients were being reviewed in person by a consultant intensivist within 12 hours of their admission.

Learning from complaints and concerns

- Complaints, both formal and informal, were reported on monthly at the CCA business meeting. They were discussed in turn and an update provided. At the time of inspection the unit reported having five open complaints. The evidence showed that learning was taken from the complaint investigations and actions undertaken to improve the service. For example, issues

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around the availability of ambulances for ECMO retrieval had resulted in review of the ECMO contract. Also, additional patient-controlled analgesia pumps had been procured and were in use following a shortage that necessitated a patient having an alternative analgesia source.

- The complaints shown in the CCA meeting minutes appeared to have been predominantly raised by staff and were related to equipment or facilities. The report showed only one complaint that had been raised by relatives which related to issues with care, compassion and communication. This had been investigated and specific multidisciplinary actions had resulted.
- Written information was available for patients, relatives and carers on how they could access support should they wish to raise any concerns.

Are critical care services well-led?

Good



The service had an effective governance structure that promoted a high level of staff confidence. The staff we spoke with felt happy with the level of engagement with senior staff on the unit and felt confident that they could discuss any concerns that they might have and that they would be listened to. We heard from both medical and nursing staff that they felt the unit was well run and that senior staff and peers were supportive.

There was clear clinical leadership at service level for both medical and nursing staff.

Vision and strategy for this service

- When asked, senior staff did not articulate a corporate vision for the service but reflected a more personal view that they were there “to deliver the best possible care”.
- Staff were aware of the plans to build a new hospital on the Cambridge Biomedical campus. It was understood that building will start in 2015/16 and that the new hospital will include a 44-bedded critical care facility.

Governance, risk management and quality measurement

- The service demonstrated a dedicated focus on understanding and addressing the risk to patient care and safety.

- The risks inherent with the delivery of safe care were understood and identified on the unit’s risk register, which was updated and recorded as part of the monthly Quality, Safety and Risk report. However, it was noted that two of the open Critical Care Area (CCA) risks, namely harm to staff from violent/aggressive patients and the continued use of potassium chloride (strong) injection had both been on the register since 2006. Both risks had related actions underway and progress was updated and reported. The subsequent impact of the actions being taken were subject to further review with the hope that the risks could then be mitigated and removed from the register.
- We saw that a range of meetings were held every month to assist with communication, learning and management of the unit; for example, staff meetings involving all grades.

Leadership of service

- The CCA had two full-time matrons who led the nursing team. Both impressed with their knowledge, compassion and enthusiasm.
- The medical team on the unit was led by a dedicated consultant intensivist. The previous post holder had now been appointed to the role of clinical director for the CCA and understood the needs and challenges for the unit.
- An additional consultant appointment early in 2015 should enable the medical staffing aspects of the Intensive Care Society standards to be met in full.

Culture within the service

- Both the nursing and medical teams were well-led. We heard testimony from medical and nursing staff that “things” on the unit had improved over the past 12–18 months. Staff felt supported and confident to raise any issues or ask for support. For example, the nurse staffing model had been reviewed and with improved numbers of supernumerary staff now provided more senior practical support and advice in caring for patients.
- We had been made aware of an allegation of bullying within this service consequently we specifically asked staff if they had experienced bullying at work directly or witnessed bullying of others. We could find no evidence throughout our interviews and observations to support this assertion.

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- We were told by nursing staff that they felt engaged in service improvement. For example, issues had been raised about the effectiveness of some of the care plans. These concerns were welcomed and a group was set up to suggest and develop improvements.
- Consultant medical staff told us that team working had improved; staff were more confident and able to challenge any poor behaviour among colleagues.
- Staff expressed pride in and commitment to working at the hospital. Administration staff (ward clerks) told us that they felt valued and very much part of the team on the unit.

Public and staff engagement

- We were told that much work had been directed at stabilising the nursing workforce on the CCA. This had involved listening to staff concerns and anxieties before putting actions into place, such as an increase in the support being given to those staff working in the potentially isolating environment of side rooms and an increase in the number of supernumerary band 6 nurses on duty.
- While it was still early in the planning, we were told that staff would be consulted about all aspects of the new hospital critical care unit. For example, it was envisaged that in the new hospital all critical care beds would be single rooms. This would require clinical engagement with the nursing team to ensure that the new unit was managed safely.

- The relatives we spoke with said they felt very included and involved with the care of their loved ones.

Innovation, improvement and sustainability

- The CCA was an active member of the Norfolk, Suffolk and Cambridgeshire critical care network. Membership of the network enabled the unit to focus on making improvements where they were required, through collaborative working with commissioners, providers and users of critical care.
- The CCA had a service improvement programme. Progress was displayed on the unit's staff noticeboard and also reported on at the monthly Quality, Safety and Risk meeting. Current service improvements included a reduction in registered nurse sickness, reduction in agency spending and an increase in timely repatriations.
- The CCA was actively involved in a number of national audit programmes and was participating in numerous research projects. This included 'Breathe: a protocolled trial of invasive and non-invasive weaning off ventilation', which was being sponsored by the Heart of England NHS Trust, and a study into the impact of sleep-disordered breathing on immediate postoperative outcomes in patients undergoing elective surgical coronary revascularisation.

End of life care

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

Information about the service

Papworth Hospital's specialist palliative care team are known as the supportive and palliative care team because much of the care delivered is in line with 'supportive care', as defined by the National Council for Palliative Care. The team consists of 1.7 whole time equivalent (wte) specialist nurses, 0.4 wte specialty registrar; 0.3 (3 sessions) consultant; 0.8 wte team Personal Assistant and administrative support. The team aim to offer a Monday to Friday service with core hours of 9am to 5pm. Out of hours there is 24-hour/seven-day advice available from a palliative medicine consultant (this rota is shared with neighbouring trusts and a local hospice).

People with palliative/end of life needs were nursed on the general wards in the hospital. They were supported by a hospital consultant-led specialist palliative care team.

We visited four wards plus critical care, where end of life care could be provided. We also visited the multi-faith spiritual centre and chapel, the hospital mortuary viewing room and the Patient Advice and Liaison Service (PALS) office.

During this inspection we spoke with five patients and four relatives on the wards. We spoke with a range of staff, including healthcare assistants, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We also spoke with members of the hospital supportive and palliative care team, including the clinical lead for palliative care and nurses from the supportive and palliative care team.

We observed care and treatment and we looked at care records. We looked at appropriate policies and procedures.

End of life care

Summary of findings

The quality of end of life care provided by the hospital was of a good standard. There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for and those close to them were supported sensitively and compassionately.

Patients care was highly individualised. Pain relief and aids to comfort were provided in timely way.

There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.

We found that the family viewing area and mortuary was fit for purpose. Records were comprehensive and 'Do not attempt cardio-pulmonary resuscitation' documentation was in place and completed appropriately.

Are end of life care services safe?

Good



End of life care was provided to meet the individualised needs of patients and those close to them. Patients at the end of life were nursed and managed both in the ward and critical settings.

There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skills mix to ensure that patients receiving end of life care were well cared for. There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.

There were systems for reporting actual and near-miss incidents across the hospital.

There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.

'Do not attempt cardio-pulmonary resuscitation' forms were appropriately completed and the decision had either been discussed with the patient themselves or, in cases when patients did not have capacity to consent to end of life care, decisions were made in accordance with the patient's best interests, with the inclusion of relevant professionals and those close to the patient.

Incidents

- There were systems for reporting actual and near-miss incidents across the hospital. Staff told us they understood what to report and were able to show us how they would report an incident through the electronic reporting system. Serious incidents related to palliative care would be reviewed through the end of life steering committee.
- The mortuary service reported incidents through the pathology service governance structure.
- The supportive and palliative care team did not have its own risk register but monitored issues through the end of life steering group. Mortality and morbidity meetings were held regularly and all relevant staff were encouraged to attend.
- The data available from the trust electronic reporting system for the period April to September 2014 showed

End of life care

that two incidents related to supportive palliative care had occurred. We saw evidence of actions taken in response to the incidents; for example, the review of information received on admission from an external provider and internal communications to ensure that families are able to talk with a doctor in a timely way.

Medicines

- Policies and procedures were accessible to staff on the trust's electronic shared drive and staff were aware of the procedures to follow.
- The hospital used a comprehensive prescription and medication administration record chart for patients that enabled the safe administration of medicines.
- Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the medication administration record charts for a number of patients and saw where appropriate end of life medicines were prescribed. Medical staff told us they were provided with advice and support from the trust's specialist palliative care team.
- Records confirmed that a pharmacist visited all wards each weekday. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date.
- Medicines, including those requiring cool storage, were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw controlled drugs were stored and managed appropriately.

