This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

Cambridge University Hospital (CUH) NHS Foundation Trust includes both Addenbrooke’s Hospital and the Rosie Hospital in Cambridge. The trust is a 1,268-bedded teaching hospital, which provides acute and specialist healthcare for the local people of Cambridge, together with specialist services, dealing with rare or complex conditions for a regional, national and international population.

Addenbrooke's Hospital provides emergency, surgical and medical care for local people and is the Major Trauma Centre (MTC) for the East of England. It is also a regional centre providing specialist services such as transplantation, cancer, neurosciences, paediatrics and genetics. Based on the same site as Addenbrooke's, the Rosie Hospital is a women's hospital and a regional centre for maternity care.

CUH also provides satellite and outreach services at other locations to meet the needs of patients; for example, in other hospitals, GP practices and patient’s own homes.

The hospital campus opened in 1962 and became a foundation trust in July 2004. The trust serves an estimated population of around 578,264 and employs approximately 10,132 members of staff.

The trust has 1,165 inpatient beds and 103 day care beds; of these, 142 are paediatric beds (122 inpatient and 20 day case) and 54 inpatient wards. In addition, the number of outpatient clinics per week at Addenbrookes is 1,565 and 108 outpatient clinics per week at the Rosie.
Acute hospital sites at the trust

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
<th>Geographical area served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addenbrooke's Hospital</td>
<td>Hills Road, Cambridge CB2 0QQ</td>
<td>Provides emergency, surgical and medical care for local people. Also, a regional centre of excellence for specialist services such as organ transplantation, neurosciences, paediatrics and genetics.</td>
<td>Healthcare for the local people of Cambridge, together with specialist services for a regional, national and international population.</td>
</tr>
<tr>
<td>Rosie Hospital</td>
<td>Hills Road, Cambridge CB2 0QQ</td>
<td>A women's hospital and the regional centre of excellence for maternity care. The hospital has its own theatre suite, fetal assessment unit, ultrasound department and neonatal intensive care unit.</td>
<td></td>
</tr>
</tbody>
</table>
Is this organisation well-led?

To write this well-led report and rate this organisation, we interviewed members of the board, both the executive and non-executive directors, and a range of senior staff across the trust. We met and talked with a wide range of trust staff to ask their views on the leadership, performance and governance of the trust. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes, and papers to the board. We reviewed investigations, complaints and feedback from patients, local people and stakeholders.

**Leadership**

*Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. The trust board had the appropriate range of skills, knowledge and experience to perform its role.*

We undertook checks to determine whether appropriate steps had been taken to complete employment checks for executive staff in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. A fit and proper persons (FPPR) procedure was in place.

Fit and Proper Person checks were in place. We reviewed the personnel files of four executive directors and four non-executive directors to determine the necessary fit and proper person checks had been undertaken. Our checks included the chief executive officer (CEO), Chief nurse, medical director and the chief operating officer. Board members completed annual self-declaration forms to confirm they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found all files we reviewed were fully compliant with FPPR.

*There was clear leadership of the trust to drive and improve the delivery of high quality person centred care.*

The board of directors managed the trust's services and developed plans and strategies for the future. The board included full-time executives and part-time non-executive directors. Non-executive directors are not full-time employees of the trust. They help to ensure the trust is accountable to the people it serves. They are people who have shown an interest in the provision of health services for the local people.

The board included full-time executive directors who oversaw the day-to-day running of the trust and non-executive directors (NEDs) who brought with them a blend of knowledge, experience and expertise from both the public and private sector. The trust board was made up from 16 voting members and one non-voting member, a chair, seven NEDs and nine executive directors. The seven NEDs had joined the trust at a variety of dates between 2012 and 2017.

Since our last inspection, which took place in September 2016, there had been significant changes to the trust board, leading to a stable substantive senior leadership team. The longest standing member of the board was the director of workforce, having been in post since 2014, followed by the chief executive officer (CEO) who had been in post since 2015. Since our last inspection, which took place in September 2016, a number of the senior leadership team had changed, with all interim roles being appointed to substantively. The chair of the organisation had been in post since April 2017 and the trust had also appointed a substantive medical director, chief operating officer, chief finance officer and a director of corporate affairs in 2017. More recently in 2018, a director of strategy and major projects and a director of improvement and transformation. In July 2018, the trust appointed a new chief nurse.
The trust had eight patient governors, one of which was the lead governor, seven public governors and four staff governors on its council. The council of governors helped to shape the strategic direction of the trust. Their role was to hold the non-executive directors individually and collectively to account for the performance of the board on behalf of all trust members and the public. The governors oversaw the performance of the trust, appointed the chairman and non-executive directors and acted as a link between the trust and its members and the wider community. Elections for the patient, public and staff governors took place on a rolling three-year period.

We met with seven of the governors; they told us the trust had open and communicative NEDs and an accessible executive team. They felt they could raise anything with the NEDs, chair and the executives. They were struck by how engaged the NEDs and executive team were. The governors observed committee and public board meetings. They were able to ask questions both before and after the meeting and the NEDs ensured that they received answers. They felt this gave them a better understanding of what was happening throughout the trust enabled them to observe how the NEDs challenged the executive team and made them feel valued. The governors were an active team and were involved in things throughout the trust, for example, patient experience, nutrition and end of life care.

The trust board members were a group of individuals with a wide range of experience, knowledge and skills, and long service in senior management. There was evidence from our conversations with senior people, including the NEDs, of an environment of cohesive constructive challenge among the leadership team and a close working relationship. In addition, we observed though our attendance of one of the trust's board meetings there was constructive challenge among the leadership team. It was apparent the board members were open and challenged each other in an appropriate professional and open manner. Challenge was equally balanced with support.

The trust board and senior leadership team displayed integrity on an ongoing basis. Throughout our well-led inspection, we saw evidence of collective leadership from the trust board with a strong focus on delivering patient-centred care and on staff development. Leadership and expertise were correlated at every level when undertaking tasks. This collective leadership created a culture in which high quality, compassionate care could be delivered. The board was not reliant on any one individual to function effectively. Without exception, we found the board to be a cohesive unitary board that had a shared understanding of not only the trust's issues, challenges and priorities, but beyond, into the wider network system. This was evidenced by everyone we interviewed as part of our well-led inspection.

The trust board played a major part in the Cambridgeshire and Peterborough sustainability and transformation partnership (STP), in order to contribute to improving the health and wellbeing of people living in Cambridgeshire and Peterborough. The chief executive officer, the chair and the Chief finance officer occupying these roles within the STP.

The Board, both the executive directors and NEDs, had the relevant operational and financial experience, qualifications, and expertise. For example, the chief finance officer and NED Chair of the Performance and Finance Committee could clearly articulate the trust's financial position its interdependency with operational pressures and the clinical strategy.

The trust’s senior leadership team had a comprehensive knowledge of the trust’s current priorities and challenges and acted to address them. We attended a trust board meeting in May 2018, and we studied the board minutes and associated papers throughout our inspection. The meetings were well attended and we observed a unitary board where there was appropriate challenge. The meeting was well chaired and there were healthy discussions from and between the executive and
the non-executives. Performance reports were discussed and individuals were well-sighted on the issues presented.

Throughout our core service inspection and staff focus groups, feedback about the executive team was positive. Staff felt that senior leads were invested in the clinical work of the service. Most staff told us the senior leadership team, including the board were engaging and approachable.

The trust had an operational structure which sat across five divisions. These were Divisions A, B, C, D and E. Each division was led by a triumvirate team, consisting of a divisional director, an associate director of operations and a divisional head of nursing. The triumvirate team for each division were supported at a local level by clinical directors, operational managers and matrons. In addition, each division was supported by a divisional head of work force, divisional head of finance, divisional quality manager. Divisions B, C, D and E were also supported by a divisional transformation manager.

The trust recognised the need for leadership to be consistent across the whole organisation, and for it to be clearly focused on delivering high-quality care to patients. Clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership were in place, with a leadership development and training programme under way. The trust was focused on ensuring the values of collective leadership, were modelled by leaders at all levels of the organisation.

Leadership development opportunities were available, including opportunities for staff below team manager level. The executive team were clearly sighted on the development needs of senior staff within the organisation and recognised leadership development and succession planning to empower staff was instrumental to further shaping the culture within the organisation and to ensure the trust continued to develop effective leaders.

Working across the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP) the trust has trained seven facilitators to deliver the Mary Seacole leadership academy programme locally. At the time of our inspection, there had been four cohorts organised with another four cohorts due to take place between January to March 2019. The aim was to bridge the gap in the development for staff taking up their first leadership role.

**Board Members**

Of the executive board members at the trust, 0% were Black Minority Ethnic (BME) and 22.2% were female.

Of the non-executive board members, 0% were BME and 37.5% were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>37.5%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board tab)

Of the executive and non-executive board members at the trust, 0% were BME, this was not reflective of the local population. However, the trust was aware of this and were undertaking work to develop a more diverse senior leadership team. The board was working to support actions to address talent management of staff from a BME background. In addition, all board members were going to be taking part in a BME reverse mentoring programme. The next cohort was due between October 2018 and April 2019. The trust had also recently established a new workforce race equality standard (WRES) implementation group, which was a multidisciplinary group, chaired by
the associate director of workforce with representation form the BME workforce. The chief executive officer was the BME network board champion.

**Vision and strategy**

The trust had a clear vision for what it wanted to achieve, which had been developed with staff, patients and external stakeholders, and there was a realistic strategy with workable plans to progress and take action.

The trust had a clear vision that was underpinned by deep rooted values. The trust’s vision was to improve people’s quality of life through innovative and sustainable healthcare. The trust’s values were to work together to be safe, kind and excellent. These values defined the way everyone within the trust worked and behaved towards patients, partners and each other. The trust’s shared values were developed by staff and patients. Staff throughout the core services we inspected were aware of the values and we saw that staff provided a kind and compassionate service for patients. Staff were also aware of how the values were aligned to their work and the work of their team.

The values were a key focus of the trust’s corporate induction programme and managers were clear how their teams delivered them. For individual staff the trust's values were a key element of appraisal, which included demonstrating how they had incorporated the values in their work over the last year. The trust's values were displayed throughout the hospital to inform patients and members of the public of the trust’s values.

The trust’s vision and values were embedded at board level and were demonstrated through how the senior leadership team operated. The board culture was open and honest and demonstrated respect for patients and those who worked in the trust. Without exception, every member of the senior leadership team demonstrated they were proud of their workforce and the importance of being there for the population they served.

To achieve their vision, the trust had a robust and realistic strategy for achieving its priorities and developing good quality, sustainable care. The strategy had been developed in consultation with the trust’s staff, patients and partners to ensure it reflected something meaningful to all. The trust was focused on ensuring the patient was central to everything it did and to ensure the trust was an exciting and supportive place to work. This was demonstrated throughout our well-led inspection when we interviewed members of the senior leadership team.

The strategy, entitled CUH together strategy had three strategic aims, these were to:

- Become sustainable by 2021 across finance, care quality, teaching and research
- Build on the trust’s position at the centre of a biomedical hub
- Maximise the benefits for patients, staff and the UK economy through four major programmes (priorities) of work over a three to five year time period

The four priorities were:

- Improving patient journeys – We want our patients to have the best possible outcomes and experience, receiving care from the right teams at the right time. We will constantly strive to improve the way we organise our services. From the smallest change in a local ward or department to trust-wide projects, we can all make a positive difference to the way that we care for patients while they are in our hospitals.
- Working with our communities – We will work closely with partners to ensure that organisational boundaries do not get in the way of providing better health and social care for our local population. That means working together to provide care closer to people’s homes; having timely access to specialist services when needed; and ensuring patients can leave hospital for a more appropriate care setting as soon as they are ready to do so.
• Strengthening the organisation – We will invest in our people and make sure this is a great place to work, supporting all our staff in caring for our patients and making improvements in services. We will also invest in facilities, technology and equipment within the financial constraints we face. And we will improve the way that we organise ourselves and make decisions to benefit patients and staff.

• Contributing nationally and internationally – Located at the heart of the Cambridge Biomedical Campus, we will be a leader in the UK life sciences sector and bring together the latest advances in science and medicine through world-class research and education to develop new forms of disease prevention, detection and treatment for our patients.”

These four priorities were focused on improving quality, safety and experience of care for patients. Each priority had annual objectives for 2018/19 and three year objectives for 2018/19 to 2020/21.

The strategy and plans in place were fully aligned with plans in the wider health economy including working to improve the mental and physical health of the local population, and there was a commitment by all board members to system-wide collaboration and leadership.

The trust leadership team were outward focused and acknowledged the importance of improving the care for people using a variety of services. They had employed an executive director of strategy and major projects to focus on the trust’s highest strategic priorities, including through collaboration with external partners, to improve outcomes for patients. One of these projects was the development of a regional children’s hospital to serve the East of England. This would provide outreach to other hospitals in order that children and parents could receive care closer to home. Shortly after our inspection we were informed that capital funding for this had been approved.

One of the trust’s priorities was to contribute nationally and internationally, and the trust had submitted a proposal to build a cancer research hospital in partnership with the University of Cambridge and industry. The trust was thinking carefully and creatively in relation to funding and was working with stakeholders and industrial sponsors to raise capital.

The trust had a strategy governance structure and this was used to monitor progress and delivery against the strategy and local plans. The strategy steering group monitored delivery and performance of the strategic programmes of work implementing the strategy against planned outcomes, escalating and escalated significant issues to the management executive by exception as required. In addition, there was also a governor’s strategy steering group that provided a forum for communication with governor representatives, enabling them to help shape strategy development.

Board meeting minutes we reviewed demonstrated an update was provided to the board of directors in September 2018, where the board was asked to comment and provide feedback on a proposed plan for monitoring the strategy and plan going forward.

Work undertaken so far had identified there would be 17 cross-cutting programmes under the trust’s four strategic themes. Each core programme had an executive sponsor and work was required to ensuring a high degree of collaborative working across teams was essential.

The trust had taken steps to start to embed the vision, strategy and values throughout the organisation. For example, staff had access to a quality guide, there was also a CUH together leaflet that had been distributed to all staff. This information had also been used as a tool for discussion with teams and with individuals, for example as part of their appraisal about how their work fitted in with the strategy. This information was also available to members of the public through the trust’s public facing webpage.

The trust had a pharmacy and medicines optimisation (MO) strategy (2018-2021), which was aligned with the trust’s vision and strategy as well as the national hospital pharmacy transformation plan (PTP). Key priorities for the MO strategy included:
• Transformation of pharmacy clinical services across seven days
• Digital enabling of medicines handling and pharmacy/medicines optimisation services.
• Collaborative working with the local sustainability and transformation partnership (STP) to create a system wide strategy and joint formulary
• Expansion of education, training and research capabilities of pharmacy staff

The MO strategy was shared with the trust board of directors through the Quality Committee. Progress on the implementation of the strategy was reviewed monthly against set performance metrics and reported annually to the Quality Committee.

Key achievements to date based on the Carter metrics included in the HPTP:
• An increase in the time spent by pharmacists on clinical activity (currently 72%, baseline 50%)
• An increase in the number of pharmacists who hold the independent prescribing qualification (currently 59%)

Data collection on the percentage of medicines reconciliation completed within 24 hours remained a struggle (estimated at around 60%) but the department was working on using the trust’s electronic prescribing system to obtain data more robustly for this metric in addition to using information from a range of sources to ensure the right patients were seen, based on risk and acuity.

The trust had a strategy for the management of risks associated with infection prevention and control. This set out the priorities relating to how the trust achieved compliance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.

In addition to the CUH together strategy, the medicines optimisation strategy and the strategy management of risks associated with infection prevention and control, the trust also had a number of other strategies, such as:

• Learning disability strategy
• Dementia strategy
• End of life care strategy
• Risk management strategy
• Membership strategy
• Workforce strategy
• Information governance strategy
• Digital strategy

**Culture**

**Managers at all levels at the trust were committed to promoting a positive culture that supported and valued staff, created a sense of common purpose based on shared values. Staff felt supported, respected, and valued.**

The trust’s strategy, vision and values also underpinned a culture that was patient focused and centred and every conversation we had with members of the senior leadership team focused around what was right for patients.