Records

- In relation to decisions not to resuscitate, we looked at four patient records, both hard copy and on the Critical Care Area (CCA) computerised information system. There were no patients on the unit subject to a DNAR CPR decision at the time of our inspection, so we looked in the electronic archive for three recent records. Each contained a separate section in the electronic record detailing the decisions made not to resuscitate. These included an entry by the medical staff, which included an explanation of the decision-making process, its rationale and details of conversations that had been undertaken with the patient's relatives. The entries were all signed and dated, with a review date included.
- In all the cases we reviewed, the patients had passed away within an hour or two of the decision not to

resuscitate being made and the records included their time of death. In all three cases reviewed the patients had been made comfortable on the CCA and had not been subjected to a move to the ward. We also reviewed a patient on end of life care with paper records. We found that the trusts 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) order documentation had been completed appropriately with the relevant signatures in place in line with the trust's own DNACPR guidance.

- We found that effective systems were in place in the mortuary to ensure that people were correctly admitted and safely placed. The correct release forms were signed before a deceased person was released to the undertaker.
- The PALS had robust documentation in place to record actions taken as the main contact for relatives after the death of a loved one.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect.

Mandatory training

- All the members of the end of life service were up to date with their mandatory training. The mandatory training was competency based and staff felt well supported to access the training.

Assessing and responding to patient risk

- Once the decision that a patient is likely to be in the last days of life is made, the hospital has clear guidance to ensure that a clear assessment of patient needs is in place.
- At the beginning of each shift the named nurse for the patient was responsible for documenting and updating any assessments and conversations about the individual. An individualised plan of care was put in place and care plans developed for all needs identified through the risk assessment of the patient in regard to hygiene needs, symptom and pain relief, skin care, mouth care, managing anxiety, managing excess secretions and care of the family.

Nursing staffing

- Patients with palliative/end of life needs were nursed both in the wards and the intensive care unit/CCA.

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- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for in all the settings we visited.
- The specialist palliative care/end of life team consisted of 1.7 whole time equivalent (wte) specialist nurse and 0.8 wte Personal Assistant and administrative support.

Medical staffing

- For patients with palliative/end of life needs, medical cover was provided in accordance with the care setting, with support from the palliative care consultant.
- The palliative care consultant also worked at the local hospice, allowing for improved continuity and management of any local patients using the service.
- Specialist support was available from the supportive and palliative care team when required through the trust electronic referral system. Out-of-hours specialist advice could be sought from the medical consultant on-call through the switchboard.

Are end of life care services effective?

Good



The supportive and palliative care team told us care was based on NICE quality standard 13. The trust had reviewed its own processes in response to the national review of the Liverpool Care Pathway and had introduced new documentation in July 2014 titled 'Guidance for staff on the palliative management of patients thought to be in the last days of life'. The hospital had developed DNAR Guidelines in line with national guidance for 'Do not attempt cardio-pulmonary resuscitation' (DNACPR), which fully complied with the guidance issued by the BMA/RCN/Resuscitation Council (UK) (2007).

Patients receiving end of life care were managed effectively. Patients received specialist support from a multidisciplinary team, which included specialist palliative care nurses and a palliative care consultant.

The trust completed its own End of Life Care Quality Assessment Tool. The latest assessment carried out in October 2014 showed that the trust was compliant in over

80% of the key areas with the rest partially compliant. The service had identified actions to achieve full compliance within set timescales; progress against the timescales was regularly monitored.

Evidence-based care and treatment

- The supportive and palliative care team told us care was based on NICE quality standard 13. This quality standard defines clinical best practice within end of life care for adults. We saw a review of the service that had been carried out by the local commissioning group that had been based on the current available national guidance. The trust performed well overall in terms of the range of guidance for staff and signposting to the supportive and palliative care service.
- The palliative care consultant confirmed the use of the hospital's own guidance for end of life care and so had not had the same issues as other trusts in response to the directive to discontinue the use of the Liverpool Care Pathway. The service had reviewed its own processes and had introduced new documentation in July 2014 titled 'Guidance for staff on the palliative management of patients thought to be in the last days of life'. Staff were aware that the new guidance was available on the internet. Each ward also had a comprehensive 'Supportive and Palliative Care' folder as a reference and guidance resource for staff.
- The supportive and palliative care team had reviewed the Department of Health's national End of Life Strategy recommendations. They had identified the need to introduce the "amber care bundle", which is a simple approach used in hospitals when doctors are uncertain whether a patient may recover and are concerned that they may only have a few months left to live. It encourages staff, patients and families to continue with treatment in the hope of a recovery, while talking openly about people's wishes and putting plans in place should the person die.
- Due to staff absence the service had experienced capacity issues in terms of rolling out the care bundles. We spoke with the director of nursing who was working on the implementation of a care bundle with the multidisciplinary team and those close to the patient. The service was continuing to review its introduction of amber care bundles through the end of life steering group.
- Nineteen patients had been urgently referred to the supportive and palliative care team in the three months

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before our inspection and all were seen within 24 hours of referral. We were also told that 54 patients were referred to the service over the last three months, (September, October and November) of whom 38 (70%) were seen within 24 hours, although half of those patients were not classed as urgent.

Pain relief

- Pain was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients.
- Staff told us they were able to access clear guidance on the prescription of medications to be given 'as required' for symptoms that may occur at end of life, such as pain, anxiety, nausea and vomiting, breathlessness. This showed that patients had access to the most appropriate pain and symptom relief. The Critical Care Area (CCA) electronic documentation contained with information specifically for end of life prescribing and medication regimes covering such aspects as pain control and agitation.
- Junior staff told us that they received support in relation to prescribing medications to relieve symptoms for patients who were dying. Medical staff were provided with advice and support from the supportive and palliative care team.
- Staff confirmed the syringe drivers were accessible if an end of life patient required subcutaneous medication for pain relief. This was available seven days a week and out of hours.

Environment and equipment

- Equipment was maintained and checked to ensure it continued to be safe to use. Staff we spoke with confirmed that they had access to equipment to enable them to carry out their role and support patients appropriately.
- The family viewing area and mortuary was fit for purpose, if a little dated. Staff told us that they had applied for trust funds to refurbish the family viewing area to update the facilities and improve the experience for those who had been bereaved, and had verbal agreement to proceed.
- The mortuary was secured to prevent inadvertent or inappropriate admission to the area. Fridges were lockable to reduce the risk of unauthorised access.
- Staff told us that they tried whenever possible to provide side room accommodation for patients who were at the end of life.

- Access to syringe drivers for people needing continuous pain relief was available. The trust had standardised all its syringe drivers to one type, which minimised the risk of potentially harmful errors and incidents. There were systems in place for checks to be carried out in relation to the use of syringe drivers such as the volume of infusion remaining in the syringe. The T34 syringe drivers had all been serviced and staff were trained to use them. Staff told us, and training records confirmed, they had access to syringe drivers and had received the appropriate training.

Nutrition and hydration

- The new documentation introduced by the trust included guidance to assist staff in assessing the patient's nutrition and hydration needs.
- When possible, there was a period over mealtimes when all activities on the wards stopped, if it was safe for them to do so. This meant that staff were available to help serve food and assist those patients who needed help. We also saw that a coloured tray system was in place to highlight those patients who needed assistance with eating and drinking.
- The ward staff supported patients to eat and drink normally for as long as possible. Two patients said that the food was plentiful but not particularly nice. One person told us that the food, although plentiful, was not always suitable for a specialised high-calorie diet.

Patient outcomes

- Patients receiving end of life care were managed effectively. Patients received effective support from a multidisciplinary team, which included specialist palliative care nurses and consultant.
- The patient records we looked at were accurate and clinical notes were completed to a good standard.
- Staff told us that many patients at the end of life chose to remain at the hospital because they felt safe there after many years of care from the hospital.
- The hospital had introduced an electronic referral process to both the supportive and palliative care team and the chaplaincy to ensure that there was timely referral to the service when required. Staff confirmed they had access to other electronic registers in the region, but this was view-only. This meant that they did not have access to communicate with other providers through the register. It is important to have clear access to communications to ensure that the whole team

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understand what has been communicated to the patient and their family to ensure that any discharge plans are carried out in accordance with the patient's wishes.

- The service had submitted information to the National Care of the Dying Audit; however, as most deaths occurred in the CCA, which is not included in the survey, the data were excluded. The hospital was carrying out its own review of end of life care that was ongoing at the time of our inspection. This showed that the service was proactive in assessing itself against good practice.
- The hospital had completed its own End of Life Care Quality Assessment Tool self-assessment, which was monitored through the end of life steering group. The latest assessment carried out in October 2014 showed that the trust was compliant in over 80% of the key areas with the rest partially compliant. The service had identified actions to achieve full compliance within set timescales; progress against the timescales was regularly monitored.

Competent staff

- The supportive and palliative care team were all specialist nurses and had access to specialist training and development as required.
- Training was offered to non-specialists by the supportive and palliative care team. During 2013/14, the team presented an update on end of life care and the role of the palliative care team at each 'Stat and Tech' mandatory training session. Since April 2014, in recognition of the withdrawal of End of Life Care training provided from an external resource, the team have updated the ward area 'link nurse' group membership, and have provided education through these meetings.
- A link nurse confirmed that they had attended a formal 'study day', which had helped them to develop understanding of the provision of care for patients with life limiting diagnosis and to develop their communication skills. Theatre staff carried out work-based scenarios for patients who died in theatre to ensure that individuals were treated sensitively and with dignity and respect. This was a competency-based assessment that ensured that staff were skilled in managing such events.
- The consultant and registrar contributed to the junior doctor training programme. Records confirmed that additional opportunities for education were used

whenever possible, such as Grand Round presentations to all staff as well as Consultant and Directorate meeting presentations to alert senior staff to new guidance/policy change.

- The trust had a system of annual performance development reviews for all staff. The trust data showed that 77% of staff had completed the process so far this year. Staff we spoke with told us that during their review they had the opportunity to discuss their progress, any difficulties and any training requirements with their line manager. All the supportive and palliative care team confirmed that they had completed an appraisal.
- The hospital had developed DNAR Guidelines in line with national guidance for DNACPR, which fully complied with the guidance issued by the BMA/RCN/Resuscitation Council (UK) (2007) and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK) standards for clinical practice and training.

Multidisciplinary working

- The multidisciplinary team worked well together to coordinate and plan the care for patients at the end of life. The team included dietetic, occupational, therapy physiotherapy, psychiatry and psychology. The service included spiritual support from the chaplaincy team and excellent support from the PALS team after the death of an individual.
- The palliative care lead told us that the team tried to attend as many multidisciplinary team meetings as possible to share the work of the team and help to identify and coordinate an individual at end of life or requiring supportive care. The team regularly attended the CCA multidisciplinary team meeting because the critical care team made the most referrals to the supportive and palliative care team.
- The hospital had a social worker based on site and worked closely with the supportive and palliative care team to arrange discharges.

Seven-day services

- The supportive and palliative care team were available 9am to 5pm Monday to Friday, excluding bank holidays. Staff told us that they did not have the staffing to provide a seven-day service but were hoping to introduce this in the future as part of service improvement.

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- Specialist consultant palliative care advice and support was available 24 hours a day, seven days a week. Out of hours, consultant support could be sought from the medical consultant on-call through the switchboard. The palliative medicine consultant rota was shared with neighbouring hospitals and the local hospice team.

Access to information

- The trust had reviewed its own processes in response to the national review of the Liverpool Care Pathway and had introduced new documentation in July 2014 titled 'Guidance for staff on the palliative management of patients thought to be in the last days of life'.
- We found that the supportive and palliative care team were proactive in informing a person's GP that they had been identified as requiring end of life care. The team were proactive in working with the patient's GP and any local services in order to facilitate seamless and rapid discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a comprehensive consent policy. It covered all aspects of consent including responsibilities for the consent process and mental capacity guidance and documentation for gaining consent. The trust also used a number of forms with clear information available to describe the risk and benefits of a procedure.
- The consent policy was referred to as part of the resuscitation procedure when considering DNAR orders and Advanced Decisions. The overall responsibility for decisions about DNAR orders rested with the consultant in charge of the patient's care. Clear guidance was in place for the decision-making process to enable staff to identify a patient's capacity and was closely considered in any decisions regarding resuscitation.
- The trust had developed DNAR guidelines in line with national guidance for DNACPR, which fully complied with the guidance issued by the BMA/RCN/Resuscitation Council (UK) (2007) and the recommended standards issued in the Joint Statement from the Royal College of Anaesthetists, the Royal College of Physicians, the Intensive Care Society and the Resuscitation Council (UK) standards for clinical practice and training.
- We were shown copies of the 2013 and 2014 DNACPR audits and related action plans. The audit report for 2014 showed that the trust had a drop in compliance with the standard related to the documentation of discussion with other members of the team (for paper

records). In this standard, compliance of 33% was achieved, compared with the previous year's 55%. A related action plan had been implemented, including a review of the doctor's induction hand-out and a presentation at the doctors' meetings with a view to improving performance in this area.

- The hospital had clear consent processes in place for managing both tissue removal after death and for hospital post-mortems. Information booklets and consent forms were in place for next of kin to read and sign.

Are end of life care services caring?

Good



The supportive and palliative care team, the chaplaincy, nurses across the trust and the PALS provided support to patients and relatives. Patients and relatives told us staff were supportive to both patients and those close to them and offered emotional support. One person told us "It is very caring here".

Staff told us that they felt well supported by the management team and could describe examples of when they had received emotional support following the death of a patient. The trust provided memorial services for people who had received a donor organ.

We found that there was no dedicated relatives room or office on most wards where sensitive conversations could be conducted. However, we found that staff went out of their way to provide a private area for families if required, such as moving out of their own staff area to allow families some privacy.

Patients were treated with dignity, respect and compassion from the clinical setting to the mortuary. There was a single viewing room where relatives were able to spend time with their deceased relative. We visited the mortuary and the staff we spoke with showed how they continued to treat patients with dignity and respect after their death. We found people were transported to the mortuary in a discrete and dignified manner.

End of life care

We found that the PALS was excellent and had been very proactive in developing its service and providing practical support, such as accommodation for families as well as emotional support and signposting to other services in the community.

Compassionate care

- Staff told us that they did not have a lot of people who died on the wards, but felt they generally had enough time to spend with patients and their relatives when they were delivering end of life care.
- We observed staff closing the curtains when a patient required privacy and we heard them speaking with them in a respectful manner. We were told and staff confirmed that a magnetic tree emblem was used to discreetly indicate that someone was at the end of life, and this would also be used on the outside of a door to alert staff to the needs of the particular individual and family members.
- We found that there was no dedicated relatives room or office on most wards where sensitive conversations could be conducted. However, we found that staff went out of their way to provide a private area for families if required, such as moving out of their own staff area to allow families some privacy.
- Patients were treated with dignity, respect and compassion from the clinical setting to the mortuary. There was a single viewing room where relatives were able to spend time with their deceased relative.
- The chaplaincy staff and PALS staff demonstrated a caring and compassionate approach towards patients, relatives and staff.
- We found that the PALS was excellent and had been very proactive in developing its service and providing practical support, such as accommodation for families as well as emotional support and signposting to other services in the community. The service acted as the main contact for families after the death of a loved one and guided people through the necessary steps needed following bereavement. This included registering a death on behalf of someone who did not live close to the hospital.
- We visited the mortuary and the staff we spoke with showed how they continued to treat patients with dignity and respect after their death. We found people who had died were transported to the mortuary in a discrete and dignified manner.

Understanding and involvement of patients and those close to them

- We spoke with patients and relatives about how staff had worked over the years to establish a good rapport with patients and their relatives/close friends.
- Patients and their relatives were overwhelmingly positive about their care and the way staff communicated with them and they told us they felt involved in decision making. One patient told us “I have built up trust with Papworth over 30 years. I can’t fault the staff here.”
- ‘Do not attempt cardio-pulmonary resuscitation’ (DNACPR) forms were in place for patients if indicated. We spoke with one nurse who could clearly outline that although all active care was being given, the patient had been given the choice regarding DNACPR.
- The trust had introduced a shared communication sheet, which was available to be used for communication by and between patient/family/ward members. This was considered to be good practice.
- During our visit we found that there were a wide range of leaflets available for patients and their families, such as on pain relief and things to expect during the last days of life. We noted that few of these were available for people whose first language was not English, although information could be provided in other languages and formats on request.

Emotional support

- The supportive and palliative care team, the chaplaincy, nurses across the trust and the PALS provided support to patients and relatives. Patients and relatives told us staff were supportive to both patients and those close to them and offered emotional support. One person told us, “It is very caring here.” Another told us, “I have a plan of care; I know where I am going and the staff have been supporting me all the way.”
- Staff told us that they felt well supported by the trust and could describe examples of when they had received emotional support following the death of a patient.
- The trust provided memorial services for people who had received a donor organ. Staff told us that this was also an opportunity to remember the donor individuals and to give thanks to them and their families.
- Chaplaincy support was available 24 hours a day through an on-call system. There was access to spiritual

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support for other faiths, which was coordinated through the chaplaincy. There were appropriate provisions of care for the deceased and their families that met their personal or religious wishes.

Are end of life care services responsive?

Good



Local patients were discussed at the local hospice to ensure the needs of individuals were met. The service had representation at the cross-cutting network group for specialist palliative care.

Once referred to the supportive and palliative care team, the team supported the ward staff in coordinating and involving relevant services within the hospital and community. A member of staff was able to describe an example from December 2013 when staff worked together to get a patient home in time for Christmas before the end of life. Staff confirmed with us that because of the wide geographic area served by Papworth Hospital, the percentage of patients who achieved their preferred place of death was difficult to report. People's needs were assessed and care and treatment were planned and delivered in line with their individual care plan. We found people's diverse needs were met. There were appropriate provisions of care for the deceased and their families that met their personal or religious wishes. We saw that the hospital had a comprehensive equality and diversity policy in place and that staff were mindful of their responsibilities in this regard.