Members of the executive team told us how they felt proud of their colleagues and workforce throughout the trust. They demonstrated a shared purpose by where they were encouraging and motivating staff to improve and succeed.
Triumvirate leadership teams told us the culture within the trust was positive and that they found the executive team extremely supportive. We heard the healthcare groups and divisions were supportive of each other and where appropriate, they worked in collaboration.

Managers across the trust promoted a positive culture that supported and valued staff, created a sense of common purpose based on shared values. Leaders at every level of the organisation encouraged pride and positivity within the organisation to empower staff to make decisions and to put patients at the centre of their care. We met with all divisional leads and all were keen to receive feedback and support staff. Divisional leads had different ways of encouraging staff to feel involved and valued within the organisation. One division was using postcards to engage new staff in feeding back their experiences at the start of their career with Cambridge University Hospitals NHS Foundation trust. Others had similar ways of engaging staff and empowering them to make changes to the way in which they worked.

We met with different grades of staff throughout our core service inspection, and prior to our inspection we held staff focus groups. We also received staff feedback through our National Customer Service Centre. Most staff we spoke with felt equally respected, supported and valued. Most staff felt positive and proud about working for the trust and their team and were encouraged to instigate change through a quality improvement process. Given the size of the trust and the number of staff employed, a low number of staff told us they felt morale was low.

During our interviews with the executive and non-executive team, we observed that leaders were aware of areas where morale was low and were taking action to address concerns. In addition, there was a strong emphasis on the wellbeing of staff throughout the organisation. This was also emphasised in the trust’s quality plan 2018 to 2023, where one of the priorities was to further improve the health and wellbeing of staff to ensure a fit-for-purpose workforce, leadership team and organisational culture.

The trust’s organisational development programme aimed to improve culture, leadership and engagement, which had moved on significantly since our last inspection.

**NHS Staff Survey 2017 – results better than average of acute trusts**

The trust has 15 key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 11. Percentage of staff appraised in last 12 months</td>
<td>95%</td>
<td>86%</td>
</tr>
<tr>
<td>Key finding 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>29%</td>
<td>31%</td>
</tr>
<tr>
<td>Key finding 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Key finding 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.78</td>
<td>3.73</td>
</tr>
<tr>
<td>Key finding 31. Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.70</td>
<td>3.65</td>
</tr>
<tr>
<td>Key finding 17. Percentage of staff feeling unwell due to work related stress in the last 12 months</td>
<td>34%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Key finding 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 18</td>
<td>49%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Key finding 19. Organisation and management interest in and action on health and wellbeing

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 19</td>
<td>3.69</td>
<td>3.62</td>
</tr>
</tbody>
</table>

Key finding 15. Percentage of staff satisfied with the opportunities for flexible working patterns

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 15</td>
<td>57%</td>
<td>51%</td>
</tr>
</tbody>
</table>

Key finding 1. Staff recommendation of the organisation as a place to work or receive treatment

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 1</td>
<td>3.92</td>
<td>3.75</td>
</tr>
</tbody>
</table>

Key finding 6. Percentage of staff reporting good communication between senior management and staff

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 6</td>
<td>35%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Key finding 2. Staff satisfaction with the quality of work and care they are able to deliver

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 2</td>
<td>3.96</td>
<td>3.91</td>
</tr>
</tbody>
</table>

Key finding 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 22</td>
<td>13%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Key finding 23. Percentage of staff experiencing physical violence from staff in last 12 months

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 23</td>
<td>1%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Key finding 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 25</td>
<td>24%</td>
<td>28%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

Throughout our core service inspection, staff told us they received regular appraisals, which they found meaningful. Staff also told us that as part of their appraisal, they discussed their development and any training needs to facilitate their revalidation. The trust set a target appraisal rate of 90% and data provided by the trust indicated they mostly met this target. This was also indicated in the 2017 NHS staff survey, where 95% of staff indicated they received an annual appraisal, which was better than the national average of 86%.

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has five key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 20</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Key finding 21</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Key finding 4</td>
<td>3.89</td>
<td>3.92</td>
</tr>
<tr>
<td>Key finding 8</td>
<td>3.87</td>
<td>3.91</td>
</tr>
</tbody>
</table>
Key finding 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

<table>
<thead>
<tr>
<th></th>
<th>42%</th>
<th>45%</th>
</tr>
</thead>
</table>

(Source: NHS Staff Survey 2017)

Throughout our conversations with the senior leadership team and with divisional managers we heard the senior team were concerned that staff did not always treat each other with civility. Whilst we did not hear of this from the junior staff our teams spoke to the senior leaders were concerned that everyone treated each other with dignity and respect. They were championing and role modelling positive behaviours in order that all staff treated each other well.

Staff Diversity

The trust provided the following breakdowns of medical and dental, nursing and health visiting and nursing and midwifery staff by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff</th>
<th>Qualified nursing &amp; health visiting staff</th>
<th>Nursing and midwifery staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>White – British/Irish/any other white background</td>
<td>61.3%</td>
<td>59.3%</td>
<td>89.7%</td>
</tr>
<tr>
<td>BME - British</td>
<td>17.9%</td>
<td>4.9%</td>
<td>3.3%</td>
</tr>
<tr>
<td>BME - Non-British</td>
<td>15.5%</td>
<td>18.1%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Not stated</td>
<td>5.3%</td>
<td>17.8%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

As of March 2018, the trust employed 10,006 members of staff and 19.1% (1,915) of these staff were from a BME background, which was greater than the local population of Cambridge City at 17.5%.

The trust had an equality and diversity lead and recognised that equality and diversity for staff, patients and the public was central to their values and behaviour standards. The trust had several groups in place to oversee any issues associated with equality and diversity, for example there was an equality, diversity and dignity steering group, which was responsible for leading on monitoring and evaluating equality and diversity within the trust. In addition, staff networks were in place promoting the diversity of staff. For example, there was a BAME staff network, an equality and diversity staff group, a LGBT and straight alliance and a learning disability working group.

The trust used the Equality Delivery System (EDS2) as a tool to drive equality improvements to engage with patients, staff and the community to review service and equality performance and to identify future priorities and actions for the trust’s equality objectives.

The Trust’s EDS improvement plan for 2017 to 2018 was agreed following an EDS equality engagement and rating event on 26 September 2016, with a panel of community groups who rated the trust’s equality performance, identified the EDS outcomes to focus on for their equality objectives and a revised EDS improvement plan to meet them was then agreed. The EDS improvement plan was a standing agenda item at the trust’s Equality Diversity and Dignity Steering Committee meetings which met on a quarterly basis.

The trust published the results of the EDS2 rating report and annual equality objectives on its external website, so they were available for members of the public to view.
Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) is designed to help organisations gauge their current state of race equality and track what progress is being made to identify and promote talented black, Asian and minority ethnic (BAME) staff, as well as helping to eliminate wider aspects of discrimination in the treatment of BAME staff.

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The WRES takes a small number of indicators and requires NHS organisations to close the gap between the BAME and white staff experience for those indicators.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</th>
<th>Your Trust in 2017</th>
<th>Average (median) for acute trusts</th>
<th>Your Trust in 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>White 23%</td>
<td>27%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 24%</td>
<td>28%</td>
<td>24%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>White 24%</td>
<td>25%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 29%</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>White 86%</td>
<td>87%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 70%</td>
<td>75%</td>
<td>74%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?</td>
<td>White 8%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 17%</td>
<td>15%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Of the four questions above, the following three questions showed a statistically significant difference in score between White and BME staff:

- Key finding 26. Percentage of staff experiencing harassment, bullying or abuse from staff the last 12 months
- Key finding 21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
- Question 17b. In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues?

(Source: NHS Staff Survey 2017)

In relation to key finding 21, Percentage of staff believing that the trust provides equal opportunities for career progression or promotion; most staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. However, these figures had reduced slightly from 2016. WRES was high on the trust’s agenda and
an action plan had been co-produced with BME staff and directors following a joint focus group involving the Director of WRES Implementation team at NHS England.

The trust had used the nine WRES indicators to help them better understand why BME staff often receive poorer treatment or opportunities than white staff and act to close the gaps in treatment and experience. However, the trust recognised there was still work to be undertaken in relation to closing the gap. The trust had published the results of the Workforce Race Equality Standard (WRES) survey on their website.

The trust had a duty of candour policy, which set out the responsibilities of staff at all levels to be open and honest throughout the organisation. It also set out the process for being open. Staff we spoke with throughout our core service inspection described a no blame culture and how they were actively encouraged to raise concerns and report incidents without fear of retribution. They also told us they were encouraged to be open and honest in relation to issues arising. Candour, openness, honesty, transparency and challenges to poor practice were encouraged by senior leaders. The senior leadership team actively promoted staff empowerment to drive improvement. Staff felt they could actively raise concerns and report incidents without fear of reprisal and those who did told us they were supported.

Duty of candour was reported on at the board’s bi-monthly public board meetings as part of the integrated report. At the November 2018 board meeting we saw that up to July 2018, the trust had achieved 100% for stage one and stage two of the duty of candour process. However, between October 2017 to September 2018 the trust had achieved trust wide duty of candour compliance within the 10 working days timeframe between 54% and 88% of the time.

Throughout our inspection of the core services, many staff told us they were encouraged to speak up if they experienced any concerns.

Following Sir Robert Francis’s Freedom to Speak Up (FTSU) review in 2015, NHS England and NHS Improvement expected all NHS organisations in England to adopt the Freedom to Speak Up: Raising Concerns policy for the NHS (April 2016), as a minimum standard. The trust had appointed a freedom to speak up guardian who worked with the trust leadership teams in continuing to be an open and transparent organisation and to enable a safe means by which staff could speak up. In addition, the trust had 12 local speaking up listeners who supported the freedom to speak up guardian to ensure staff had easy access to a trusted colleague.

The trust took whistleblowing seriously and had a designated executive lead to support staff in raising concerns. The freedom to speak up guardian was passionate about enabling staff to raise concerns and providing a link by which they could be heard.

Other routes for raising concerns included a confidential raising concerns line and email address. The 2017 staff survey indicated that 95% of staff knew how to report concerns about unsafe clinical practice. Staff we spoke with throughout our core service inspection, knew about the whistleblowing process and how to raise concerns.

The trust submitted information to the National Guardian’s Office on the cases that had been raised with the trusts freedom to speak up guardian. Between July 2018 and September 2018 staff had raised 20 issues.
From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person.

Systems and processes were in place to address behaviour and performance that was inconsistent with the trust's vision and values. The trust suspended or supervised the practice of 35 staff from 2016 up to 26 July 2018.

**Friends and Family test**

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored about the same as the England average for recommending the trust as a place to receive care from September 2017 to August 2018.

![Graph showing attendance rates for the trust and England average](image)

(Source: Friends and Family Test)

Throughout our core service inspection, we spoke with patients about the care and treatment they had received by the trust. All patients we spoke with were positive about the care and treatment they had received.

**Sickness absence rates**

The trust’s sickness absence levels from June 2017 to May 2018 were below the England average. The rates followed a similar trend to the England average throughout the period, with an increase in sickness rates over the winter period.
The trust had an occupational health department, through which staff could access support for their own physical and emotional health and wellbeing.

**General Medical Council – National Training Scheme Survey**

In the 2018 General Medical Council Survey the trust performed the same as expected for all indicators.

*(Source: General Medical Council National Training Scheme Survey)*

**Governance**

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers and leaders regularly reviewed these structures.

The trust had an accountability framework, the purpose of which, was to support the achievement of the trust’s objectives in a way that was consistent with the trust’s values. The accountability framework established expectations at all levels of the organisation, including across the clinical divisions. It provided clarity on the how the trust was organised, where responsibilities for decision making lay, how issues and risks were escalated, and how progress was reported and monitored in an open and transparent way.

Governance and lines of accountability at this trust was complex, but the trust board was supported by five board assurance sub committees that met regularly to ensure trust services and systems were performing to required expectations. These included the:

- **Audit committee**, which met five times a year. This was chaired by an appropriate non-executive director, and the executive lead for this committee was the chief finance officer. The audit committee provided independent assurance to the board on the adequacy of the
trust's systems and processes for corporate, governance, integrated risk management and internal control. It also monitored and reviewed organisational and financial risks, and sought assurance from the quality committee on all matters of clinical governance and clinical risks.

- **Quality committee**, which met bi-monthly. This was chaired by an appropriate non-executive director and the executive leads were the chief nurse and the medical director. The quality committee provided assurance to the board on all aspects of the quality of care provided to patients, and ensured the trust had adequate and appropriate quality governance structures, processes, systems and controls in place to achieve quality care.

- **Remuneration and nomination committee**, which met at least annually. This committee was chaired and led by an appropriate non-executive director. This committee was responsible for appointing the chief executive, executive directors and senior managers for the trust. It also advised the trust board on size, structure and membership of the board and executive directors.

- **Performance committee**, which met monthly. This committee was chaired by an appropriate non-executive director and the executive leads were the chief finance officer and the chief operating officer. This committee provided the board with independent and objective oversight and assurance on the financial and operational performance of the trust.

- **Workforce and education committee**, which met quarterly. This committee was chaired by an appropriate non-executive director and the executive lead was the director of workforce. This committee provided assurance to the board on the development and effective delivery of the trust’s workforce, organisational development, and education strategies, including performance against key performance indicators and the management of key risks.

These board assurance committees provided assurance to the board on the performance and operation of the trust. Each of these committees had terms of reference, all of which were in date for review.

The trust had a clear structure to indicate further groups, such as the quality steering group, the clinical effectiveness group, patient experience group and the patient safety group that fed into the quality committee. The trust also had a management executive risk oversight committee, which received exception reports, including the top risks from divisions and corporate areas and escalation from performance reviews, clinical effectiveness, patient experience and patient safety. The weekly serious incident executive review panel also reported directly to the management executive risk oversight committee. The management executive risk oversight committee reported directly to the board.

The board of directors held public meetings six times a year. The meetings covered a range of strategic as well as operational topics. Members of the public were invited to attend the board meetings. In addition, the trust chair was available to meet with members of the public to discuss issues in the months when the board of directors did not meet in public. Proposed dates and times for these meetings was published on the trust's public facing web page.

We studied board and committee papers and attended a trust board meeting in May 2018. Papers for board meetings and other committees were of a good standard and contained appropriate information. Board minutes evidence that an appropriate amount of time was spent discussing finance and other resourcing issues (including workforce and estates). Non-executive and executive directors were clear about their areas of responsibility, each holding a portfolio. All the
executive and non-executive directors we spoke with were aware of what sat in their portfolio and what sat in the portfolio of others.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. We observed an open and honest culture which encouraged blame free reporting of issues and this promoted a culture of learning, learning from mistakes and improvement.

Mental health was integrated into the trust’s governance structure. The trust had a mental health committee, which was a sub group of the joint safeguarding committee. This committee was chaired by the chief nurse and was attended by staff from the neighbouring Mental Health Trust, as well as relevant senior members of staff from Cambridge University Hospitals NHS Foundation Trust. The committee produced a Mental Health Act report that was presented to the board as part of the trust’s integrated report on a quarterly basis.

A neighbouring mental health trust provided a mental health liaison service to the trust and the trust was a member of the psychiatric liaison accreditation network (PLAN). Liaison Psychiatry is a sub-specialty that provides psychiatric treatment to patients attending general hospitals. Therefore, it deals with the interface between physical and psychological health. The trust were one of five services in the UK and Ireland who had achieved an ‘excellent’ rating through this accreditation process. This service was available 24 hours a day, seven days a week.

Pharmacy and Medicines Optimisation was integrated into the trust’s governance structure. Evidence of the reporting structure across divisions and various committees was seen and there were no identified gaps in reporting lines of communication. The chief pharmacist was a member of the quality steering group and was accountable to the medical director.

The Medicines Safety consultant pharmacist attended the patient safety group and reported on medicines safety. Other members of the pharmacy department also reported into various committees such as the Drug and Therapeutics Committee, Antimicrobial Stewardship, Homecare subgroup and the Controlled Drug (CD) steering group. Senior pharmacists also report quarterly to each division on medicines safety and governance.

The pharmacy team had input into medicines management training for nursing staff. The consultant pharmacist in Medicines Safety (MS) had developed core medicines training packages for nurses which included training on the self-administration of medicines and at the time of our inspection, was designing learning packages on insulin, opiates and anticoagulation medicines.

During our inspection we found that nurses were issuing medicines on discharge from pre-labelled stock. Although there was a trust policy in place, there were no records of training and competency assessment of staff. The MS consultant told us however, that training on the supply of pre-labelled medicines was incorporated into the mandatory medicines management training for nurses. In addition, there was also an audit being undertaken on the accuracy of nurse checks of patients’ own medicines. Findings from the audit were going to be used to inform the training provided on medicines management.

The trust recognised that good patient care was dependent on building good relationships with other hospitals, GPs and the local authority and was readily engaged with partnership working and were able to demonstrate where this was the case, for example the trust worked closely with their local mental health trust, GPs, hospitals, as well as local universities and charities. The trust was
passionate about and was engaged in the Cambridgeshire & Peterborough sustainability and transformation partnership (STP) working and had ensured its strategy aligned with the STP priorities. The trust chair, chief executive officer and chief finance officer also held these roles within the STP.

**Board Assurance Framework**
The trust’s director of corporate affairs was the corporate governance lead for the organisation and supported the executive and non-executive directors in risk management and took the lead for maintaining the board assurance framework (BAF). The BAF defined the principal risks to achieving the trust’s strategic objectives together with associated controls, sources of assurance and action plans.

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of these is below.

1. Improving patient journeys
2. Working with our communities
3. Strengthening the organisation
4. Contributing nationally and internationally

*(Source: Trust Quality Report 2017/18)*

The BAF had a front sheet that gave an overview of each risk and was ranked by risk rating. At the time of our inspection, there were 12 strategic risks on the BAF, four had a current rating of 20, four were rated at 16, one was rated at 15, five were rated at 12 and one was rated at 10. Accountability lines were clearly defined and were communicated to everyone involved. For example, an executive lead had been identified as well as the board monitoring committee.

Each risk had an action card that detailed the strategic objective, the risk, the executive lead and the board monitoring committee. The risk rating was clear, reference to any corporate risk register entries, key controls and assurances on controls. Gaps in control and actions to address gaps in control were clearly identified along with a due date. The risk score for each month was clearly identified, so it was easy to see whether risks had increased, decreased or stayed the same. The BAF was clear and easy to follow.

We reviewed a selection of the risks on the BAF. These risks were clearly linked to relevant risks on the trust’s corporate risk register and had been reviewed on a monthly basis. An executive lead had been identified and key controls were in place. The board received assurances from a number of sub committees.

Our interview with the director of estates and facilities confirmed the trust had an estates strategy and that appropriate plans were in place for managing the top risks associated with the environment, such as the backlogs maintenance, fire safety, and capacity and availability of capital.

The BAF was integrated into the trust’s governance processes and was reviewed by the appropriate committees within the timeframe identified. The BAF was reviewed at board level on a quarterly basis. However, all members of the executive team met monthly where scrutiny of the BAF took place. There was evidence of monthly reviews of the BAF at all relevant formal meetings of the board, sub and executive committees.
Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, the trust was in a challenging financial position.

The trust had a robust and effective framework in place to provide assurance around the quality of care it offered and to monitor organisational performance. The board of directors and executive director-level groups received regular performance reports which presented performance against national and local targets and priorities. These reports adopted a risk-based approach to reporting to ensure that the consequences of under-achievement were highlighted to the executive team and board of directors, as well as the actions that were in place to improve performance. The framework provided a good level of assurance and supported effective decision making.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The chief nurse was the nominated executive director responsible for ensuring the trust had appropriate arrangements in place for managing and reporting incidents.

All patient safety incidents were reported on the trust’s quality surveillance information system (QSIS) and were reviewed and investigated locally, with actions developed in response.

There was a clear policy for the management of incidents and serious incidents requiring investigation.

Finances Overview

NHS Improvement’s single oversight framework provides the framework for overseeing providers and identifying potential needs for support. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

Based on the information from these themes, providers are segmented from one to four, where four reflects providers requiring the most support and one reflects providers who have maximum autonomy. At the time of our inspection, the trust was in segment two.

The senior finance team at the trust were a stable and experienced team. As well as two experienced and able deputy directors of finance, the trust also had a director of commissioning. The executive and senior leadership team at the trust demonstrated a shared knowledge of the financial issues faced by the trust and engage positively with NHS Improvement when discussing financial performance and issues impacting upon their financial sustainability.

Delivery of the financial plan was a documented risk on the trust’s board assurance framework (BAF). In July 2018, the risk level for the financial plan had been reduced from 16 to 12, reflecting the controls the trust had put in place to manage the risks associated with this. Controls include budget holder training and acknowledgement of the Plan and cash requirements by NHSI.
The trust had key controls in place to manage the risk and assurances on these controls was gained from a monthly review of financial performance by the non-executive chaired performance committee and through the board of directors group meeting. In addition, the trust had monthly performance review meetings with NHS Improvement.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£779.5m</td>
<td>£856.7m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£53.1m)</td>
<td>(£32.4m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£832.6m</td>
<td>£889.1m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£53.6m)</td>
<td>(£42.1m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Financial outcomes had improved over recent years following the introduction of enhanced project management arrangements, especially in relation to the development and delivery of the trust’s cost improvement programme (CIP) plan.

Whilst, the trust’s financial position needed further improvement, it exceeded delivery against its plan in 2017/18 and received additional sustainability and transformation funds (STF), which it had been able to use to fund part of its capital programme in 2018/19.

The trust routinely reviewed its performance against the plan. The trust’s chief finance officer presented a finance report which set out the trust’s financial position to the board at each public board meeting. At the most recent board meeting the chief finance officer reported for September 2018 (month six) and reported the trust’s year to date deficit stood at £51.6m, which was on plan. The financial information provided to the board was clear and consistent with the monthly financial returns submitted to NHS Improvement.

Finance was also discussed at divisional governance meetings, where the divisions discussed their financial plans and delivery of CIPs.

Where CIPs were taking place, there were plans in place to consider the impact on patient care. Each CIP was subject to a quality impact assessment before being approved and included in the CIP overall plan. Throughout our well-led inspection and discussions with the executive and non-executive members of the team, we were assured that quality impact was a real focus when looking at business cases and CIPs.

The Trust routinely engaged with NHS Improvement where required in terms of taking advice or seeking support on significant issues such as management of its capital programme.

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust. Please see the separate use of resources report for details of the assessment.
Trust corporate risk register

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff told us was on their worry list. The trust had sight of their most significant risks and these had been recorded on the trust’s corporate risk register of board assurance framework.

The trust had a risk management strategy and policy, which provided the overarching principles, framework and processes to support managers and staff in the management of risk. The trust’s overall strategic aim was to make the effective management of risk an integral part of everyday management practice.

Since our last inspection, the trust had made significant progress in strengthening their risk management process and together the director for clinical quality and the director of corporate affairs had worked together to review the trust’s risk register and board assurance framework.

The corporate risk register was reviewed monthly by the risk oversight committee and governance of risk was effectively monitored through the:

- Board of directors
- Executive team
- Divisional management teams

The trust provided a document detailing their 18 highest profile corporate risks. The 10 risks with a red RAG rating indicating a current risk score of 15 or over are shown in the table below. These were last reviewed in August 2018.

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR03</td>
<td>Risk to water quality and water borne infections - Legionnaires Disease/ Pseudomonas</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>CR04</td>
<td>Risk of not replacing unsupported/aging/ unsuitable medical equipment</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>CR05</td>
<td>Insufficient trust space/capacity to adequately meet patient needs</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>CR10</td>
<td>Resilience in the high voltage electrical infrastructure</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>CR13</td>
<td>Management of mental health patients in ED/CDU</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>CR14</td>
<td>Information governance breaches - patient data</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>CR21</td>
<td>Asbestos management - site wide</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>CR22</td>
<td>Non-compliance with fire regulations in clinic 8</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>CR23</td>
<td>Subcontractor failure/ liquidation</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>CR24</td>
<td>Site wide ventilation</td>
<td>16</td>
<td>8</td>
</tr>
</tbody>
</table>

(Source: Trust Corporate Risk Register)

The trust board had sight of the most significant risks and mitigating actions were clear. Staff had access to the risk register at team and division level and could effectively escalate concerns as needed.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their ‘worry list’.
Throughout all our interviews undertaken at both our well-led inspection and at core service level, staff were clear about risks within their division and corporately throughout the trust. Staff concerns matched those on the risk register.

As part of the risk assessment process, risks were scored and graded monthly, regardless of the level of risk. The risk register documented whether the risk had increased, decreased or stayed the same for each month. The risk register documented a lead director, description of the risk, inherent rating, current rating and target rating. It also identified the controls, gaps in controls, assurance and gaps in assurance. However, the risk register did not identify the date the risk was added to the risk register. It was therefore difficult to see how long the risk had been on the risk register. We raised this with the director for clinical quality who assured us the date would be visible on the trust’s quality surveillance information system (QSIS).

The trust had a separate pharmacy risk register, which clearly defined risks relating to pharmacy and there was a comprehensive plan in place to manage these risks. Several high-risk issues (such as verification of prescriptions by pharmacists and supply of immunosuppressants to transplant team) in the register were arising from lack of capacity in the team.

There were several internal audits being undertaken to review the clinical input and impact of various pharmacy teams, for example the SAFE pharmacist role, respiratory, antimicrobial stewardship, and the emergency department. The audits helped to identify any issues and make improvements where necessary.

During our core service inspection, we identified an issue relating to the safe storage of medicines, whereby the date of opening was not written on liquid medicines. To tackle this issue in the past the pharmacy department had introduced the use of stickers to remind staff to record this. The pharmacy department undertook regularly medicines storage and security audits and were looking to review the audit requirements to include liquid medicines. In addition, we also had a concern about the clarity of the trust’s guidance relating to the escalation of medicine fridge temperatures. At the time of our inspection an audit was being undertaken by the pharmacy department to look at whether issues with fridge temperatures were being escalated appropriately, and the trust was also considering changing to an automated process for temperature monitoring to tackle these issues.

There were plans in place for emergencies and other unexpected or expected events. For example, adverse weather, a flu outbreak or a disruption to business continuity. A business continuity plan was in place to support the trust in anticipating risks for the purpose of reducing them or preparing for them.

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

The trust was aware of its performance using key performance indicators (KPIs) and other metrics. For example, targets had been set for mandatory training, harm free care and hand hygiene amongst other elements of care. These were monitored through the trust’s quality dashboard.

Information governance is a framework that ensures personal and corporate information is dealt with legally, securely, efficiently and effectively to appropriate ethical and quality standards. Information governance systems were in place including confidentiality of patient records. The trust had an information governance and information security policy and an information
governance strategy. There was also an information governance steering group. The director of improvement and transformation who was the trust’s senior information risk owner (SIRO) reporting to the board. There was also a Caldicott guardian who was responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

The Information Governance (IG) Toolkit is a self-assessment audit completed by every NHS Trust and submitted to NHS Digital on 31 March each year. The Trust complied with the requirements of the NHS Digital Information Governance Toolkit for the management and control of risks to information. The current level of compliance with the Information Governance Toolkit at this trust was 83%.

Information governance breaches was featured on the trust’s risk register, with a risk score of 15 (extreme risk). Between August 2017 and July 2018 there had been 33 data security breaches across the trust. The main themes of the incidents were that information such as discharge letters had been given or sent to an unintended person. The trust had clear guidance about the types of information governance breaches that were required to be reported to the information commissioner’s office. Each case was assessed and graded to establish whether it needed to be reported to the information commissioner’s office and appropriate action was taken. These breaches were treated as serious incidents and were reported to the clinical commissioning group (CCG).

Integrated reporting supported effective decision making. The trust had innovative information systems and processes. These systems were used to drive and support internal decision making as well as system wide working and improvement.

In 2014, as part of its eHospital digital transformation programme, the trust introduced a secure state of the art electronic patient record system across Addenbrooke’s and the Rosie hospitals.

In line with the Carter report 2016, and recommendations to have key systems in place, the trust had embraced digital technology and had fully integrated and used e-rostering systems; e-prescribing systems; patient level costing and accounting systems; e-catalogue and inventory systems for procurement; electronic health records and systems associated with systems to ensure equipment was maintained.

The trust had also integrated digital systems that interfaced with primary care providers such as GPs and community nurses to securely access clinical patient information directly from the trust.

At the time of our inspection, the trust had been ranked internationally amongst the elite health care organisations to recognise best practices through the adoption, use and implementation of information technology.

CUH was the first NHS trust to implement the EPIC electronic patient record system across both its hospitals in October 2014, and the first to launch a patient portal (MyChart) that integrated directly with an electronic patient record system, giving patients access to their medical information. In 2017, NHS England selected CUH as one of 16 Global Digital Exemplar (GDE) trusts – those who were leading the way in digital healthcare and supporting other trusts to develop digitally.

The board were aware of national risks, including cyber-security, and supported information management and technology colleagues to ensure appropriate strategies and systems were in place. In addition, a wide range of policies and procedures were in place to provide guidance and give assurance to the trust and individuals on information governance.
The trust had a Pharmacy and Medicines Optimisation dashboard, which monitored progress against set performance and quality metrics. The dashboard was reported monthly to the divisions and executive team.

The pharmacy department had made good use of the electronic prescribing and medicines administration system to identify and prioritise patients who were taking high risk medicines. The pharmacy team could access community summary care records and GP prescribing system records to support the safe use of medicines at transfer between services.

The trust reported incidents, including serious incidents as required to the NHS National Reporting and Learning System (NRLS) or the NHS Strategic Executive Information System (StEIS) in a timely manner. Where required, the trust submitted notifications to the Care Quality Commission in line with their statutory responsibilities.

Engagement
There was a high level of engagement patients, staff, members of the public and local organisations to plan and manage appropriate services. The trust also collaborated with partner organisations effectively.

Managers at all levels shared leadership responsibilities to improve communication and coordinate engagement activities between staff, patients and external stakeholders.

The trust’s staff engagement score in the 2017 NHS staff survey was slightly higher than the national average at 3.84 (average 3.8). Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged.

The senior leadership team recognised the importance of staff engagement in helping them to understand how staff perceived the trust as a place to work. They also recognised that staff who felt engaged with were more likely to provide quality care for patients, take fewer sick days and recommend the trust as a good place to work.

The trust had a ‘You made a difference’ award scheme, which awarded staff who had been nominated by patients, visitors, or colleagues for making a difference to them.

Staff could opt in to the trust’s private dedicated social media page. This enabled the sharing of any news, updates to practice, safety alerts, staffing issues, successes, good news stories and feedback from lessons learnt from incidents or complaints.

The trust shared learning from incidents and good practices throughout the trust through their monthly ‘hotspots’ and ‘topspots’ newsletters.

Every year the trust held an Annual Public Meeting (APM). Everyone was welcome to attend and ask questions or raise concerns with the Board of Directors and Governors.

Throughout our core service inspection, and through our focus groups, we spoke with staff at all levels throughout the trust. Staff mostly told us that executives and board members were engaged and accessible throughout the trust.

The public could join the Cambridge University Hospital foundation trust membership. Members received regular information about the latest developments in the trust. As of 31 March 2018, membership consisted of 19,425 individuals. The trust divided membership into three groups:

- Patient – for patients and carers (4,383)
• Public – for people who live in the catchment area (5,067)
• Staff – automatic membership for eligible staff, opt out was available (9,535)

The trust had an online ‘have your say’ web form to encourage members of the public to provide feedback through the trust website.

The trust engaged and involved patients to shape services and culture. Members of the public who wished to give some of their free time could apply to the trust to be volunteers. The trust supported a team of volunteers to help staff deliver care to patients. The volunteers were part of the trust teams and complimented the work of paid staff to enhance the experience of patients, carers, visitors and staff.

The trust used various social media platforms to engage with patients, the public, staff, and stakeholders such as media, annual board meetings and patient feedback and complaints.