Complaints were handled in line with the trust policy. 'Quality of Service' leaflets were available in all clinical areas for patients/relatives to raise a concern/make a formal complaint or pass on a compliment should they so wish.

Service planning and delivery to meet the needs of local people

- As part of our inspection we were aware of the sudden death of a patient undergoing a clinical procedure in the cardiac catheterisation laboratory. Good practice for moving a deceased person was not followed and there

was a lack of dignity and respect afforded to the patient. We escalated this issue immediately to the director of nursing who confirmed that this process had been reviewed and the practice had been stopped.

- The trust had representation at the cross-cutting network group for specialist palliative care. This group was led by the local commissioners and its purpose was to ensure coordination and consistency across the local network for specialist palliative care policy, practice guidelines, clinical guidelines, audit, and research and service improvement. The group ensured that service planning and delivery was in line with national guidance/standards across the whole care pathway. The group also was active in seeking the views of patients and carers. The hospital had worked with this group as part of its work in introducing the new guidance and documentation for end of life care.
- We observed and staff told us that there was no specific room available for relatives to use on the wards. Staff told us of individual cases when staff allowed relatives to use meeting or staff rooms, but we found this to be as required and not always very practical.
- Information from the trust confirmed that there were some challenges in fast-tracking patients that were out of the trust's control. These included access to community support (continuing health care related), and sometimes delays transferring to the local hospice. We were told that these issues were being addressed at the local network group.

Meeting people's individual needs

- We observed that one patient had been moved into a larger room with en-suite facilities to support the needs of themselves and their family as part of their palliative care.
- People's needs were assessed and care and treatment were planned and delivered in line with their individual care plan. We saw that risk assessments were recorded by nursing staff, updated as people's condition changed, and care was directed at preventing harm from known risks. Assessments included falls, nutritional needs, moving and handling, risk of pressure sores, catheter and cannula care. We found that the trust revised documentation ensured that there was an individualised plan of care and written record of conversations between the consultant and the patient (where possible) and the carers (with the patient's permission).

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- Pain was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individuals. Staff were able to access clear guidance on the prescriptions of medications to be given 'as required' for symptoms that may occur at end of life, such as pain, anxiety, nausea and vomiting, breathlessness.
- We found people's diverse needs were met in the main. There were appropriate provisions of care for the deceased and their families that met their personal or religious wishes. We saw that the hospital had a comprehensive equality and diversity policy in place and that staff were mindful of their responsibilities. Staff we spoke with were aware of people's identified religion and customs required at end of life. Staff also confirmed that they had access to Papworth Hospital's religious and cultural beliefs handbook on the intranet.
- Access to chaplaincy support and other faiths was through the trust electronic system. However, a recent review of referrals had indicated that the referral document did not identify a patient's religion, which may have an impact on providing the correct and timely spiritual support for patients at end of life.
- Accommodation for family and carers was available both on site and on occasion we were told that people in the village were able to provide bed and breakfast accommodation for people who had to travel a long distance.

Access and flow

- Complex/rapid discharge was included as 'reason for referral' to the supportive and palliative care team. Staff told us that this applied only to a small number of patients each year. Once referred to the supportive and palliative care team, the team supported the ward staff in coordinating and involving relevant services within the hospital and community (such as social worker, occupational therapist, pharmacist, as appropriate in Papworth Hospital; GP, district nurses, specialist nurses/hospice services as appropriate in the community). The rapidity of the discharge depended on the local resources and equipment available to support the patient in the community (or care home) and varied considerably over the wide geographic area served by Papworth Hospital. A member of staff was able to describe an example from December 2013 when staff worked together to get a patient home in time for Christmas before end of life.

- After discussions in the hospital end of life care steering group regarding some experiences of 'rapid discharge', a working group was set up to create guidance applicable in all areas of the hospital, outlining a process that can be started and followed by staff at any time, with the aim of expediting discharge when this is possible.
- Staff confirmed with us that because of the wide geographic area served by the hospital, the percentage of patients who achieved their preferred place of death was difficult to report. Data provided by the trust showed that out of 32 patients, for whom information was available, eight had died in their preferred place of death, four had not, and for 20 this was unknown.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy. 'Quality of Service' leaflets were available in all clinical areas for patients/relatives to raise a concern/make a formal complaint or pass on a compliment. This process was managed through the PALS. Staff told us there were posters in clinical areas informing patients how they can raise a concern and volunteers regularly went around the hospital to make sure that leaflets were available. During our visit we did not see any of the leaflets in a format for someone whose first language was not English or who had a visual impairment
- We were told that the PALS service deals with low-level concerns. The wards are advised and supported to deal with and resolve concerns at a local level when possible. All patients raising a concern or making a complaint are contacted by the clinical governance department to discuss how they would like to manage and resolve their concern. The trust has a clinical governance management group consisting of members of PALS/ Complaints.
- Data provided by the trust indicated that there had been one complaint related to end of life care regarding issues with paperwork for a death certificate. The trust was able to describe how it had learned from the complaint and had revised information leaflets for both patients and their families regarding the dying process and for the recently bereaved.

End of life care

Are end of life care services well-led?

Good



There was no written strategy for end of life care. The service was linked into the local palliative care network. The service had a clinical lead for palliative care as well as a trust executive board lead and a governor.

There was no overarching performance quality dashboard for end of life care. The service was monitoring its own performance with monthly updates of its quality standard self-assessment tool. This information was also reviewed at each end of life steering group.

Because of the specialist nature of the work at the hospital, we found that medical and surgical teams were keen to coordinate the holistic approach to a patient's care from within their own teams. We saw many good examples of caring, and good care and support offered to patients. However, we felt that the trust could work to develop a culture of earlier referral and more open conversations about sharing the expertise of the supportive and palliative care team as part of the patient's journey.

Vision and strategy for this service

- There was no written strategy for end of life care. However, the trust End of Life Care Steering Group had recorded their agreement to follow the National End of Life Care Strategy 2008, and 'the route to success in the end of life care – achieving quality in the acute hospitals (2010)', and to develop services in line with the NICE quality standard for End of Life Care. The service was linked into the local palliative care network and the trust end of life steering group was updated on national policy and guidance to achieve high-quality end of life care in the hospital.
- We were told that the lead did not have the capacity to write the strategy for end of life care, as the end of life care priority was to focus on working on an action plan developed as per NICE requirements. Complaints, incidents, audits and quality improvement initiatives were discussed at the end of life steering group. We saw evidence of learning from these events.

Governance, risk management and quality measurement

- There was no overarching performance quality dashboard for end of life care. The service was monitoring its own performance with monthly updates of its quality standard self-assessment tool. This information was also reviewed at each end of life steering group.
- Complaints, incidents, audits and quality improvement initiatives were discussed at the end of life steering group. We saw evidence of learning from events.
- Audits results for 'Do not attempt cardio-pulmonary resuscitation' forms go to the end of life steering group and also to the Cardio Pulmonary Resuscitation steering group, and then to the overarching safety and quality committee. There was evidence of action plans and learning as a result of these audits.

Leadership of service

- The service had a clinical lead for palliative care as well as a trust executive board lead and a governor. The nurse specialists were managed through the nurse practice development lead and through to the Director of Nursing. We did not see evidence of visible discussion at board level of end of life care.

Culture within the service

- Supportive care is the 'umbrella term' for all services that may be required to support people with life-threatening illness. Because of the specialist nature of the work of the hospital we found that medical and surgical teams were keen to coordinate the holistic approach to a patient's care from within their own teams. We saw many good examples of caring and good care and support offered to patients. However, we felt that the trust could work to develop a culture of earlier referral and more open conversations about sharing the expertise of the supportive and palliative care team as part of the patient's journey.
- Staff we spoke with across the trust were very positive about the supportive and palliative care team and felt that they were both responsive and supportive to staff managing end of life care.

Public and staff engagement

- The service was continually looking for ways to improve the care for patients and worked closely with the PALS team to ensure that patient and family feedback was sought and used to improve services.

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- We saw examples of surveys such as in outpatient clinics that were used to improve the patient's experience.
- The hospital was very visible in the local community and local residents were very supportive of the work carried out there. Local residents offered affordable bed and breakfast to visitors to the hospital and gave good support to relatives from outside the local areas.

Innovation, improvement and sustainability

- The trust acknowledged that they wished to promote the role of the end of life team more robustly. The team had given a number of presentations at the medical 'Grand Round' as a way to improve communication with staff and promote the work of the service.
- The service needed to raise its profile and required strong management support to assist in developing a strategy for the end of life service.

Outpatients and diagnostic imaging

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

Information about the service

The hospital is a specialist cardiothoracic hospital and heart and lung transplant centre. The trust offers a range of services for outpatients, including cardiac, thoracic, transplant, radiology and pathology services.