Members of the public were invited to join the trust’s bi-monthly board meetings, and could ask questions if they wished. If members of the public could not make the board meetings, they could send any questions they had in writing in advance of the board meeting. In between board meetings, members of the executive team and non-executive team were available to meet with members of the public and answer any questions they had.

The pharmacy team worked collaboratively across the Cambridgeshire & Peterborough STP to support new and improved ways of providing care.

Examples included:
• Launching a joint medicines formulary across primary and secondary care,
• Developing new pharmacist posts to deliver services in care homes,
• Centralising the Medicines Information service to support the new Papworth hospital which will be opening on site
• Developing the pre-registration training programme to include rotations in local GP practices.

The trust held positive and collaborative relationships with external partners to build a shared understanding of the challenges faced by the local population across the health and care system. The trust was one of the leading organisations on the Cambridgeshire and Peterborough sustainability and transformation partnership (STP) and was therefore actively engaged with GPs, acute, mental health and community trusts, as well as the ambulance service, local clinical commissioning groups (CCGs) and local authorities.

The trust actively engaged with the local CCGs, NHS England and NHS Improvement to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs.

We reviewed a selection of meeting minutes from a number of external stakeholder meetings including for example, CCG contract meetings and STP meetings and meetings. Meeting minutes demonstrated there was transparency and openness with all stakeholders about performance.

In addition, the trust engaged with stakeholders such as local universities, research centres and accrediting bodies.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect. For the 12-month period from Apr 2017 to Mar 2018, HSMR was lower than expected with a value of 87.5 (compared to 100 for England) and 1,300 deaths compared to an expected 1,485 deaths. HSMR had remained within the lower than expected banding since 2009. Weekend HSMR was within expected range for this timeframe.

The trust had one active mortality alert, which was intracranial injury. The trust had recently been notified of this alert formally by the Care Quality Commission. However, the trust was already aware of this through their own analysis of data and had undertaken a deep dive within the neurosurgical department and reported to the mortality surveillance committee. No concerns were identified.

In March 2017, the National Quality Board introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. This trust had put in place all the key mandated requirements from the national guidance, with a policy was in place by September 2017 and data provided to the Board from December 2017.

The trust had a process in place for reviewing all inpatient deaths in line with the National Quality Board's 'Learning from Deaths guidance. The trust had a learning from deaths policy, which detailed the systems and processes that needed to be followed to ensure all deaths that required a review received one. It also detailed the requirements for medical examiners to screen all inpatient deaths by undertaking an initial review of each patient's care, in line with national guidance.

The trust had a mortality surveillance committee, which was responsible for the implementation of the national guidance across the trust. This committee was chaired by the medical director and had a strategic oversight of mortality within the trust; ensuring deaths were reviewed and lessons were learnt and shared. A consultant from each of the five divisions attended the meetings. The Quality Committee had responsibility for receiving assurance that adequate governance arrangements were in place to monitor the completion of mortality reviews and the effectiveness of any risk reduction measures.

Any unexpected death or death relating to care concerns or harm were expected to be reported through the trust’s electronic incident reporting system and all mortality reviews were expected to be undertaken within 25 working days of the patient's death. To support objectivity, case record reviews were expected to be undertaken by clinicians other than those directly involved in the care of the deceased patient. Reviews were undertaken using a standardised structured judgement review form as recommended by the Royal College of Physicians.

The bereavement team provided support for families and carers who had died at the trust.

Learning from deaths and mortality reviews were reported to the board of directors’ bi-monthly as part of the trust’s integrated report at each board meeting. This included information about the number of deaths occurring at the trust, the number falling in scope for a review, compliance with undertaking reviews, the number of potentially avoidable deaths identified from the subjective judgement reviews. The report also included the number of deaths of patients who had a learning disability. Governance arrangements were good and the board of directors had oversight of all deaths across the trust.

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.
Question | In days | Current performance |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>50% of complaints to receive a full written response within 30 working days</td>
<td>39.4% of complaints received a response within 30 days from July 2017 and June 2018, meaning that 78.8% of complaints met the trust’s internal target.</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>The trust does not have a separate target.</td>
<td>n/a</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Individual response times were negotiated with complainants where 30 working days are exceeded</td>
<td>76.6% of complaints met individually negotiated timeframes (longer than 30 days) from April 2017 to March 2018</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>2,322 concerns closed via PALS process (August 2017 to 31 July)</td>
<td>n/a</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

The trust received 725 complaints from August 2017 to July 2018. The outpatients core service received the most complaints with 222.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients</td>
<td>222</td>
<td>30.6%</td>
</tr>
<tr>
<td>Surgery</td>
<td>155</td>
<td>21.4%</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>115</td>
<td>15.9%</td>
</tr>
<tr>
<td>Urgent and emergency services</td>
<td>51</td>
<td>7.0%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>47</td>
<td>6.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>41</td>
<td>5.7%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>39</td>
<td>5.4%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>30</td>
<td>4.1%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>21</td>
<td>2.9%</td>
</tr>
<tr>
<td>Critical care</td>
<td>4</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>725</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)  

The trust had a management of complaints and concerns policy. The chief nurse had board level responsibility for complaints; whilst an assistant director of nursing had corporate oversight of the patient experience agenda, which included patient advice and liaison services (PALS) and complaints. Operationally, the divisional directors in conjunction with assistant directors of operations (ADOs) and divisional heads of nursing were responsible for ensuring compliance within their divisions. The head of patient experience had responsibility for ensuring adherence to the policy and for providing the complaints and PALS function to the public.

All complaints were informally risk assessed to establish severity and screen for potential harm. The PALS and complaints department used a three-level grading system to grade complaints and concerns. This categorised complaints and concerns into low, medium and high severity.

Front line staff, receiving informal complaints, wherever possible were encouraged to resolve them at a local level. All formal complaints were forwarded to the complaints team and the trust aimed to
acknowledge the complaint within three working days. In addition, the trust aimed to complete 50% of all complaints within 30 working days of receipt.

Complaints and contact with the PALS was the main source of recorded patient initiated feedback received by the trust. Prior to our inspection, the complaints department had been under resourced due to staff leaving and maternity leave, which had impacted on the timeliness and response to complaints and feedback, however at the time of our inspection, the service was fully resourced, but still had a back log of complaints to respond to.

The inspection team reviewed five complaints during this inspection and saw where people’s concerns and complaints had been listened and responded to appropriately and used to improve the quality of care. Two of these complaints had been investigated and responded to within thirty days. The timeliness of the other three complaints was worse than the trust target of 30 days at 35, 45 and 49 days respectively. However, where the trust had exceeded the 30 days, we acknowledge an extension had been agreed with the complainant.

Throughout our core service inspection, staff told us that learning from complaints was shared through team meetings. In addition, the trust also produced a ‘hotspots and topspots’ newsletter that was distributed to all staff at the trust. This included information to highlight up-to-date learning from incidents, complaints, PALS concerns and any other information that had been shared with the safety and quality support team. Topspots focused on areas of great practice, improvement and learning, highlighting good practice throughout the organisation, celebrating successes that had helped to improve patient experience and also supporting staff in finding solutions to a better working environment and improved practice.

Governance of complaints was rigorous, with complaints being monitored through the patient experience group, divisional quality governance committee meetings, divisional board meetings and the quality sub-committee of the board.

The board had a good oversight of complaints. Complaints and patient experience was reported to the executive team through the integrated report on a bi-monthly basis. Information provided to the board included the number of complaints received, the percentage that were acknowledged within three working days, the number responded to within 30 working days, the number of agreed extensions, the number of complaints meeting the extended timeframe as well as other information such as those that had been accepted for further investigation by the parliamentary health service ombudsman (PHSO).

Compliments

From August 2017 to July 2018, the trust received a total of 386 compliments. A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Services</td>
<td>89</td>
<td>23.1%</td>
</tr>
<tr>
<td>Surgery</td>
<td>79</td>
<td>20.5%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>75</td>
<td>19.4%</td>
</tr>
<tr>
<td>Medical care (including older people’s care)</td>
<td>60</td>
<td>15.5%</td>
</tr>
<tr>
<td>Maternity</td>
<td>26</td>
<td>6.7%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>19</td>
<td>4.9%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>18</td>
<td>4.7%</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>7</td>
<td>1.8%</td>
</tr>
<tr>
<td>Not core service specific</td>
<td>6</td>
<td>1.6%</td>
</tr>
<tr>
<td>Critical care</td>
<td>6</td>
<td>1.6%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>0.3%</td>
</tr>
<tr>
<td>Total</td>
<td>386</td>
<td>100%</td>
</tr>
</tbody>
</table>
Without exception, all staff we spoke with throughout the trust were aware of the risks associated with its ageing estate. These risks were reflected on the trust’s corporate risk register and board assurance framework and the trust was acting to address them. The ageing estate had reflected in the trust’s patient led assessment of the care environment (PLACE) which the trust recognised as deteriorating. In response, the trust had introduced a campaign called ‘Our PLACE – a place to be proud of’. This campaign recognised that hospital buildings did not have to be new to be safe, welcoming and well maintained, but ensuring that everyone took responsibility for ensuring the hospital ‘our PLACE’ was a place to be proud of and in ensuring everyone played a part in keeping the hospital clean, safe and clutter free. Our PLACE was broken down into:

- Our clean PLACE
- Our safe PLACE
- Our well-maintained PLACE
- Our Welcoming PLACE

This empowered staff to take action and to be proud of where they worked.

There was a strong focus on innovation and research, which supported local, national and international best practice. The trust was a government comprehensive biomedical research centre, one of six academic science health centres in the UK. The trust worked collaboratively with other NHS organisations, universities, research councils, charities and councils to build research capacity and to support clinical research. A research and development report was presented to the board by the trust’s medical director on a quarterly basis.

The trust had a clinical trials unit (CTU), which was part of the National Institute for Health and Research (NIHR) UK Clinical research Collaboration (UKCRC).

Cambridge University Hospitals CUH NHS Foundation Trust was the first NHS trust to implement the EPIC electronic patient record system across both its hospitals in October 2014, and the first to launch a patient portal (MyChart) that integrated directly with an electronic patient record system, giving patients access to their medical information. In 2017, NHS England selected CUH as one of 16 Global Digital Exemplar (GDE) trusts – those who were leading the way in digital healthcare and supporting other trusts to develop digitally.

The Trust became the first in the UK to validate against the new Stage six criteria of the Healthcare Information and Management Systems Society’s (HIMSS) international Electronic Medical Records Adoption Model (EMRAM); recognising its effective use of digital technology in providing high quality patient care. Since then the trust has won awards for its progression with digital technology. For example, the trust had achieved:

- Trust of the Year - ehi Awards 2017, national awards that recognise IT excellence in healthcare (October 2017)
- CCIO of the Year ehi Awards 2017, national awards that recognise IT excellence in healthcare (October 2017)
- Best place to work in digital - large organisations - Digital Technology Leaders Awards (July 2017)
- Most Wired 2017 - first non-US trust to rank among America’s elite healthcare organisations that use advanced digital technology to provide high quality patient care (July 2017)
- Data Quality Award - CHKS Top Hospitals Awards (May 2017)

The digital improvements within the trust meant that:

- Patient records were fully integrated, including all physiological monitors and ventilators in 40 operating theatres and 148 high dependency areas.
- A reduction in sedation related prescribing errors in the paediatric areas.
• Real time bed occupancy information meaning the electronic bed occupancy status was available to all. This enabled teams to better manage bed occupancy and enable more effective discharge planning.

The digital team were developing an automated alert system to help the critical care outreach team receive timely information about patients who were deteriorating.

The trust had a sepsis action group that implemented systems within the trust’s patient record system to enable the recognition of sepsis and provide decision support. At the time of our inspection, this had enabled an increase in the compliance of sepsis six within 60 minutes in the emergency department from 26% (June 2015/baseline) to 72% in September 2018. Within inpatient areas the increase was from 20% (April 2017/baseline) to 44% in September 2018. Early indications from a limited data set suggested a reduction in hospital mortality associated with sepsis of up to 40%, since the improvement programme began. The methodology to accurately capture sepsis mortality data was a focus of the current sepsis improvement work within the Trust.

There were systems in place to support improvement and innovation at work. A consultant pharmacist, told us about current research they were undertaking on high risk medicines in collaboration with universities and the National Institute for Health Research (NIHR). The research aimed to develop and embed in the electronic prescribing system, a scoring tool for identifying high risk patients based on comorbidities and/or medicines they were taking and to support clinical staff in prioritising them. There was also a project being undertaken to look at medicines related hospital re-admissions. This will also involve looking at the impact of the Specialist Advice for Frail Elderly (SAFE) pharmacist role.

The trust had made efforts to modernise the medicines storage and supply chain by piloting automated storage units and electronic keys in some areas such as critical care with the view to rolling out across other inpatient areas if deemed successful.

Barcode enabled Medicines Administration (BCMA) has also been rolled out on all inpatient areas to reduce the risk of medication errors, however during our inspection staff nurses reported technical issues with the process and felt that that it increased the time required for completing a medicines administration round.

The trust’s electronic record system also helped to prevent at least 850 significant adverse medication reactions a year with electronic prescribing and clinical decision support.

The outpatient antibiotic therapy (OPAT) and bone infection service teams had developed an innovative approach to teach patients to administer their own intravenous antibiotics at home. This empowered patients to have more control of their care, reduced the number of days patients were staying hospital and avoided the need for community nurses to administer the antibiotics. The service was recognised for this at the October 2017 Health Enterprise East Innovations Awards, where the service won the Service Innovations Award.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation or are working towards one:
<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy Department for 2017</td>
</tr>
<tr>
<td>Imaging Services Accreditation Scheme (ISAS)</td>
<td>Imaging Department for 2017</td>
</tr>
</tbody>
</table>
| Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189 | Tissue Typing Lab, Genetics & Histopathology 2017/2018  
CPA accreditation awards are in place for HODS, biochemistry & immunology and haematology (including blood transfusion). All the laboratories holding CPA are still waiting for feedback regarding their ISO awards. All evidence has been submitted and this currently sits with the United Kingdom Accreditation Service |
| Improving Quality in Physiological Services Accreditation Scheme (IQIPS) | Actively working towards this accreditation in: audiology, cardiology (invasive and non-invasive), GI, respiratory and sleep studies and urology dynamics. Also, a pilot site for MPACE clinical engineering accreditation. |
| Commission for the Accreditation of Rehabilitation Facilities (CARF) | Rehabilitation services submit to UKROC rather than CARF for Lewin ward & J2 neuro rehab (not trauma rehab). |
| CHKS Accreditation for radiotherapy and oncology services | Department has ISO 9001. |
| Memory Services National Accreditation Programme (MSNAP) | Working towards accreditation. |
| Lloyds Register Quality Assurance (LRQA) | Accreditation for medical physics & clinical engineering and sterile services. |
| British Society of Urogynaecology | Accreditation for uro-gynaecology. |
| BSI | Accreditation for Cambridge IVF. |
| UKAS- MPACE | Accreditation ongoing for clinical engineering. |
| UKAS | Accredited for immunology labs. |
| PHE Screening Quality Assurance Service | Accreditation ongoing for cervical cytology HPV pathway at Newmarket site.  
Accreditation ongoing for cervical cytology at Newmarket site followed by CUH histology and colposcopy. |
| JACIE | Accreditation ongoing for cancer - haematology, stem cell lab. |
| BSI | Accreditation ongoing for cancer - oncology, haematology, radiotherapy, physics. |

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Urgent and emergency care

Facts and data about this service

The urgent and emergency care services included the emergency department (ED), major and minor trauma areas, a resuscitation area, paediatrics area, and a clinical decisions unit (CDU). The ED is a consultant-led emergency care and treatment service and is the major trauma centre for the East of England and provides the trauma Network Co-ordination Service (NCS). Patients could access care and treatment by GP referral, walking in, by ambulance and by air ambulances from across the region.

Details of emergency departments and other urgent and emergency care services

The trust has the following urgent and emergency care services at Addenbrooke's and the Rosie Hospitals:

- Emergency Assessment Unit 2: Clinical decision unit; adult and paediatric emergency department
- Emergency Assessment Unit 3: Ambulatory care outpatients
- Clinic 9: Urgent Treatment Centre (GP Streaming Service from the emergency department)

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Urgent and emergency services are based around the Emergency Department with a single front door model of care and the provision of major trauma services (for the East of England).

The Emergency Department consists of five minors’ cubicles (with a dedicated eye room), seven resuscitation cubicles, 19 majors’ cubicles and a chair centric area for seven patients. There is a dedicated paediatric area which has a waiting area, two side rooms and eight cubicles. Patients are managed by the Emergency Department team, the on-call medical team which is based within the department and by in-reach from specialty teams for both adult and paediatric patients.

A general practitioner and/or an emergency care practitioner/ advanced care practitioner is based within the Urgent Treatment Centre at peak times (11am to 11pm Monday to Friday and 8am to 11pm Saturday and Sunday). The Urgent Treatment Centre is GP-led and is also managed by the Emergency Department.

The Emergency Department team is also responsible for care on the adjacent Clinical Decisions Unit (eight beds and a chair centric area). The emergency department works closely with the Ambulatory Care Unit and the Medical short stay wards, Emergency Assessment Unit 4 (EAU4) and EAU5 (Acute Hub) which are run by the acute physicians.

Minor Injury Units in Ely, Wisbech and Doddington are commissioned by Cambridge and Peterborough Clinical Commissioning Group, with services provided by Cambridge and Peterborough Foundation Trust, who are also a subcontractor to Cambridge University Hospitals.

(Source: Routine Provider Information Request (RPIR) – Context acute)

Activity and patient throughput

From June 2017 to May 2018 there were 155,764 attendances at the trust’s urgent and
emergency care services as indicated in the chart below.

Total number of urgent and emergency care attendances at Cambridge University Hospitals NHS Foundation Trust compared to all acute trusts in England, June 2017 to May 2018.

(Source: NHS England)

Urgent and emergency care attendances resulting in an admission
The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2017/18 when compared to the previous year, 2016/17. In both years, the proportions were higher than the England averages.

(Source: NHS England)

Please note that the trust informed us following our inspection that they operate a single front door model which may impact upon the proportion of attendances that result in an admission.

During this inspection we:
- Spoke with 51 staff members; including service leads, matrons, nurses, doctors, health care assistants, allied health professionals, ambulance staff, porters, volunteers and
administrative staff.
- Spoke with 18 patients/relatives who were using the service.
- Checked 12 pieces of equipment.
- Reviewed 14 sets of medical care records.
- Reviewed 15 prescription charts.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*A abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service had a comprehensive training programme to provide staff with the training they required.

Staff we spoke with told us they were supported to attend training and the electronic data base was helpful to remind them when their training was due. Throughout our inspection, it was evident the service was proud of their training achievements and there was a recognition that mandatory training was a priority.

The practice development nurse for the Emergency Department (ED) provided a comprehensive training programme for staff to access extended training skills. For example, some topics of training included: triage training, venepuncture (taking bloods) and advanced plastering.

Nursing staff received annual refresher training for breakaway and de-escalation techniques. This included an update relating to the violence and aggression policy, the flow chart, verbal warning, yellow card and red card system. Staff told us that this was used when there were patients who were not able to use the service due to their continued violent behaviours, if patients received a red card they were not allowed to receive treatment from the ED and needed to access health care from another hospital; except in life threatening circumstances.

The trust’s training database demonstrated that all staff had completed chemical, biological, radiation and nuclear (CBRN) training. The ED demonstrated regular major incident drills for decontamination exercises to test staff knowledge and response to CBRN situations the last one was June 2018. The major incident drill was planned and coordinated with the Royal Airforce in advance. It had been recorded and lessons learnt were identified and shared with staff. For example, when there are multiple patients requiring decontamination the team leader should not get directly involved in decontaminating casualties.

Mental health training was not mandatory, but staff had requested it and take up was high. All staff had received the mental health triage training and mental health first aid training. Staff had an opportunity to attend one full day training with a neighbouring trust’s psychiatrist. Online training was also available on topics such as the first response service and personality disorders.

Mandatory training completion rates
The trust set a target of 90% for the completion of all mandatory training.
A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>26</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>147</td>
</tr>
<tr>
<td>Health and safety</td>
<td>26</td>
</tr>
<tr>
<td>Infection control</td>
<td>146</td>
</tr>
<tr>
<td>Information governance</td>
<td>146</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>142</td>
</tr>
<tr>
<td>Fire safety</td>
<td>134</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>133</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 96.3% for qualified nursing staff in urgent and emergency care. The trust’s training targets were met for all eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>27</td>
</tr>
<tr>
<td>Health and safety</td>
<td>27</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>57</td>
</tr>
<tr>
<td>Fire safety</td>
<td>56</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>56</td>
</tr>
<tr>
<td>Infection control</td>
<td>56</td>
</tr>
<tr>
<td>Information governance</td>
<td>55</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>41</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 91.7% for medical staff in urgent and emergency care at the trust. The trust’s training target was met for seven of the eight mandatory training modules for which medical staff were eligible. The module with the lowest completion rate was resuscitation with 68.3%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The staff we spoke with told us they received annual sepsis training, they were aware of the trust’s policy and were committed to improving compliance with the sepsis policy. The ED had a sepsis champion, sepsis champions are staff members that promote the compliance with the sepsis six tool, provide additional sepsis training to staff members in their department. Sepsis-six is the name given to a bundle of therapies designed to reduce the risk of death for of patients experiencing sepsis. During the inspection we observed a one to one, face to face teaching session.

During our inspection we raised a concern with the senior team regarding the medical staff compliance with resuscitation training and requested an update on the attendance. Updated information from the trust indicated that 94% of nursing staff for Division C who were required to attend advanced resuscitation training had completed the training. However, we were advised that the trust did not monitor medical staff advanced resuscitation training centrally, this was part of the
educational supervision process and would be captured through the appraisal process, therefore we were not assured as to what training the medical staff had completed.

**Safeguarding**

**Staff were aware of processes and standard procedures to keep people safe from abuse, and received training to assess, recognise and report abuse.**

Staff we spoke with understood how to keep patients safe from abuse. They were aware of the trust’s safeguarding policy and how to access it. Staff knew who the safeguarding leads were throughout the trust for adults and children.

The service used an electronic patient record system which had a safeguarding alert system. When staff accessed a patient’s record it would alert if there were any adult or children’s safeguarding alerts. Administrative and reception staff applied a safeguarding search for any young person under the age of 19, or pregnant women accessing the service to ensure that safeguarding concerns were highlighted on admission. They were aware of escalation procedures, and who they would speak with if they had a concern.

We observed good safeguarding assessment and practice during our inspection when a concern was raised due to an adult’s behaviour towards a child. The nurse liaised immediately with the medical staff reviewing the child and completed a referral to alert other agencies of the service’s concerns.

The trust employed a safeguarding team to support staff with any safeguarding queries or concerns. Staff explained that they worked in partnership with external agencies to safeguard adults and children.

Staff had knowledge of different types of abuse. They were also aware of child sexual exploitation (CSE) and of female genital mutilation (FGM) and received training on how to recognise and report it.

We observed chaperone posters in all the children’s areas. This informed parents that a responsible adult needed to be present with the child during any assessments, care or treatment. Chaperones were available to be present with adult patients and vulnerable patients.

The ED completed a safeguarding audit to review the referrals made within the paediatric treatment area. Results and recommendations were shared at the safeguarding children monthly team meeting and the paediatric ED link meeting for staff learning.

The service was meeting the safeguarding children standards produced by the Royal College of Emergency Medicine (RCEM). For example, the department had access to a senior paediatrician, 24 hours a day for child welfare issues.

If a patient was assessed to be at risk of suicide or self-harm, the ED made arrangements to enable them to remain safe. The department had two interview rooms, which met the RCEM standards. Both rooms had a clear entry and exit, had panic alarms and were ligature point free (A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation).

Staff had received training to make them aware of potential needs of people with mental health conditions, learning disability, autism and dementia.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.
A breakdown of compliance for safeguarding training courses as of July 2018 for qualified nursing staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>147</td>
<td>147</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>148</td>
<td>148</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>147</td>
<td>148</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>144</td>
<td>148</td>
<td>97.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent level 3 (WRAP)</td>
<td>138</td>
<td>145</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>129</td>
<td>145</td>
<td>89.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 96.8% for qualified nursing staff in urgent and emergency care at the trust. The trust’s 90% completion target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible. The module with the lowest completion rate was safeguarding children level 3 with 89.0%.

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>55</td>
<td>59</td>
<td>93.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>53</td>
<td>60</td>
<td>88.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>51</td>
<td>60</td>
<td>85.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>47</td>
<td>60</td>
<td>78.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>39</td>
<td>51</td>
<td>76.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent level 3 (WRAP)</td>
<td>35</td>
<td>51</td>
<td>68.6%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 82.1% for medical staff in urgent and emergency care at the trust. The trust’s 90% completion target was not met for five of the six safeguarding training modules for which medical staff were eligible. The module with the lowest completion rate was prevent level 3 (WRAP) with 68.6%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We were provided with up to date training attendance on our inspection and saw that all staff had complete safeguarding training to the correct level for their role. Safeguarding level three training compliance was 92.6% for the medical staff and nursing staff was 91.8% which met the trust’s 90% completion target.

**Cleanliness, infection control and hygiene**

There were reliable systems in place to ensure standards of cleanliness were met and protect people from a healthcare-associated infection.

All areas of the emergency department were visibly clean and uncluttered. Environmental cleaning audits in September 2018 demonstrated that cleaning scores for all areas in the ED were above 98%.

Staff were aware of and practiced infection prevention and control in line with national guidance. Handwashing facilities and hand sanitiser stations were readily available throughout the department. On entrance to the department a recorded message reminded patients and visitors to wash their hands. The hand hygiene audit from November 2017 to September 2018 showed three
months no data was submitted, for eight months results were below the trust target of 95% and one month was above the trust target of 95%. Although during our inspection we observed staff washing and sanitising their hands appropriately.

All staff followed the trust’s bare below the elbow guidance and staff used personal protective equipment (PPE) such as gloves and aprons to prevent the spread of infection.

There were zero reported cases of Methicillin-resistant Staphylococcus Aureus (MRSA). MRSA is a type of bacterial infection and is resistant to many antibiotics.

There were zero reported cases of clostridium difficile (C.difficile) infections. C.Difficile is a bacterium affecting the digestive system; it often affects people who have been given antibiotics and has the capability of causing harm to patients.

Patients who needed a urinary catheter inserted or a vascular access device had their risk of infection minimised because staff followed an aseptic technique in line with the infection prevention and control (QS61) NICE guidance statement four and statement five.

Clean linen was accessible and stored on covered trolleys. Staff told us that even in busy times they could replenish their linen stock.

All the store rooms we observed were clean, tidy and well ordered.

Curtains in the department were disposable, there was a replacement schedule they were changed every three months. Soiled curtains were removed and replaced immediately.

The ED had side rooms that could be used for barrier nursing or reverse barrier nursing when patients needed protection. We observed appropriate signs for an infective patient being nursed in the clinical decisions unit (CDU).

The emergency department had a decontamination room which was used for any chemical incidents to decontaminate patients appropriately and cleaned according to procedure.

**Environment and equipment**

The service had systems, processes and practices in place to manage the environment and equipment to keep people safe.

The ED environment was no longer a sufficient size to accommodate the number of patients that attended. The service saw 115,017 patients in 2017 an increase of 3000 patients since 2016 and an increase of 11,000 since 2015. However, the service effectively managed capacity daily to keep patients safe.

The layout of the department was appropriate for supporting easy access to diagnostic and imaging services. It provided X-rays for adults and children. Staff were confident that access to computerised tomography (CT) or magnetic resonance imaging (MRI) scans was not delayed when required for urgent investigations.

Clinical and domestic waste was separated and disposed of correctly. This included sharps such as needles, sharps boxes were labelled and dated and not overfilled to prevent needle stick injuries.

We checked 12 items of electrical equipment within the department and found that all had been safety tested and serviced appropriately. The service invested in the recruitment of a full-time health care support worker who was responsible for equipment, this ensured annual checks and maintenance was completed.

There were adequate supplies of available, accessible and suitable equipment, including resuscitation equipment. There was a schedule for regular checks for equipment which had been
followed and recorded in all areas we inspected. All of the department’s emergency resuscitation trolleys were tamperproof and records we reviewed demonstrated between September 2018 to October 2018 staff completed daily checks of emergency resuscitation equipment.

The department had a separate entrance for ambulances, which enabled critically ill patients to be triaged and transferred to the correct area.

Dedicated, appropriately equipped interview rooms were available in the emergency department for patients with mental health conditions. These areas complied with the requirements of Health Building Note Building Note 15-01: accident & emergency departments 2013 which states 17.9 (2013) which states an interview room should be considered for use by staff for talking to disturbed and distressed patients and relatives.

The resuscitation bays were standardised with the same equipment and trolleys, which were set up for each emergency scenario. Bays were set up to accommodate both adults and children, which meant that the department was able to deal with any major incident presented to them involving any age group.

Security for the department had improved since our last inspection, staff used electronic pass cards to gain access to the clinical areas. There was a closed-circuit television (CCTV) in use 24 hours a day and this was continually recorded.

At our last inspection 2016 the dedicated paediatric area was not secure and we raised this as a concern with the trust. At this inspection, we saw the trust had taken action and had made the paediatric area partially secure. Children continued to pass through the main waiting area to access the paediatric waiting area, which was only accessible by authorised staff who used a swipe card to let them through to access the paediatric waiting room. However, we were concerned that patients from the minors area could access the entrance to the paediatric waiting area and paediatric treatment area. We saw an occasion where a patient in a wheelchair was pushed by a relative through the cubicle area where children were being treated, staff directed them to the x-ray department. We also observed three other occasions where adult patients had accidentally entered the corridor adjacent to the paediatric treatment area and waiting room. Neither of these areas were security locked or continually observed by staff or CCTV. This was not in line with Health Building Note 15-01: accident & emergency departments 2013 which states ‘The waiting area should be provided to maintain observation by staff but not allow patients or visitors within the adult area to view the children waiting’. We raised this as a concern with the trust, who were aware of the risk and informed us that the risk was on ED risk register and staff we spoke with were also aware the issue was on the ED risk register.

At our last inspection, we raised concerns that the entrance gate to the paediatric waiting area was permanently open and staff could not see the paediatrics waiting area from within the main paediatrics treatment area. We found these concerns had not been addressed at this inspection. The gate to the waiting area remained open and staff did not do regular walk arounds in the waiting room. This meant the area was not routinely monitored by staff and if a child deteriorated there was a risk this may go unnoticed. In addition, adult patients from minors could potentially enter this area at any time unchallenged. We looked into this further at our well-led inspection. The trust had considered all options for the paediatric area of the department but had been limited because of the layout of the department. At our well-led inspection, we were assured the trust was taking action to mitigate risks within this area and the trust had identified this as a risk and had developed plans to address the visual screening and security aspect in both the paediatric waiting area and paediatric treatment area. The service had suitable arrangements to manage casualties contaminated with chemical, biological, radiological or nuclear substances (CBRN). There was guidance to direct such patients to the decontamination area which was outside the department to prevent further contamination. There was a red line which guided emergency ambulance services and patients around the outside of the department to the correct area for treatment.
Assessing and responding to patient risk

The service responded appropriately to changing risks to patients who used the services. There was a clear streaming triage process in place, and walking patients could access the ED through one front door area. They were greeted by a qualified nurse who completed a triage assessment and pain score; they then directed the patient to the appropriate treatment pathway within the department. Children were directed to the paediatric waiting area.

All patients were triaged on arrival and transferred to the area best suited to provide treatment. All areas where fully stocked with equipment, emergency trolleys and medicines to treat patients. Patients who were critically ill or required resuscitation were brought directly into the resuscitation area. This facility was appropriately equipped for the resuscitation of adults, children and babies. If arriving by ambulance, the ambulance service telephoned ahead, which allowed the department to prepare to receive the patient.

To ensure they were given appropriate care, patients were placed on relevant care pathways. This included patients with a fractured neck of femur, stroke or sepsis. The pathways were based on best practice guidance.