Papworth Hospital provides outpatient care to patients from all over the UK. Outpatient care is also provided to paying patients from overseas. The outpatients department provided 124,066 outpatient appointments during 2013/14. Of those appointments, 25% were new referrals, but most were follow-up appointments and accounted for 67% of all the appointments provided. The follow-up appointments offered to new patients was among the highest in the country at 25%.

Summary of findings

As part of this inspection we visited all the outpatient areas. We spoke with 15 patients and those close to them. We also spoke with 16 members of staff, including doctors, nurses, allied health professionals and support staff.

The quality of services in outpatients and diagnostic imaging was good. Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. There were appropriate protocols in place for safeguarding vulnerable adults and children. Staffing levels and skill mix were planned to ensure the delivery of outpatient and diagnostic services at all times. Any staff shortage identified was responded to quickly and adequately.

The departments provided an effective service that was based on national good practice guidance and evidence-based treatment regimes. There were good examples of innovation, such as nurse-led clinics to support patients with long-term conditions and fast-track processes to access imaging services that had a positive impact on outcomes for patients.

Staff were competent and were supported by their managers to provide a good quality service to patients. The outpatient service operated six days a week, with plans to operate seven days a week.

The care provided by staff to patients in the outpatient and diagnostic imaging services was outstanding. All the feedback we received from patients and those close to

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them was universally positive about the way staff treated and cared for them. People were clear that staff went the extra mile and the care they received exceeded their expectations. The service adopted the 'hello my name is' campaign, which aims to put the patient at the centre of the care received. This demonstrated that people's needs were highly valued by staff and were embedded in their care and treatment.

The service was responsive when planning the service to meet the needs of local people. Effective consultation encouraged and supported patients and those close to them to influence the design and delivery of the service. However, the physical space available to provide and deliver these services was limited. After targeted and ongoing work, the hospital had a low number of patients who failed to attend for their appointments, with a 'Did Not Attend' rate of 3.7%. This was continually monitored to enable adaptations to be made to meet the needs and demands of the population.

Overall, the service was well-led. Staff felt their line managers were approachable, supportive and open to receiving ideas or concerns. Staff knew and understood the vision for the hospital, but this was perceived as solely focused on the opening of a new hospital; staff knew little about any other visions for the service.

We found that the local managers demonstrated good leadership within the department and the directorate, but there was a lack of connection between the trust board and the local departments in relation to delivering the vision and strategy for both the service and the trust.

Are outpatient and diagnostic imaging services safe?

Good



The quality of service in the outpatients and diagnostic imaging departments was good. Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. Lessons were learnt from incidents locally and staff felt confident in raising incidents through the reporting system.

There were appropriate protocols in place for safeguarding vulnerable adults and children, and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.

Staffing levels and skill mix were planned to ensure the delivery of outpatient diagnostic services at all times. There were vacancies in some services, but the trust was continually working to recruit new staff. Any staff shortages were responded to quickly and adequately.

Risks to people who use services were assessed and managed appropriately. There were clear protocols in place for providing care to people with specialised conditions, including the need to monitor for any deterioration in a patient's condition. Staff were trained in medical emergencies and could demonstrate through past events that their skills were used appropriately and promptly.

The outpatient and diagnostic imaging service did not have a major incident plan or business continuity plan in place. At the time of our inspection the service was experiencing difficulty in securing pathology test results in a timely way. Staff managed the disruption locally to ensure patients' test results were available for their consultations, but there was no formal tested plan in place for such events.

Incidents

- All staff we spoke with were knowledgeable about the incident reporting systems and we were provided with several examples of incidents that had been reported appropriately.
- Managers provided feedback and learning opportunities arising from reported incidents at team meetings.
- A serious incident had been reported where a patient had an anaphylactic reaction to contrast dye for the

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radiology scan. This incident was investigated and staff were provided with feedback. All of the staff we spoke with in MRI and CT scanning services were aware of the incident and the outcome of the investigation.

- There was evidence of learning from incidents involving medicines. Staff were able to describe an incident that had led to a reinforcing of the correct procedures for a routine task.

Cleanliness, infection control and hygiene

- The outpatient settings were clean and regularly maintained. Regular cleaning was being undertaken by domestic staff, including during breaks in between clinic sessions.
- The cleaning records for the department confirmed that the environment was cleaned regularly. This was displayed publicly for patients to see.
- Staff in the outpatients department were complying with the trust's policies and guidance on the use of personal protective equipment and adhered to 'bare below the elbow' guidance.
- There was hand-sanitising gel available throughout the area and we observed staff using this, in accordance with good practice.
- Within the haematology laboratory, we observed that staff were wearing appropriate laboratory coats and access to the laboratories was restricted for infection control reasons.
- The cystic fibrosis (CF) service had difficulty in ensuring that its service was always clean before patients attended for their appointment. This was because of the high number of patients using the area. Staff were able to demonstrate their plans for ensuring, when possible, they maintained a clean environment for CF patients to minimise infection risks. These plans were robust and no adverse incidents relating to infection had been reported.
- Cleaning audits were undertaken by managers on a monthly basis. We viewed the audit results and found that the majority of the service areas performed well, with results of above 95% for compliance with required standards of cleanliness.

Environment and equipment

- The hospital consisted of multiple buildings spread across the site.
- Many of the outpatient areas had been refurbished, but space was limited and the service was physically

confined. There were approximately 120 clinics a week within 12 consulting rooms in three buildings. It was evident that the growth in demand for the service was outgrowing the physical space available to provide it.

- Equipment within the department had been portable appliance tested for electrical safety.
- Equipment was appropriately stored within store rooms and our checks of the equipment revealed that the equipment was well maintained and ready for use.
- We examined the resuscitation trolleys located throughout the department. The trolleys were an older design and unlockable. Medicines and stock inside the trolley were appropriate, had been checked daily and the defibrillator had also been tested daily.
- Within the cardiac outpatients department we observed that oxygen cylinders were stored behind the main reception desk; these were not secured or locked away.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the department.
- All outpatient clinic areas had a minimum of one registered nurse on duty during clinic opening hours and they signed for the medication storage keys for that area.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open.
- Annual medicines storage audits were undertaken. The results were good and showed staff followed medicines storage policies appropriately.
- Prescription pads were stored securely and their appropriate use monitored.
- Pharmacy staff reinforced medicine safety instructions and information to patients when they collected their prescriptions following their consultation. Many of the specialist nurses also provided information and support about medication as part of the patient's consultation. There were also advice/telephone helplines for patients in relation to safe medicines management.

Records

- The on-site Medical Records Library held all patient records for patients currently receiving treatment. Medical records were available and ready for patients' outpatient appointments. Staff confirmed that there were no concerns in relation to obtaining records for patient appointments.

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- However, concerns were raised with regards to obtaining and accessing timely records and results for pathology specimens. This was predominantly because the services were outsourced to another trust that had been experiencing difficulties in transferring its records to an electronic system.
- We viewed the daily retrieval of results for pathology specimens. The service sends out on average 200 specimens a day for testing. This means that the average returns of results in the system will be approximately 200 every three days. On the first day of our inspection, two results had been received and reported on, and on the second day three results had been returned and reported on.
- The concerns in relation to being able to secure pathology results in a timely way had been escalated by the outpatients team, but no resolution to these concerns was likely to be forthcoming until February 2015.
- However, we found that all patients who required results for their appointments had them available because staff within the department ensured that the results were available by contacting the provider service directly before the patient's appointment. This action by the staff mitigated the risk of a patient's diagnosis or treatment being delayed as a result of delayed test results.
- Patient records within the outpatients department were kept in secure locations that promoted and maintained the patient's confidentiality.

Safeguarding

- The trust had a chaperone policy that was followed in the outpatients department.
- Staff within the service had access to a safeguarding policy that followed the national template. This was available to staff to access through the trust's intranet site.
- All staff received training in adult safeguarding.
- Staff we interviewed were clearly able to explain their role in raising safeguarding concerns and how they would escalate concerns in this regard.

Mandatory training

- We examined the mandatory training data for the outpatient services. We found that the majority of staff received access to training in subjects including health and safety, fire safety and infection control through e-learning modules.

- We viewed the CADS directorate meeting as well as the quality and safety committee meeting minutes and the trust board meeting minutes. We established that mandatory training availability, monitoring and compliance were not routinely discussed at local and trust-wide meetings. The meetings discussed research and education, but this did not relate to basic mandatory training of staff.

Assessing and responding to patient risk

- Staff within outpatients were trained to use the early warning score system used by the hospital to assist in identifying patients at risk of sudden deterioration in their condition.
- If a patient became unwell in outpatients, the service had a clear protocol to follow. Staff would treat the patient within the department and either transfer them to the nearby acute hospital or to a ward within the main hospital for full assessment and treatment. Staff were able to talk about and demonstrate a good knowledge of the emergency procedures.
- There was evidence that staff in the department respond to deterioration in a patient's condition in an appropriate and timely way.
- All staff working in the department had completed Basic Life Support training. In addition, nursing and medical staff all received advanced life support training. Staff informed us that the majority of staff were Advanced Life Support trained because of the number of high-risk patients attending the department.