There was a detailed mental health risk assessment for staff to complete for all patients who presented with a mental health condition. There was a triage system in place to enable a patient presenting in crisis to be managed safely. Patients were red/amber/green (RAG) rated according to their symptoms. Amber patients received 15-minute observations and red patients received one to one care by a member of staff. However, we asked several members of staff where the 15-minute observations were recorded and were told they were not always documented. There were no patient’s records we could review on inspection.

Nursing handovers were planned at the beginning of each shift. We observed one handover during our inspection. All nurses attended for the initial allocation session where key information and announcements were made, such as the key pad locks being changed, the chief nurse’s weekly message and any information to cascade about lessons learnt from incidents. A more detailed handover then took place for each patient in the department between the nurse in charge for both shifts and the senior clinical nurse. During this time, each nurse took a ‘bedside’ handover of patients in the areas they were allocated from the outgoing nurses.

A safety huddle took place twice a day. This enabled staff to discuss patients’ needs within the ED and any admissions expected or those on route by ambulance. Other topics included staffing, meal breaks, handover messages and vulnerable patients. This meant the service was planning care to meet the needs of patients within the department.

A National Early Warning System (NEWS) and a Paediatric Early Warning System (PEWS) were in use throughout the ED until September 2018, when the trust implemented NEWS 2. Staff used National Early Warning Scores 2 (NEWS2) to record routine observations such as blood pressure, temperature and heart rate. The NEWS2 system had been implemented in September 2018, as an advancement on the NEWS system, to help improve assessment of patient risk. Accurate and regular NEWS2 documentation supports early recognition of a patient deterioration by grading the observations and prompting nursing or medical reviews at specific trigger points. The NEWS2 scores were recorded on the electronic patient records system and there was evidence of escalation when a patient was scoring as a risk on NEWS2. It flagged up automatically on the electronic patient records system that these patients might be at risk and required a further review.

An audit published in the July 2018 patient safety report showed compliance targets with NEWS2 completion from June 2018 to July 2018. Compliance for the trust overall was 96%, against a minimum target of 90%. Staff could recognise deteriorating patients and we saw that patients were escalated appropriately.
Following our last inspection, we asked the trust to improve on the sepsis six response times. Sepsis-six is the name given to a bundle of therapies designed to reduce the risk of death for of patients experiencing sepsis. Early treatment of sepsis reduces complications and improves outcomes for patients. The 'Sepsis Six' had been introduced again across the department, to prioritise timely diagnosis of patients admitted with infections. Staff were proud of the improvement they had made in treating patients and there was healthy competition within the department, where staff posted their achievements of antibiotics given within the hour on the media platform they used to share information. The sepsis data we received in the ED matters newsletter demonstrated, from April 2018 to June 2018 antibiotics within 60 minutes compliance was 72% which was an improvement from August 2016 which was 67%. However, this did not meet the trust target of 95%. We were able to review the care of a patient at risk and observed that the pathway was followed.

Patients left unattended were given call bells to use if they were worried, felt unwell or required assistance from staff.

The ED had major incident plans and action cards accessible in each are of the department and at reception. The action cards provided clinical guidance for staff and supported them to treat patients during times of a major incident. All staff we spoke with could describe the process and knew where to access the action cards.

Senior staff described the weekly emergency drills they held in the adult and paediatric areas. We observed such a drill which was Halloween themed. Staff worked effectively as a team, senior staff praised them and held a debrief afterwards to discuss the drill. Staff told us they found the drills very helpful and it promoted teamwork within the department.

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Median time from arrival to initial assessment (emergency ambulance cases only)**

The maximum waiting time between patients arriving at the department and having an initial assessment of their condition should be four to six minutes. This standard is set by the Royal College of Emergency Medicine.

The median time from arrival to initial assessment was consistently better than the overall England median over the 12 month period from September 2017 to August 2018.

In the most recent month, August 2018, the median time to initial assessment was three minutes
compared to the England average of seven minutes.

**Ambulance – Time to initial assessment from September 2017 to August 2018 at Cambridge University Hospitals NHS Foundation Trust**

![Ambulance Time to Initial Assessment Graph]

(Source: NHS Digital - A&E quality indicators)

**Percentage of ambulance journeys with turnaround times over 30 minutes for this trust**

**Addenbrookes Hospital**

Patients arriving by ambulance should be handed over to department staff within 30 minutes. This standard is recommended by the Royal College of Emergency Medicine.

From October 2017 to September 2018 there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Addenbrookes Hospital.

In the most recent month, September 2018, 55% of ambulance journeys had turnaround times over 30 minutes.

**Ambulance: Number of journeys with turnaround times over 30 minutes - Addenbrookes Hospital**

![Number of Journeys Graph]

**Ambulance: Percentage of journeys with turnaround times over 30 minutes - Addenbrookes Hospital**

(Source: National Ambulance Information Group)
Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff.

From August 2017 to July 2018 the trust reported 170 “black breaches”. The highest numbers of black breaches occurred in November and December 2017 (32 and 36, respectively) and March and April 2018 (34 and 26 black breaches).

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

During our inspection we discussed the higher number of black breaches with the senior team who told us this was due to winter pressures. This was also prolonged due to the snowfall in the months of March and April 2018.

Nurse staffing

Staffing levels were planned and reviewed to ensure patients received safe care and treatment.

At our last inspection in 2016, we asked the trust to ensure there were sufficient numbers of suitably qualified skilled & experienced staff employed to care for paediatric patients’ needs and to safeguard their health, safety & welfare.

We reviewed the paediatric rota and found there was a trained children’s nurse on all shifts. On the shifts with just one trained children nurse, the risk was mitigated by having an adult trained nurse who had completed a paediatric competency pack, or/and extra paediatric training for example, a paediatric high dependency training module, staff also rotated through the department to provide cover in unplanned situations. We reviewed the competency pack which was comprehensive and staff were required to achieve level three before they were signed off.

The trust reported the following qualified nursing staff numbers in urgent and emergency care from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th></th>
<th></th>
<th>April to July 2018</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
<td>Fill rate</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>134.8</td>
<td>168.9</td>
<td>79.8%</td>
<td>135.6</td>
<td>198.5</td>
<td>68.3%</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of 79.8% for nursing staff in urgent and emergency care from...
April 2017 to March 2018. This had decreased to 68.3% from April to July 2018, predominantly due to the addition of 29.6 WTE planned posts.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From August 2017 to July 2018, the trust reported a vacancy rate of 23.0% for qualified nursing staff in urgent and emergency care. This was higher than the trust target for nursing and midwifery staff of less than or equal to 11%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Senior staff we spoke to were continually recruiting and thinking of ways to attract staff to want to work within the trust. The trust had adopted a ‘grow your own’ scheme where staff were paid by the trust to undertake nurse training. Senior staff were also visiting and recruiting nurses from overseas. Overseas nurses worked as a health care assistant until they had their personal identification number from the nursing and midwifery council, and completed competencies and assessments.

The ED maintained a recruitment action plan which included the staff vacancy and actions in the ED. This was updated weekly by the senior clinical nurse within the ED.

Turnover rates
From August 2017 to July 2018, the trust reported a turnover rate of 12.4% for qualified nursing staff in urgent and emergency care. This was higher than the trust target of 10.56%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates
From August 2017 to July 2018, the trust reported a sickness rate of 2.8% for qualified nursing staff in urgent and emergency care. This was slightly higher than the trust target of 2.7%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
From August 2017 to July 2018, the trust reported that 12.1% of qualified nursing FTE shifts in urgent and emergency care at the trust were filled by bank staff and 2.6% of shifts were filled by agency staff. In addition, 4.5% of the qualified nursing staff FTE shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 36.3% of non-qualified nursing staff FTE shifts in surgery at the trust were filled by bank staff and none were filled by agency staff. There were 4.9% of non-qualified nursing staff FTE shifts that were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Bank FTE shifts</th>
<th>Agency FTE shifts</th>
<th>Unfilled FTE shifts</th>
<th>Total FTE shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Qualified</td>
<td>231.7</td>
<td>12.1%</td>
<td>48.9</td>
<td>2.6%</td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>229.8</td>
<td>36.3%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>461.5</td>
<td>18.2%</td>
<td>48.9</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Bank and Agency tab)
Medical staffing

The trust reported the following medical staff numbers in urgent and emergency care from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>56.0</td>
<td>64.7</td>
</tr>
</tbody>
</table>

The trust reported a similar staffing level in both time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Emergency medicine consultants provided on duty cover for the department between 8am and 2am daily with ‘on-call’ cover outside of these hours. There was a plan to cover 24 hours a day, seven days a week from April 2019. Which would increase the senior medical support to the ED.

In the children’s ED an allocated doctor was available. In addition, one paediatric doctor was allocated to the department. Outside of these hours, doctors from the adult ED attended to see patients and staff could access the paediatricians on call at any time this was in line with national guidance ‘Facing the Future: Standards for Children in Emergency Care Settings’ 2018.

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 11.4% for medical staff in urgent and emergency care. The trust does not have a target vacancy rate for medical staff.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported no turnover for medical staff in urgent and emergency care. The trust has a target of 10.56%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 1.3% for medical staff in urgent and emergency care. This was lower than the trust target of 2.7%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and locum staff usage

The table below shows the numbers and percentages of hours in urgent and emergency care from August 2017 to July 2018 that were covered by medical bank or locum staff or left unfilled.

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
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<td>Urgent and emergency care</td>
<td>56.0</td>
<td>64.7</td>
</tr>
</tbody>
</table>

Of the 14,382.1 FTE shifts available, 4.4% were filled by bank staff and 0.3% were covered by locum staff to cover sickness, absence or vacancy for medical staff. In the same period, 2.5% of the available hours were unable to be filled by either bank or locum staff.
### Core service

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Locum usage</th>
<th>Not filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>FTE shifts</td>
<td>%</td>
<td>FTE shifts</td>
</tr>
<tr>
<td>Urgent and Emergency Services</td>
<td>14,382.1</td>
<td>633.0</td>
<td>4.4%</td>
<td>39.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical locum tab)

### Staffing skill mix

In June 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 55 whole time equivalent staff working in urgent and emergency care at Cambridge University Hospitals NHS Foundation Trust.**

```
<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>36%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>4%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>51%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>9%</td>
<td>23%</td>
</tr>
</tbody>
</table>
```

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty

~ Registrar Group = Specialist Registrar (StR) 1-6

* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

### Records

**Staff kept detailed records of patients care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**

The service used an electronic patient record system. All nursing and medical staff had received training in using the system. Staff we spoke with felt confident in using the system.

All patient details were documented directly onto the electronic patient record system.

Patients clinical records were stored confidentially on the electronic system the ED had no paper records.

We reviewed 14 electronic patient records. All the records we reviewed contained details of patients’ presenting conditions, medical history and current medication. Details of their GP and next of kin were also recorded. We observed that risk assessments were fully completed in all the records we reviewed.
Medicines

Medicines including controlled drugs were stored, managed, administered and recorded safely and appropriately.

Medicines were checked, managed, stored and disposed of safely. Controlled drugs (medicine that are controlled under the Misuse of Drugs legislation 2001), were checked by two members of qualified staff twice a day in line with the trust’s medicines policy and were stored correctly in a locked cupboard.

Medicines and equipment used for emergencies were accessible, checked daily and stored in a tamper proof way.

Pre-labelled medicines stock was available in the ED and on wards to support discharges. There was a trust policy in place authorising registered nurses to supply these medicines, however there were no records of staff training and competency assessment. This meant we were not assured that staff had received training and were competent to supply pre-labelled medicines as well as the associated record keeping.

We reviewed 15 electronic prescription charts and saw that medicines were administered in a timely manner. In addition, personal information, the patients weight in 14 and allergies in all 15 were documented. Patients with allergies wore a red armband to easily identify that they were allergic to a medication.

Antimicrobial treatments which inhibited the growth of microorganisms were prescribed and reviewed appropriately. We looked at a sample of electronic prescription charts and found no missing or delayed doses of antibiotics.

There were trust protocols, for the administration and supply of certain medicines by advanced clinical practitioners (ACPs) and nurses under Patient Group Directions (PGDs). PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The process for administering medicines under PGDs was safe and effective and nurses received appropriate training for this.

Medicines reconciliation was carried out effectively where possible. Medicines reconciliation is the process of identifying an accurate list of a patient's medicines prior to hospital admission and comparing it with the current list in use to ensure the correct medicine is given). Due to the high patient turnover identified discrepancies were not always dealt with until patients were transferred to a ward. However, we saw examples of arrangements made for appropriate follow-up of patients in relation to their medicines following their discharge from the emergency department.

There was a dedicated pharmacist and technician in the department to deal with medicines related issues, optimise medicines use and to support the discharge process. An extended weekday pharmacy service was also provided. There was scope however, to develop the role of the pharmacist further to maximise their clinical input in the department. Staff informed us that there were plans for the pharmacist to undertake the independent prescribing qualification in the future to help achieve this.

Staff had access to several resources for information on medicines and could contact the Medicines Information team for further advice.

Medicines were stored securely. All medicines we randomly checked were within their expiry dates. Oxygen cylinders were full and within their expiry date. Oral syringes were available for the administration of oral medicines.
When medicines were administered, nurses checked the name, date of birth and any allergies and the chart to confirm the right medicine was given to the right person.

**Incidents**

The service reported safety incidents well, staff recognised incidents and reported them appropriately.

Incidents were reported using a trust wide electronic system. All staff we spoke with understood their responsibilities to raise concerns and to report safety incidents internally and externally. Staff received automatic feedback through the incident reporting system following the reporting of an incident.

ED clinical leads attended risk and governance review meetings and shared learning from these was then cascaded back to the department. Staff told us that key learning from incidents was communicated at handover, through the monthly newsletter, emails or face to face.

All staff we spoke with were aware of the requirements of duty of candour when giving feedback about incidents to patients and relatives. The trust provided us with information which showed that from October 2017 to September 2018 they were 100% compliant for 10 months out of the 12 month period.

Mortality meetings were attended by multidisciplinary staff to ensure that any learning was shared, and to improve practice. We reviewed three sets of minutes for the mortality surveillance committee meeting August, September and October 2018. Minutes included a medical examiner update, mortality alerts, learning identified from death reviews and a tracked action plan with named ownership of actions to be completed.

**Never Events**

Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

From October 2017 to September 2018, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: Strategic Executive Information System (STEIS))*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the breakdown of incident types reported were:

- Treatment delay meeting SI criteria with seven (58%) of incidents
- Confidential information leak/information governance breach meeting SI criteria with one (8%) of incidents
- Diagnostic incident including delay meeting SI criteria (including failure to act on test results) with one (8%) of incidents
- Incident still pending review in order to assign category with one (8%) of incidents
- Suboptimal care of the deteriorating patient with two (17%) of incidents

*(Source: Strategic Executive Information System (STEIS))*
We reviewed two serious incident reports and observed that the incidents were investigated by a multidisciplinary team, a full root cause analysis had been undertaken and recommendations identified. Learning was shared with staff through handovers, ED matters newsletters and by email.

**Safety Thermometer**

The service monitored performance and activity to understand risks and provide a clear accurate picture of patient safety.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards and departments can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from September 2017 to September 2018 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment that was planned and delivered in line with current evidence based guidance.

Staff could access local policies and procedures on the trust’s intranet.

Care and treatment for example mental health, pain, feverish children and head injury in adults as was delivered in line with the National Institute of Health and Clinical Excellence (NICE) and College of Emergency Medicine clinical standards (2014).

There were a range of clinical care pathways in use that aligned with national guidelines. We reviewed four pathways: sepsis, asthma, stroke and fractured neck of femur. All four pathways were multidisciplinary and up to date. Staff also had access to databases that provided information on poisonous substances.

The department ensured care was provided in line with the ‘Clinical Standards for Emergency Departments’ guidelines.

The ED was the designated receiving unit for patients experiencing a stroke and major trauma as the trust could provide specialist treatment.

Staff we spoke with told us that patients with non-traumatic chest pain, unplanned readmissions within 72 hours and febrile children under 12 months would be seen by a consultant. This meant that these patients were receiving care and treatment in line with national guidance.

Venous thromboembolism (VTE) risk assessments were undertaken to identify patients potentially at risk of a VTE, in line with NICE guidance (QS3 statement 5). A VTE is a life-threatening condition where a blood clot forms in a vein. VTE Compliance (assessed within 24
hours) for the clinical decisions unit (CDU) from May 2018 to October 2018 was consistently over 95%.

Staff followed NICE guidance CG138. This guidance relates to the patient experience in adult NHS services and improving the experience of care for people using adult NHS services. Staff handovers routinely referred to the psychological and emotional needs of patients, as well as their relatives/carers.

The emergency department (ED) completed regular audits, results were collated and shared with staff. We were able to review the following audits, ‘Vital signs in Children’, ‘Moderate and Acute Severe Asthma’ ‘Neck of Femur’ audits and ‘Severe Sepsis and Septic Shock’. There were documented recommendations and action plans with plans to re-audit where appropriate to measure the quality of care and to evidence improvement.

The department used the “sepsis six-tool” interventions to treat patients and identify those at high risk. The department monitored compliance which had improved since our last inspection in 2016. We reviewed the records of patient who had presented as a risk for sepsis, and observed the sepsis bundle and treatment was given within the recommended timeframe of an hour.

**Nutrition and hydration**

**Staff assessed patient’s nutrition and hydration needs appropriately.**

Staff reviewed patient’s nutrition and hydration needs following the initial triage assessment. If patients were able to eat and drink, staff offered food and drink to meet their needs. We observed staff offering a child and their mother food and a drink following a medical assessment which discontinued the requirement for the child to be ‘nil by mouth’.

There were drinks and snacks as well as water dispensers were available for patients to access throughout the emergency department.

The ED had a kitchen area, which provided hot drinks and sandwiches, we observed a comfort round where staff offered patients food and drinks. Accompanying relatives were also offered a hot drink. Staff were also able to access hot meals for patients.

Staff assisted patients who were unable to independently eat and drink. We observed staff assisting an elderly patient to have a drink and during this time engaging the patient in conversation and encouraging them to talk about their family.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 7.3 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was about the same as other trusts.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Pain relief**

**Staff assessed, managed and reviewed patient’s pain relief effectively.**

Staff monitored patients’ pain using pain assessment tools. They had a visual chart ranging from zero to 10, zero being the least pain with a happy face and 10 the worst the pain could be with a very sad face. This was useful to use for children and patients with learning disabilities or for those with impaired communication skills.
We spoke with an elderly patient who had fallen. On arrival to the ED, the patient had been given pain relieving gas to self-administer and was offered further pain relief by ED staff straight away.

Staff asked patients if they were in pain and when they were staff responded promptly. Patients did not have to wait long to receive pain relief. Nurses were able to administer simple pain relief (paracetamol, anti-inflammatory, local anaesthetic and inhaled gas) under a patient group direction (which permits suitably trained staff to supply prescription-only medicines to groups of patients, without individual prescriptions).

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.3 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

The trust scored 8.0 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

**Patient outcomes**

**Information about outcomes was routinely collected and monitored.**

The NICE Quality Standard for Trauma was published in March 2018 and describes six specific, concise statements and related measures intended to support priority areas for quality improvement across the entire trauma pathway. The ED had reviewed each of the six statements and it met five of the six. This was because the trust did not have a dedicated ward for major trauma patients. The senior team were developing an options appraisal to move from the ‘Shared-Care’ model to the ‘Trauma Service’ model.

The trust’s data entry to the trauma audit and research network (TARN) quarterly dashboard from April 2018 to June 2018 demonstrated the trust met seven of the nine standards. The two not achieved were the time patients received a computed tomography (CT) scan and patients’ airway care the trust explained that at present the statistics are capturing patients who should not be included in the data.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, the emergency department at Addenbrooke’s and the Rosie Hospitals failed to meet any of the national standards.

The department was in the upper UK quartile for two standards:

- Standard 2a (fundamental): As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 52.5%; UK: 26%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

This department: 85.2%; UK: 52%.

The department’s results for the remaining five standards were all within the middle 50% of
We observed a completed action plan in response to the 2016 audit to address the issues identified. For example, appointing a named medical lead for specialist asthma services.

**RCEM Audit: Consultant sign-off 2016/17**

In the 2016/17 Consultant sign-off audit, the emergency department at Addenbrooke's and the Rosie Hospitals failed to meet any of the national standards.

The department was in the upper UK quartile for one standard:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 46.2%; England: 11%.

The department’s results for the remaining three standards were all within the middle 50% of results.

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 Severe sepsis and septic shock audit, the emergency department at Addenbrooke's and the Rosie Hospitals failed to meet any of the national standards.

The department was in the upper UK quartile for five standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 94.0%; UK: 69.1%.

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 92.0%; UK: 64.6%.

- Standard 3: O₂ was initiated to maintain SaO₂>94% (unless there is a documented reason not to) within one hour of arrival. This department: 91.1%; UK: 30.4%.

- Standard 4: Serum lactate measured within one hour of arrival. This department: 82.0%; UK: 60.0%.

- Standard 5: Blood cultures obtained within one hour of arrival. This department: 76.6%; UK: 44.9%.

The department’s results for the remaining three standards were all within the middle 50% of results.
The department worked together to improve sepsis audit results. The actions implemented were the appointed sepsis champion, the audit results were published in the ‘ED matters’ newsletter, sepsis pathways and posters were visible in all areas of the ED, the electronic system alerted staff to patients at risk of sepsis and staff shared achievements of compliance on the closed media site.

**Unplanned re-attendance rate within seven days**

From September 2017 to August 2018, the trust’s unplanned re-attendance rate to A&E within seven days was consistently worse than the national standard of 5%. The rate was better than the England average in seven of the 12 months.

In the most recent month, August 2018, the trust had a rate of 9.0% compared to the England average of 8.1%.

**Unplanned re-attendance rate within seven days - Cambridge University Hospitals NHS Foundation Trust**

(Source: NHS Digital - A&E quality)

**Competent staff**

Staff were trained to have the correct qualifications, knowledge and skill to perform their role.

All staff we spoke with told us they had the correct qualifications and skills to carry out their roles effectively. Staff told us they attended continual professional development and learning opportunities, which were fully supported by their manager.

All staff rotated to different areas within the ED. This allowed staff to have the skills and confidence to be allocated to any area within the ED during busy times.

The department employed a band seven nurse to facilitate education programmes and assist staff with education and training. The facilitator was responsible for carrying out learning needs.
analysis for the staff across the department ensuring staff were up to date with training.

Staff we spoke with told us that ED staff have access to a full day mental health training day. The trust had a partnership arrangement in place for the provision of psychiatric liaison services. Colleagues from this trust told us that staff embraced mental health training and were skilled at dealing with patients with mental health conditions.

New members of staff completed a structured induction programme and all new staff were required to complete an induction booklet, which was signed off by the ward manager. We spoke with a new member of staff who was working through their booklet and had a named member of staff to liaise with whilst they were new to the trust.

Managers supported staff through the process of revalidation with their professional body the nursing and midwifery council.

**Appraisal rates**

As of July 2018, 97.8% of staff in urgent and emergency care at the trust received an appraisal compared to a trust target of 90%. The appraisal target was met for all five staff groups with eligible staff, including the medical and nursing staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July 2018</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals</td>
<td>Appraisals</td>
<td>Completion</td>
<td>Trust</td>
<td>Met</td>
</tr>
<tr>
<td></td>
<td>completed</td>
<td>required</td>
<td>rate</td>
<td>target</td>
<td>(Yes/No)</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>19</td>
<td>19</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>133</td>
<td>134</td>
<td>99.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>62</td>
<td>66</td>
<td>93.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>90%</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>219</strong></td>
<td><strong>224</strong></td>
<td><strong>97.8%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Appraisal tab)

All staff told us that the service supported staff to receive appraisals and they found them meaningful.

**Multidisciplinary working**

Staff of different kinds worked together as a team to benefit patients.

Multidisciplinary team working was effective in all areas of the ED. Positive team relationships were evident between doctors, nurses, healthcare assistants (HCAs), and other staff. Staff were respectful of each other. Portering staff and volunteers told us they were made to feel an equal part of the ED team.

On inspection we observed that all members of staff had high levels of professionalism and worked together calmly in a coordinated way to deliver high standards of care.

The ED had multidisciplinary major incident continuity plans.

The ED had strong links and relationships with the psychiatric health liaison team, who provided support to ED and the clinical decisions unit. The teams had good working relationships and communicated together regularly to plan patient care and treatment. The team was based
outside of the department, they attend when patients were referred to them and used the rooms allocated for mental health patients within the ED.

There was a system in place for the monitoring of capacity and flow throughout the trust. This meant that staff from the ED no longer needed to leave the department to attend the trust operational bed meetings. Staff from the operational team visited the department to observe and discuss demand and capacity. This meant staff were not leaving the department for long periods of time and the central operational team had complete oversight of the demands throughout the department.

**Seven-day services**

**Patients could access services when they needed to.**

The ED and the clinical decisions unit (CDU) were open 24 hours a day, seven days a week. Patients arrived by ambulance, on foot or as a referral from their GP. The ED had 24-hour access to pathology, and diagnostic tests such as, blood tests, x-rays, computed tomography (CT) scans and magnetic resonance imaging (MRI) scans.

The emergency department used had plaster technicians who were able to apply complex plaster casts to support fractured bones. This service was available Monday to Friday between 8am and 5pm. Outside of these hours, emergency department staff were trained and competency assessed, and provided this service.

The psychiatric health liaison team had been available 24 hours a day seven days a week since July 2017. The introduction of a first response service, which was for patients who presented at the front door of ED. These patients were a private telephone call for advice and signposting for mental health issues. Staff told us this had reduced crisis presentations to ED.

The short-term assessment and rehabilitation team (START) were based within the CDU and provided seven-day cover from 8am to 6pm. The team consisted of nurses, physiotherapists, and occupational therapists who worked with patients to try to avoid hospital admissions.

Within the ED there was a ‘point of care’ for analysing blood tests within the department. This meant blood results could be ready within the hour or more quickly if requested. This also meant patients could receive treatment promptly which improved patient experience and flow within the ED.

The chaplaincy service was available 24 hours a day, seven days a week.

**Health Promotion**

**Staff were proactive in supporting patients to live healthier lives.**

The trust was a non-smoking organisation, and this helped to promote the health benefits of not smoking.

Staff informed patients of the Medicines Helpline for patients/carers/relatives to contact following discharge if they had concerns about their medication.

Staff told us they directed ‘drug users’ to community services that issued sharps boxes and exchanged used needles for new ones.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Staff obtained consent to care and treatment in line with legislation.**

Staff understood their roles and responsibilities under the Children’s Act 1989, the Mental Health Act 1983 and the Mental Capacity Act 2005. The trust had a policy for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
We observed staff routinely asking patients for consent prior to care and treatment.

Staff we spoke with understood the importance of the law relating to Fraser guidelines and Gillick competencies when caring for a female under the age of 16. The Fraser guidelines refer specifically to consent for sexual health services, and are an additional guideline to the Gillick competency framework that relates to consent for any healthcare intervention.

There were no examples to review during our inspection.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for the MCA and DoLS training module as of July 2018 for qualified nursing and medical staff in urgent and emergency care at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July 2018</th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Target</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>147</td>
<td>148</td>
<td>99.3%</td>
<td>90%</td>
</tr>
<tr>
<td>Medical staff</td>
<td>47</td>
<td>60</td>
<td>78.3%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Nursing staff in urgent and emergency care met the trust target of 90% with a completion rate of 99.3%. However, only 78.3% of medical staff had completed the MCA and DoLS training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We followed up medical attendance at MCA and DoLS training during our inspection. The updated statistics from September 2017 to October 2018 showed compliance had slightly reduced to 75%. The senior team explained that this was due to all the junior medical staff changing in August, the new medical staff had been allocated to attend training.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion, dignity and respect during all interactions.

We observed many examples of staff responding with kindness when patients needed help and support. Staff were caring offering reassurance to patients who were in pain or frightened.

All patients we spoke with told us staff were very helpful and caring and they were treated respectfully. One patient said in a compliment we read “Everyone I and partner had contact with, porters, medical staff at all levels, reception/admission staff dealt with my situation and injuries with care, compassion, professionalism and most importantly humanity and I am deeply grateful to them”.

Staff recognised patient’s individual needs. Babies and children too young to speak were treated with kindness and patience. We overheard unrushed, kind conversations with children and their parents during assessments and treatments.

Staff were highly motivated and inspired, they offered care that was kind and promoted dignity. Where patients were receiving care and treatment in cubicles we observed staff closing curtains to protect people’s privacy.

Volunteers were present in the department and we saw them taking time to talk with patients to
We observed many written compliments from patients and relatives, explaining how they received unrushed care during busy times. One relative said, “Your nurses gave us time and support to stay with my husband and allowed me to help prepare him for the mortuary. They gave no indication of being under pressure and it wasn’t until I was escorted through the main waiting area that I realised how frantically busy the department was.”

Staff in the emergency department (ED) worked with patients who presented with behaviours that staff might find challenging. We observed them to be consistently caring when a patient who was confused and shouting aggressively at the staff. They continued to maintain the patient’s privacy and dignity, being non-judgemental despite the behaviours the patient presented with.

**Friends and Family test performance**

The trust’s urgent and emergency care Friends and Family Test performance (% recommended) was consistently better than the England average from September 2017 to August 2018.

In August 2018, 93.1% of patients recommended the trust compared to the England average of 87.7%.

**A&E Friends and Family Test performance - Cambridge University Hospitals NHS Foundation Trust**

(Source: NHS England Friends and Family Test)

**Emotional support**

Patients were given support to cope emotionally with their care, treatment or condition.

Patients emotional needs were seen by staff as being as important as their physical needs. A patient who had a learning disability attended the department. The patient was distressed, staff prioritised the patient and their carer and took into account their individual needs and the effect
the environment of the ED was having on them.

During our inspection we talked with a trust chaplain who visited the department to offer emotional support for patients who wanted it. The chaplaincy department wrote a letter to bereaved relatives five weeks after the death of their loved one to offer a meeting with the ED consultant and chaplain to discuss any concerns they had or to offer further support. Chaplains were available at other times if requested.

Staff were very patient and went above and beyond to support patients and families. One comment from a relative said ‘I would like to thank all the staff who supported me and my family at this extremely difficult time and I would like to say how touched I was to receive a card of sympathy from Sister’. We observed medical staff who engaged with a young person with a learning disability by using role play to assess their injury. They pretended it was a fashion show to encourage them to walk to assess the injury.

Staff used a large dragonfly symbol on a laminated card to indicate that a patient had passed away. This meant staff were visually informed to enable them to be quieter during this time as a mark of respect until the patient had been transferred to the mortuary.

The patient who received timely pain relief told us the ‘staff were very polite and caring’.

Understanding and involvement of patients and those close to them

Patients, carers and those close to them were encouraged to be active partners in their care.

We observed all staff introducing themselves to patients they were caring for throughout the ED.

We heard staff explaining care and treatment plans in a way that people could understand. For example, a nurse used a comparison of a stick being broken to explain a broken arm to a child.

All the patients and their relatives we spoke with told us they felt listened to and involved in their care and treatment. One patient feedback to the ED stated “I will never forget the professionalism, accuracy, efficiency, incredible knowledge and capability displayed by the paramedics, doctors, nurses & healthcare assistants at Addenbrooke’s. I will never forget the kindness, the empathy or the support given”.

Staff empowered patients who used the service to be partners in their care. We observed staff talking with a patient who had presented with a mental health condition in a sensitive and kind way, as well as supporting them to be involved and make decisions about their treatment.

We spoke with a patient who told us that throughout their treatment they had received clear guidance on how to look after the injury they sustained and how to take the medication that had been prescribed. They were given a card to take to reception, which informed the staff to make a follow up appointment for a specific clinic for the patient. This ensured the correct information was given to reception staff.

The chaplaincy team worked closely with the department and could also offer ongoing support for families or staff who needed to debrief or discuss any unresolved concerns or issues.

Emergency Department Survey 2016

The trust scored better than other trusts for three of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining questions.
<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>4.5</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>8.5</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>8.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>7.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>4.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>6.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>8.1</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>Q45. Overall</td>
<td>8.1</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
Is the service responsive?