Nursing staffing

- There were a sufficient number of nursing staff on duty in outpatient services, although this was mainly a result of the dedication and good will of staff working to deliver the service.
- During the inspection we identified that thoracic outpatients were two staff nurses below the required staffing levels. We were informed by the staff that this meant the service was exceptionally busy, but they had managed to maintain the service.
- There were no vacancies in cardiac outpatients department. Nursing vacancies in thoracic outpatients were being covered internally by staff being transferred from another area to support the clinic or through the use of bank staff. Two vacancies in the respiratory physiology team were being covered by agency workers.

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- There was strong evidence in meeting records and board papers that the hospital was continually recruiting for nurses and support staff to address vacancies.

Medical staffing

- There was a sufficient number of medical staff to support outpatient services. We found that the majority of clinics were covered by specialist consultants, the exception being one clinic in lung services that had one consultant vacancy. The hospital had a clear plan in place to cover those clinics that had to be rescheduled and was working to appoint a replacement consultant.
- Within the radiology and diagnostic centre we found a sufficient number of staff on duty to meet the daily demand of diagnostic services.

Allied health professional staffing

- There were vacancies within the radiology service. The service acknowledged that the recruitment of experienced radiology staff was a challenge. We found that staff were being recruited at a lower staff band, but were offered clinical education and professional development to further qualify in radiology functions including MRI and CT as part of the recruitment package.
- There was an ongoing recruitment campaign to recruit staff within diagnostic services.
- Within the blood bank there was a limited staff resource available out of hours and at weekends. We found that at weekends and into the evening there were some surgical lists operating that potentially could require the support of the blood bank, but often only one or two staff were available to support demand. This reduced resource could lead to delays in delivering biochemistry results because the provision of blood for procedures was the priority.
- Within the therapy services there was a shortage of occupational therapy and speech and language staff. The need for additional Occupational Therapists has been identified and additional staff has been recruited. The service employs two speech and language therapists (SALT) following the recruitment of a Lead SALT to meet the complexity of the caseload.
- Specialist cardiac dietician support was available through registered and qualified dieticians.

Major incident awareness and training

- The service did not have any major incident or business continuity plans. There was a business continuity policy, but no plan in place.
- The service was experiencing difficulties in obtaining pathology results because of an electronic records system issue at a nearby acute centre that had the contract for pathology services. There was no contingency plan in place for the service to respond to this. The service was following a Public Health England continuity plan to respond to the concerns.
- We asked the pathology leads, nursing and consultant staff what local measures they had implemented to ensure a continued service delivery. We were informed staff were continually checking patients, providing additional ward rounds and increased monitoring regarding sepsis and changes in the patient's condition for deterioration. However, because this needed to be sustained until the system issues are resolved (expected to be approximately February 2015), maintaining this level of diligence was challenging within a limited resource.
- Locally we found the teams within pathology and clinical services were resilient in their response to a system failure, which meant that patients were receiving appropriate and closely monitored care.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The departments provided an effective service that was based on national good practice guidance and evidence-based treatment guidelines. There were good examples of innovation, such as nurse-led clinics to support patients with long-term conditions that had a positive impact on outcomes for patients.

Staff were competent and supported to provide a good quality service to patients. Staff were skilled in their specialist area and were supported in their roles by ongoing specialist training and development opportunities.

The outpatient service operated six days a week and plans were in place to extend the service to seven days a week.

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Radiology and therapy services provided cover over seven days, though this could be challenging with the available resources. There were plans for increasing staff in these areas to respond to increased patient demand. The hospital did not provide dedicated training or support in relation to the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. We identified occasions when patients who had received treatment in outpatients and the diagnostic imaging department should have had their mental capacity assessed before a procedure or test was undertaken, but this had not been carried out because staff were not clear about the requirements or responsibilities regarding the Act.

Evidence-based care and treatment

- Adherence with National Institute for Health and Care Excellence (NICE) guidelines was monitored in the directorate clinical governance meetings. For example, NICE clinical guideline 101 on chronic obstructive pulmonary disease was followed when possible and patients with chronic obstructive pulmonary disease received continuing care throughout their pathway at Papworth.
- Staff in radiology were aware of changes to NICE guidelines that required patients to have blood tests before having MRI scans with contrast. These blood tests were undertaken by local health practitioners before the patient was booked for a scan at the hospital.
- The trust took part in the national cardiac arrest audit, which identified that cardiac arrest within the radiology, imaging and outpatient areas were responded to appropriately.
- We could find little evidence that local audits were undertaken routinely outside of hand hygiene and case note availability.
- The hospital took part in the national blood sampling audit in 2012. (Latest data available) The results of the audit were shared throughout the pathology service and evidence was provided that the recommendations to improve the service had been implemented.
- The outpatient service ran 120 clinics over six days. To cope with increased demand many clinics were now nurse-led, with nurses being qualified to a level that supported nurse-led services. This is considered good practice that contributes to good outcomes for patients.

Pain relief

- Staff were able access appropriate pain relief for patients within clinics and diagnostic settings.
- Records confirmed that patients' pain needs were assessed before undertaking any tests in the majority of cases.

Patient outcomes

- The outpatients department also took part in audits such as hand hygiene, cleanliness and record keeping. Managers had responsibility for implementing and monitoring action plans to secure improvement when remedial action was required.
- Records of local audit demonstrated a high rate of compliance with good practice across the service.

Facilities

- The outpatients department provided approximately 120 clinics a week. Space was being utilised effectively, but the increased number of clinics meant that the turnaround times in clinics was a management challenge
- Increased demand for the service was challenged by the limited physical environment.

Competent staff

- We saw that the hospital employed many specialist nurses covering most sub-specialities. There were nurse-led clinics alongside medical colleagues providing care for patients awaiting a transplant, those with cystic fibrosis, lung disease and heart disease.
- The teams were skilled and knowledgeable about their specialist areas and were able to provide care, treatment and advice to patients during their appointments.
- Specialist nurses told us they attended national forums and regional meetings to share good practice. Many were undertaking a course of study linked to their specialist area as part of degree courses.
- Within radiology we found that staff were being educated and developed on fast-track programmes so that they could achieve additional qualifications within the speciality.
- Within dietetics, staff were supported with training and education to become specialists in their field, including undertaking PhD programmes in dietetic studies.

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- Revalidation of doctors was routinely monitored through the specialist directorates and at board level. The hospital had a good rate of revalidation, with all doctors being revalidated within the required timeframe.
- We viewed the appraisal rates within outpatients and diagnostic imaging and found that the majority of people had received a formal appraisal.
- The majority of staff we spoke with confirmed that they received one-to-one meetings with their managers on a monthly basis, which they found beneficial.

Multidisciplinary working

- We observed excellent multidisciplinary team working within the services. The majority of clinics had multidisciplinary team meetings related to specialities, for example in transplantation or lung services. These meetings consisted of a range of professionals, including medical, nursing, allied health professional and management support to discuss and determine an appropriate care pathway for patients.
- There were robust systems in place for working with external stakeholders. The service had working links with more than 16 clinical commissioning groups.
- Because of the highly specialised services offered, the service worked with hospitals throughout the UK to manage and support referrals from other hospitals both nationally and internationally.

Seven-day services

- Work was already underway in the department to identify where the service requirements will need to adapt to deliver outpatient services into the evening or weekends.
- Therapy, diagnostic and support services were working over seven days to provide cover to clinical areas, but because of lower than expected numbers of therapy and support staff there was a risk that this could affect the delivery of the service until the recruitment of additional staff.
- The ECG department and X-ray were not yet available over the seven days.
- Some clinics took place at the weekends; staff were monitoring how these were received by patients. The appointments staff reported that they were having no difficulty getting patients to come at weekends and said that they felt offering more flexible times was being well received.

- Seven-day outpatient clinics may also be affected by the limited public transportation network that connects the hospital locally.

Access to information

- Patients reported to us during the inspection that they had no concerns regarding access to information relating to their care or treatment.
- One patient we talked with spoke highly of the staff at the hospital and informed us that if they phoned with a problem staff always knew who they were straight away and could access their files without difficulty.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with eight members of staff specifically about the requirements of the Mental Capacity Act 2005 and found that they were not fully aware of the requirements or how to ensure that people were treated appropriately.
- There was a policy for the trust on mental capacity, but staff we spoke with were largely unaware of its existence or what it contained.
- We found that outpatient staff undertaking procedures were more aware of the requirements for consent and the Mental Capacity Act 2005 than staff within the radiology service.
- Within the radiology service we found that Mental Capacity Act assessments were not carried out for patients who required them before receiving a contrast injection or an MRI or CT scan. For example, we were informed that a patient with Down's syndrome attended recently and a contrast scan was carried out without a mental capacity assessment being undertaken. This was not checked by staff before carrying out the scan.
- Before having a procedure undertaken in outpatients, patients' consent was obtained verbally and signed in their records. For biopsies or more invasive tests, consent for procedures was formally taken and discussed with the patient before starting the procedure.

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Are outpatient and diagnostic imaging services caring?

Outstanding



The care provided by staff to patients in the outpatient and diagnostic imaging services was outstanding. We spoke with 15 patients and relatives during the inspection and all their feedback was positive about the way staff treated people. People thought that staff 'go the extra mile' and the care they received exceeded their expectations.

There was a strong, visible person-centred culture in the department. Staff were highly motivated and offered care that was kind and promoted people's dignity. Relationships between people who use the service and those close to them and staff were strong, caring and supportive and we observed many interactions throughout our inspection that demonstrated how dedicated the staff were.

People who use services were active partners in their care and all patients and relatives we spoke with told us how involved they were in decision making about their care; patients and those close to them also understood the treatment and choices available to them. There were numerous examples of staff who had worked together to overcome obstacles to ensure that people's daily lives continued despite serious illness. People's individual preferences and needs were always reflected in how care was delivered.

Staff recognised and respected the totality of people's needs. There was a real awareness of people's needs and the limitations associated with their conditions. We found that people's personal, cultural, social and religious needs were always taken into account throughout the service, particularly in the transplant outpatients where there was clear information how they meet the needs of people with a range of diverse backgrounds and specific social needs.

The service adopted the 'hello my name is' campaign, which puts the patient at the centre of the care received as soon as they arrive. This demonstrated that people's emotional needs were highly valued by staff and were embedded in their care and treatment.

Compassionate care

- We spoke with 15 patients and those close to them during our inspection and all spoke very highly of the service. Each person we spoke with said that staff could not do enough for them and went the extra mile to provide the care they needed.
- All of the patients we spoke with gave us examples of how their experience of care was personalised to them. Examples included: staff knew them personally and recalled their family members and asked after their wellbeing, addressed them by name, were polite and very approachable to ask any questions.
- An example was provided by one patient who was able to attend a family wedding with support of the staff within the outpatients department by making sure that their medicines, treatments and appointments were all scheduled in a way that enabled them to attend. The patient told us "They did not just go the extra mile; they went beyond that; they are truly amazing wonderful people."
- We observed that staff were kind and attentive to patients, regularly checking on their welfare in radiology while they were waiting for tests. It was particularly cold weather during the inspection and the patients in gowns were regularly asked about their welfare and offered a blanket if they were cold.
- We watched staff assisting people around the different outpatients department areas. Staff approached people rather than waiting for requests for assistance, asking people if they needed assistance and pointing them in the right direction.
- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff knelt or sat by the patient so that they were at the same level and maintained eye contact when conversing.
- Staff knocked on doors and waited for a response before entering.
- The hospital adopted the 'hello my name is' campaign. This campaign was set up by a doctor who had received treatment as a patient in an NHS hospital and wanted to ensure that staff introduced themselves before providing any care. Throughout the inspection we observed that staff adopted this campaign by welcoming and addressing a patient as they entered the room with "hello my name is".
- The Friends and Family Test, which assesses whether patients would recommend a service to their friends or family and whether or not staff employed by the service

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would recommend the service to their family to receive care, showed that 98% of patients would recommend the inpatient service to family and friends and 97% of Papworth Hospital staff would recommend the trust to their friends and family.

- The Friends and Family Test response rate was 50%, which was higher than the England average of 31%.

Understanding and involvement of patients and those close to them

- We spoke with 15 patients and those close to them about the care and treatment they received in outpatient services. Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see. One patient told us, "Each time I come here I know exactly why because it is explained so well, there are few surprises."
- Within the outpatient areas there was dedicated literature for people to read, in various formats, relating to specific clinical conditions such as cystic fibrosis, mesothelioma, organ transplantation. Patients were encouraged to read and understand the leaflets and literatures available before they attended appointments so that they could be prepared to ask any questions that they may have.
- There was evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.
- Within transplant outpatient services the team worked very closely with the patients and families to meet their expressed needs for going through a traumatic event such as organ transplantation. This included meeting cultural beliefs and providing social support to help the patient and those close to them.

Emotional support

- For each speciality clinic there were clinical nurse specialists, sisters and lead nurses available for patients to talk to about their conditions. Each patient we spoke with in the pulmonary, cystic fibrosis and thoracic outpatient services could tell us who their named nurse was if they wanted to discuss their condition.
- The service promoted the use of patient diaries and journals regarding their conditions, particularly in transplantation services. This practice assisted patients

with reflecting on their experience of life-threatening illness and helped them to cope with their condition before and after transplantation and throughout their recovery.

- There was a range of emotional support options for people to talk about their condition, including access to chaplains, social workers and community support staff.
- One senior nurse and doctor told us that their work often involved delivering difficult messages to patients about their condition and that they took great pride in making sure that this was done in a sensitive and compassionate way that allowed the patients and relatives to ask questions about the information they had received.
- We asked one patient who was being admitted for a complex and high-risk procedure what they felt could be done by the teams to support them through this process, given the risks of surgery, and they told us, "nothing, they have explained everything. I trust they will do right by me".

Are outpatient and diagnostic imaging services responsive?

Good



The service was responsive when planning the service to meet the needs of local people. Effective consultation allowed the service to meet the needs of the population, but the space to provide and deliver these services was limited.

The outpatients department had developed many nurse-led clinics, with additional clinics being run in the evening and at the weekend to meet the needs of the population. This was recognised by other providers as good practice, both nationally and internationally; patients attended the service from around the world.

The trust had a low number of patients who failed to attend for their appointments, with a 'Did Not Attend' rate of 3.7%. This was continually monitored to enable adaptations to be made to meet the needs and demand of the population.

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The level of complaints received regarding outpatient services was consistently low, with more compliments than complaints being received. Staff worked to address any concerns raised by patients at first point of contact and this resulted in few formal complaints.

Service planning and delivery to meet the needs of local people

- The environment within the outpatients department was limited. In three small areas there were approximately 120 clinics being held, utilising the space to the maximum degree. The service was continually developing and innovating new ways to meet the needs of the patients; however, the service was running out of physical space to meet demand.
- When we asked staff and managers in the department about service planning, we found that there was no interim plan for between now and the provisional opening date of the new hospital in approximately three years' time. Therefore there was a risk that the service may become less responsive as demand for the service grows.
- Plans were in place to introduce a way of undertaking transplant outpatient appointments remotely through online systems such as Skype, so that patients do not miss appointments or have to travel lengthy distances for routine outpatient visits. This we were told would also help with the demand on space within outpatients.
- The cardiology service had established one-stop clinics for patients with cardiology conditions to meet their needs. This meant that patients had better access to the clinic instead of having to visit their GP for a clinical condition-specific query. For example, one patient we spoke with attended to discuss their pacemaker with the staff in the one-stop clinic. The patient told us that it was very reassuring that they could access the clinic because they trusted the staff to respond to the concerns with the pacemaker when their GP may be unable to help.

Access and flow

- The outpatients department undertook 124,066 outpatient appointments during 2013/14, of which 67% were follow-up appointments.
- Meeting the referral-to-treatment time of 18 weeks for cardiology patients in the outpatients department was 98.8% and most other referral-to-treatment targets were also being met.

- For the number of patients requiring an echocardiogram ECHO there had been a steady decrease in the number of patients seen within five weeks. The rates had decreased from 70% in April 2014 to 37% in August 2014.
- The number of patients on the waiting list for diagnostic testing was 734 at 1 November 2014. The majority of these patients waited for sleep studies or computed tomography. There were clear plans in place to reduce the number of patients waiting over the coming months.
- The patient 'Did Not Attend' rate for appointments had been about 6% for the previous 12 months. The hospital implemented an action plan and as a result the rates had reduced to 3.7% by August 2014.
- To enable people to attend appointments and reduce 'Did Not Attend' rates, the trust had introduced some outpatient services in cardiology from 8am and other clinics ran until 8pm. This change and flexibility was well received by patients.

Meeting people's individual needs

- The diagnostic service had recently purchased a new CT scanner that had the capability to scan a person's entire body in one hold of breath. This is an advanced technology item of equipment and is the only one of its kind in England. The ability to scan the body in one breath meant that patients with serious heart or lung conditions could get good imaging results with the minimum of discomfort.
- Within diagnostic services we found that the reporting response rate for radiology tests was lower than the trust's target; there were set targets for all image reports. The trust target was above 80% and at the time of the inspection only 54% of reports were being turned around within the three day timeframe.
- We found that information about a patient's medicines was provided in a variety of ways, including verbal, written and direct teaching of complex techniques, such as home intravenous administration.
- Pharmacy staff were involved in patients' annual reviews and discussed newly prescribed medicines with patients. Staff were also available to provide advice to patients' GPs regarding drug interactions and specialist medicines prescribed at the hospital.
- We spoke with 12 patients, but one patient specifically about the processes in place for receiving their medicines. They gave an example when their GP was concerned about a new medicine for a short-term physical condition so they contacted the hospital

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pharmacy team who advised on an appropriate treatment that did not interact with other prescribed medicines. The patient told us that they felt reassured by the access to the hospital team.