Service delivery to meet the needs of local people

Services were tailored to meet the needs of individual needs and person-centred pathways that involved other providers.

Information about the needs of the local population was used to inform service planning and delivery. The trust was involved with local commissioners and other health care providers working together to provide urgent and emergency care to patients.

All ambulatory patients arrived at the front door of the emergency department (ED). The nurse who triaged them ensured they were directed to the area of ED that met their needs. This ensured that patients moved to the clinic nine area, paediatric area, minors’ area, major area or directly to resus. We observed that patients had a plan in place and were aware of where they needed to go to be seen. If a bed on a ward was needed it was booked through the patient flow managers.

We observed that all ambulance arrivals requiring access to the resuscitation area, pre-alerted the department by telephone to ensure the correct team and equipment was ready to receive the patient. Minor injury patients arriving by ambulance were received at the front door with the ambulance staff providing a handover. Stretcher patients transferred by ambulance arrived at a side entrance to an area where a Hospital Ambulance Liaison Officer (HALO) and ED staff received the patient after a clinical handover from the incoming ambulance crew. Patients were then directed to the correct area to receive treatment. HALO managed arriving ambulances and liaised between the ambulance service and the ED team to enhance patient flow.

A supported transfer of care (STOC) team supported patient discharge either to home or to an alternative community setting. They also assessed patients on the clinical decisions unit (CDU).

The environment of the ED was suitable to meet the needs of patients with a physical and/or learning disability. Staff we spoke with told us they would request the learning disability nurse to visit if they needed support with a patient. There was one learning disability nurse for the trust available Monday to Friday 9am to 5pm, out of hours staff would refer to the trust guidance or a senior member of the team for advice.

Meeting people’s individual needs

The service demonstrated a pro-active approach to understand the needs of the different patient groups to deliver care to meet those needs, which is accessible and promotes equality.

The ED, psychiatric liaison team, first response service, police, ambulance service and general practitioners met monthly to discuss frequent attenders. At the time of our inspection, there were 80 patients being monitored under the frequent attenders’ policy. The aim was to ensure management plans were in place and share them with the patient.

The Child and Adolescent Mental Health Services (CAMHS) team worked from 9am to 5pm, seven days a week. However, the service had difficulties meeting the demands and provision it provided as they were usually unable to take referrals beyond 2.30pm. A First Response Service was available and managed some 17 year olds by telephone.

The ED recognised this as a significant issue and aimed to increase CAMHS provision. The senior team were recruiting an extra part time band seven member of staff, employed by the local mental health provider but funded by the trust.
The ED band seven staff received training to ensure they had the necessary skills to detain patients under the Mental Health Act who needed urgent treatment for a mental health disorder and were at risk of harm to themselves or others.

Staff told us they had access to a 136 suite which was provided by a neighbouring mental health trust. Staff told us it was used approximately 15 times per month. A Section 136 suite is a facility for patients who were detained by the Police under Section 136 of the Mental Health Act. It provides a ‘place of safety’ whilst potential mental health needs are assessed under the Mental Health Act and any necessary arrangements made for on-going care.

Staff we spoke with told us that translators were offered to patients whose first language was not English.

A domestic violence nurse worked in the trust offering advice and support to patients and to staff dealing with this vulnerable group of patients.

The trust referred patients with drug and alcohol dependencies to a service in the community. Information about the community support service was available for patients. We saw staff sharing this information with patients to enable patients to self-refer to receive support.

There were processes in place to support patients with a learning disability. Staff told us they could request the support of a learning disability lead nurse if required. They told us they reviewed the ‘About me’ documentation (this provided professionals with information about the person with a disability and/or health condition which caused communication difficulties). We observed a patient who had a learning disability attend the department. The patient was distressed. Staff prioritised this patient taking account of their individual needs and the effect of the environment on them.

We observed two occasions were carers were enabled to stay with the patients at all times.

Staff we spoke with were aware of how to support patients living with dementia. Staff knew where the living with dementia trolley was located. The living with dementia trolley contained various aids designed to reduce anxiety for a patient living with dementia. One member of staff described occasions where they used the doll in the trolley to calm an agitated woman living with dementia.

The paediatric department did not have a play specialist at the time of our inspection, they were actively recruiting to a vacancy for a play specialist to work specifically with children in the ED. Play specialists work with children to make them feel at ease by using play as a distraction during treatments. The paediatric area had a variety of age appropriate toys and books in each cubicle for use. We overheard a nurse using a book to find objects within pictures to distract a child whilst they were having blood taken.

During our inspection we observed staff treating patients presenting to the department with mental health conditions with a non-judgemental approach. Patients that received emergency treatment who required a medical mental health review were transferred to the Clinical Decisions Unit (CDU) to await further assessments by the mental health team. This area was spacious and had more comfortable waiting areas or beds if required. Staff who worked on the unit told us they had received mental health training and were confident in caring for patients with mental health needs.

Patients who required a medicine review due to compliance issues or polypharmacy (concurrent use of multiple medications by a patient), risk of falls, swallowing difficulties and support with discharge planning were referral to Specialist Advice for Frail Elderly (SAFE) pharmacist. The SAFE pharmacist could also refer to medicines management technicians employed in the community by a neighbouring trust to undertake any home visits and follow up on patients post
Staff within the ED knew where to direct homeless patients, and were able to advise them to access a shelter in the local city for meals and clothing.

Staff consistently made plans for patients according to their individual needs. A member of staff called an elderly patient’s nursing home to check how they could be transported back to the nursing home. Although the patient could have sat in a wheelchair, the member of staff booked a stretcher transfer because the patient had been awake most of the night.

The ED had a relatives/family room, it was a large space with comfortable sofas for seating. There were telephone facilities to enable relatives to make outside calls, hot drinks facilities and soft lighting.

Emergency Department Survey 2016

The trust scored about the same as other trusts for all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow

Patients could access services to receive the right care at the right time. Access to care was managed by staff to take into account patients with urgent needs.

Staff regularly assessed the activity within the department. The nurse in charge observed all areas of the department to ensure staff were allocated according to patient need and flow.

Staff rotated to all areas of the department to ensure they maintained skills to enable them to work in all areas to promote flow through the department during times of high demand. During our inspection we did not see any patients nursed in corridors. The ED staff were proud that their processes ensured patients were not cared for in corridors.

In times of high demand, the nurse in charge had oversight of all areas of the department, or staff informed them when their area was not able to manage the patient demand. The senior team told us that they implemented the escalation plan in times of need and were not aware of a time when they closed the department.

Median time from arrival to treatment (all patients)

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard in eight months over the 12 month period from August 2017 to July 2018.

From September 2017 to August 2018 performance against this standard ranged from 50 minutes (October 2017) to 96 minutes (March 2018) showing a deterioration over the 12 month period.
In the most recent month, August 2018, the median time to treatment was 76 minutes compared to the England average of 56 minutes.

Median time from arrival to treatment from September 2017 to August 2018 at Cambridge University Hospitals NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From October 2017 to September 2018 the trust consistently failed to meet the standard and performed similar to the England average with the exception of March 2018 when 75.6% of patients at the trust were admitted, transferred or discharged within four hours compared to the England average of 84.6%.

Four hour target performance - Cambridge University Hospitals NHS Foundation Trust

(Source: NHS England - A&E Waiting times)
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From October 2017 to September 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average with the exception of March 2018, when it was similar.

Performance against this metric peaked in March 2018 when 19.3% of patients (634 patients) waited more than four hours from the decision to admit until being admitted compared to the England average of 19.4%.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - Cambridge University Hospitals NHS Foundation Trust

The table below shows the number of patients waiting more than four hours from the decision to admit to being admitted:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2017</td>
<td>162</td>
</tr>
<tr>
<td>November 2017</td>
<td>217</td>
</tr>
<tr>
<td>December 2017</td>
<td>31</td>
</tr>
<tr>
<td>January 2018</td>
<td>340</td>
</tr>
<tr>
<td>February 2018</td>
<td>373</td>
</tr>
<tr>
<td>March 2018</td>
<td>634</td>
</tr>
<tr>
<td>April 2018</td>
<td>152</td>
</tr>
<tr>
<td>May 2018</td>
<td>97</td>
</tr>
<tr>
<td>June 2018</td>
<td>135</td>
</tr>
<tr>
<td>July 2018</td>
<td>157</td>
</tr>
<tr>
<td>August 2018</td>
<td>88</td>
</tr>
<tr>
<td>September 2018</td>
<td>163</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E SitReps)

Number of patients waiting more than 12 hours from the decision to admit until being admitted
Over the 12 months from October 2017 to September 2018, 26 patients waited more than 12 hours from the decision to admit until being admitted. The highest number of patients waiting over 12 hours occurred in March 2018 (20 patients).

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2017</td>
<td>1</td>
</tr>
<tr>
<td>November 2017</td>
<td>0</td>
</tr>
<tr>
<td>December 2017</td>
<td>0</td>
</tr>
<tr>
<td>January 2018</td>
<td>4</td>
</tr>
<tr>
<td>February 2018</td>
<td>1</td>
</tr>
<tr>
<td>March 2018</td>
<td>20</td>
</tr>
<tr>
<td>April 2018</td>
<td>0</td>
</tr>
<tr>
<td>May 2018</td>
<td>0</td>
</tr>
<tr>
<td>June 2018</td>
<td>0</td>
</tr>
<tr>
<td>July 2018</td>
<td>0</td>
</tr>
<tr>
<td>August 2018</td>
<td>0</td>
</tr>
<tr>
<td>September 2018</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

In September 2017, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average.

However, from October 2017 to August 2018, the trust reported a rate of 0%.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - Cambridge University Hospitals NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)

**Median total time in A&E per patient (all patients)**

From September 2017 to August 2018 the trust’s monthly median total time in A&E for all patients was consistently higher than the England average.

In the most recent month, August 2018, the trust’s monthly median total time in A&E for all
patients was 156 minutes compared to the England average of 146 minutes.

**Median total time in A&E per patient - Cambridge University Hospitals NHS Foundation Trust**

![Median total time in A&E per patient graph](image)

(Source: NHS Digital - A&E quality indicators)

The Department of Health’s standard for emergency departments that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department was not met in March 2018, staff explained that this was due to the bad snow during March this year which increased the amount of injuries patients presented with.

We spoke with ambulance staff who told us that in busy times if there was a delay in getting patients off the ambulance, medical staff would assess the patient within the ambulance which ensured the most ill patients were prioritised for treatment this also avoided delays in patients receiving a medical assessment.

The ED had recruited their own physiotherapists to work in minors and across the ED to provide highly specialist treatment to patients who present with complex musculoskeletal conditions. Staff told us that this had helped to reduce admissions, length of stay, improved patient flow and patient experience.

To assist and support the senior nurse and emergency physician, the ED had introduced patient flow navigators (PFNs). Their role included ensuring patients were seen in a timely manner, following up delayed test results, booking transport, liaising with administration staff and bed management staff. This role assisted with the departmental flow and helped to reduce breaches associated with the four hour standard.

The urgent treatment centre provided GP led services in ‘Clinic nine’ seven days a week (which was situated in the outpatient department). The service operated Monday to Friday 11am to 11pm and 8am to 11pm on weekends and bank holidays. All patients were triaged by the triage nurse at the front door of the ED and directed to the most appropriate service based on their presenting condition. Staff we spoke with told us if the patient’s condition deteriorated they would immediately be referred back to ED.

In the main minors waiting area there was a flow chart on the wall explaining the journey through the department. We observed staff interacting with patients to explain the processes of the department.
Learning from complaints and concerns

The service managed and responded to concerns and complaints.

The trust had a complaints policy which ensured that systems and processes were in place to enable patients and relatives to make a complaint. Information about how to complain was available in the department. Staff understood their responsibilities to support people to complain.

All staff we spoke with were aware of the complaints process and where to direct patients to if they could not resolve the complaint within the department. We were given an example, where a missed fracture was discussed in a non-blame manner with staff to prevent it occurring again.

Managers we spoke to told us if a formal complaint was made they were managed in confidence, with a regular update for the complainant.

Summary of complaints

From August 2017 to July 2018 the trust received 51 complaints about urgent and emergency care, 7% of the total complaints trust-wide. For the 44 complaints that had been closed, the trust took an average of 47.1 working days to investigate and close these complaints. The trust does not have a specific target of closing complaints. However, their internal target for responding to complaints is for 50% to receive a full written response within 30 working days.

For the seven complaints that had not been closed, the average time these complaints had been open for was 40.1 working days.

The most common subjects of the complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>19</td>
<td>37.3%</td>
</tr>
<tr>
<td>Staff values and behaviours</td>
<td>9</td>
<td>17.6%</td>
</tr>
<tr>
<td>Communications</td>
<td>6</td>
<td>11.8%</td>
</tr>
<tr>
<td>Patient care</td>
<td>4</td>
<td>7.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

We observed a presentation that was shared with staff to highlight the themes of the concerns and complaints in the ED from January 2018 to June 2018, for example, the environment, staff attitude and communication. The learning was identified and actions recognised and implemented.

Number of compliments made to the trust

From August 2017 to July 2018 the trust received 89 compliments about urgent and emergency care.

Seventy-three of the 89 compliments (82.0%) related to the adult emergency department followed by the paediatric emergency department with seven (7.9%).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

There was compassionate inclusive and effective leadership at all levels. Leaders demonstrated high levels of experience and capability needed to deliver excellent sustainable care.

The departments at the trust were grouped together under five divisions. The urgent and emergency care department was part of Division C. A divisional director led each division supported by a divisional lead nurse, an associate director of operations, a divisional finance lead and a divisional workforce lead.

The ED prioritised leadership development and succession planning to ensure that the service continued to have effective leaders within the department.

The department was led by a speciality lead, an operational manager and a senior clinical nurse. All staff described the leadership team as highly engaging, approachable and accessible. All leaders were focused on the delivery of high quality patient care.

The senior team had recruited a full time HALO to work in conjunction with the bed flow managers and operational team to monitor arrivals and patient flow. Improved patient flow reflected good patient experiences. For example, there were fewer patients who were admitted as outliers to wards and other core services, such as medical care. Fewer patients were moved between wards to make room for new admittances.

Staff told us that due to good flow within the department patients were not cared for in corridors. There was a distinctly calm feeling despite the constant busyness of the department and this was also seen in the staff culture of the ED.

The leadership team were fully commitment to the values of improving services and supporting staff. The senior team were committed to providing 24 hour consultant presence which was due to start in April 2019.

Senior management recognised the importance of being involved in research trials. The ED were involved in a number of research trials, for example, ‘CRASH 3′ (a trial about brain injury). ‘CRYOSTAT-2’ (evaluating the effects of early high-dose blood clotting treatment in adult patients with major trauma haemorrhage), and ‘RAMPP’ (a study into lung collapse and reducing hospital stay).

Leaders empowered medical and nursing staff to roster their own shifts at work. This enabled them to experience and appreciate the difficulties of covering shifts. Staff we spoke with told us that this initiative supported them to have an improved work life balance, they were in control of the shifts they were rostered to work to suit their home life and personnel commitments.

Vision and Strategy

All staff we spoke with were aware of the trust vision and could describe them. There was a systematic approach to monitoring, reviewing and tracking progress within the trust.

The leadership team set out a vision for the service where the effectiveness of care in the ED was reflected across other services such as mental health, medical care, surgical care, children and young person’s care and end of life care.

The trusts vision was to improve people’s quality of life through innovative and sustainable healthcare. The strategy was focused on improving the quality, safety and experience of care for patients and the four values: Together, Safe, Kind, Excellent –were at the heart of patient care, defining the way staff worked and behaved.

All staff we spoke with were aware of the trust’s vision and values. There were posters throughout the hospital informing patients and the public of the trust values.
The emergency department and clinical decisions unit (CDU) had a service development plan for the period of 2018 to 2019 which aligned to the trusts quality strategy 2013 to 2018, this outlined the key service development goals. Some of these goals were; person centred care, improving the experience of our staff, harm and delay free care and clinically effective care.

**Culture**

Leaders had an inspiring shared purpose and strive to deliver and motivate staff to