- Staff had received some basic awareness in understanding dementia, though no formalised training had been provided. Information on the Alzheimer's Society was available in the outpatients department and patients with a diagnosis of Alzheimer's and their families were encouraged by staff to complete the 'this is me' booklet from the start of their outpatient journey.
- Staff had not received specific training on how to support patients with learning disabilities. Patients with learning disabilities were treated in the department and staff may benefit from training in this regard.
- Translation services were available through the main switchboard 24 hours a day.

Learning from complaints and concerns

- For the period July to September 2014 the services received 17 complaints and 85 compliments, which meant that a majority of patients were satisfied with their care.
- The governance report meeting minutes for the service demonstrated that learning from complaints was shared.
- We spoke with staff members throughout the inspection working in the outpatients and diagnostic imaging department who informed us that they were aware of complaints that had been reported and what actions were being taken to resolve them.
- Recent complaints included two cases related to delays in patients receiving letters about their outpatient appointment. We saw a report that had identified that there were concerns about issuing letters in a timely way to patients in September 2014, in response the service had a there was a robust plan in place to ensure that letters were being issued in a timely way.

Are outpatient and diagnostic imaging services well-led?

Good



Overall, the service was well-led locally. Staff felt their line managers were approachable, supportive and open to

receiving ideas or concerns. Staff knew and understood the vision of the trust, but this solely focused on the opening of a new hospital and staff knew little about any other key visions for the service.

We found that the local managers demonstrated good leadership within the department and the directorate, but there was a lack of connection between the trust board and the local departments on how they were delivering their vision and strategy.

Outpatient and diagnostic services had a clear vision for developing and improving their services to continually improve patient care; managers were able to demonstrate how this was implemented in practice. Staff told us they enjoyed their work and felt that it made a difference to how patients felt about the hospital.

Vision and strategy for this service

- Overall we found that locally there were visions, values and strategies for each service, but these were different and disconnected from the trust's vision, which went beyond the opening of a new hospital.
- The trust's vision and values were displayed through the hospital. When asked, the staff spoke about the vision and values for the trust, but referenced only the vision to open a new hospital. There was little knowledge about the strategies, vision or future for the service in the interim.
- Locally we observed that the radiology service had a good vision regarding how they would deliver a service and develop and upskill staff to meet clinical demand.
- Therapy services had a clear understanding about where they wanted their service to go, how to expand and develop it and what they needed to deliver this service for the future.
- Within outpatients, the leads for outpatients had a clear vision for the service to meet demand over the next year and were seeking further senior management approval to deliver their local strategy. This included the implementation of Skype as an option for outpatient appointments.

Governance, risk management and quality measurement

- The directorate held governance meetings with the senior managers. These were recorded and disseminated to staff electronically

Outpatients and diagnostic imaging

- Governance systems internally within the directorate demonstrated that information was shared and lessons were learnt about events that occurred within outpatients, but shared learning across directorates was more limited.
- Quality reports were sent to the managers and matrons of outpatients and diagnostics on a monthly basis; this included quality performance against internal key performance indicators and external quality reviews known as CQUINS. The reports detailed performance information as well as the number of incidents and complaints received by services to monitor themes and trends.
- There were local risk registers for directorates that included the outpatient and diagnostic services. These were linked to the main corporate risk register. There were items on the risk register that were vague in description and some had no specified timeframe for completion, for example the expansion of outpatient functions and delivering referral-to-treatment times.

Leadership of service

- Staff informed us that the Chief Executive Officer was visible throughout the hospital and that the executive team sent round regular communications on developments about the new hospital. We were told that any communications received were predominantly about the new hospital.
- Staff we spoke with during the inspection and in focus groups told us that they felt the local leadership for outpatients and diagnostic services within the directorate was good. The leaders were approachable and staff felt that concerns they raised would be addressed.
- Staff also informed us that managers were supportive and because the teams were of manageable size the managers knew all the staff and acknowledged them on a personal level, which they appreciated.
- The staff we spoke with told us that the director of nursing was always helpful and supportive, as was the lead nurse specialists for outpatient services. Staff said that they could approach their line manager and senior managers with any concerns or ideas.

- While we found that staff spoke highly of the senior management, we found little evidence of engagement from other executive board members in outpatient and radiology functions, with the exception of the director of nursing and the chief executive.

Culture within the service

- We spoke with staff openly across the outpatient diagnostic division and about bullying, harassment and whistleblowing. All felt that there was an open culture within the service and had not experienced any bullying or the need to formally raise concerns. They did provide information that occasionally the service was pressured to deliver targets, but this was expected in a busy department.
- The culture within the pathology services was that locally the managers were responsive and open to concerns, but at a senior level action was not taken quickly enough to manage risk. For example, the staff felt that the executive team had not responded quickly enough to the concerns around the retrieval of electronic pathology results and were still waiting for appropriate action to be taken.

Public and staff engagement

- The public were regularly encouraged to provide feedback on the service on-site and through NHS Choices and social media.
- Information was displayed on message boards throughout the outpatient services to engage the public in messages about the service as well as encouraging feedback.

Innovation, improvement and sustainability

- The major risk to ongoing service development and expansion was the department's physical environment. Space was at a premium and as demand increased, the current model, space design and layout may make meeting this demand unsustainable.
- Innovative approaches to support and deliver appointments through avenues such as Skype were being considered by the transplant team, but longer term plans were required to ensure sustainability.
- Locally the staff have been innovative and creative in managing and delivering approximately 120 clinics a week and this demonstrated excellent local innovation and commitment to deliver patient care.

Outstanding practice and areas for improvement

Outstanding practice

- The surgical division's effectiveness and patient outcomes were outstanding and were among the best in the UK.
- The Critical Care Area had recently developed guidelines for the prevention, recognition and management of delirium. This was a multidisciplinary piece of work led by the unit's matrons and also included members of the ALERT team and a consultant intensivist. The guidelines were about to be launched and plans were in place for the work to be shared through conference presentations.
- The hospital had direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, such as details of their current medicine.

Areas for improvement

Action the hospital MUST take to improve

- Stop the practice of routinely preparing medicines in advance of their immediate use, in contravention of the Nursing and Midwifery Council's standards.
- Ensure that incidents are reported in a timely manner and that learning from incidents takes place.
- Ensure that all fire exits are clear.
- Have an effective system in place to ensure that drugs stored in resuscitation trolleys are in date.
- Address the breach of single-sex accommodation on Duchess ward.
- Improve the way in which risk is managed and reported.
- Develop and implement a strategy for patients with a diagnosis of dementia.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

In the medical division:

- Review the routing of outpatients through inpatient wards.
- Address the lack of pre-operative MRSA screening in the catheterisation laboratory.
- Review the management of risk within individual wards and departments.
- Ensure the reporting of incidents in a timely manner.
- Develop cross-directorate learning from incidents.
- Review risk assessments for the location of resuscitation trolleys and fire safety exits.

- Improve the audit process for the maintenance of drugs required for the resuscitation trolleys.
- Review the staffing levels for allied health professionals, particularly occupational therapy, to ensure that they are available as part of the multidisciplinary team.
- Review capacity issues in some of the services, particularly in bronchiectasis services.

In the surgical division:

- Address the lack of clarity in selection criteria or pathways for patients admitted to the Progressive Care Unit.
- Review the use of regular acuity assessments of patients in the unit.
- Consider the use of competency frameworks in the Progressive Care Unit.
- Consider the options available to address the referral-to-treatment time for cardiothoracic surgery.
- Review and address the reasons for the significant number of cancelled operations and high theatre use.
- Consider the provision of a dedicated emergency theatre.

In the critical care service:

- Review the availability of facilities for relatives in the Critical Care Area.

Outstanding practice and areas for improvement

- Review the medical staffing. In terms of the consultant/patient ratio, with up to 33 patients on the unit and one or two consultant intensivists on duty, this falls below the best current evidence ratios as set out in the Intensive Care Society standards.

Regarding end of life care:

- Explore ways to share and highlight the expertise of the end of life team and encourage earlier referral and more open conversations as part of the patient's journey, with greater cross-service working.

In outpatients and diagnostic services:

- Improve the contingency plans to respond to the introduction of the new electronic records system at the nearby acute centre that was providing the hospital with pathology services.
- Assess the suitability of the environment to maintain the expansion of outpatient services.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to- (b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the Regulated activity.' The provider has established a quality assurance system but this is not sufficiently embedded yet to be assured that all risks are identified, assessed and managed to protect people using the service

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises (1) The registered person must ensure that service users and others having access to the premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises , by means of-(a) suitable design and layout. The provider has not appropriately managed the single sex accommodation and provision of privacy and dignity in the ward areas.

Regulated activity	Regulation
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This section is primarily information for the provider

Compliance actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 13 HSCA 2008 (Regulated Activities) Regulations
2010 Management of medicines

13. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity.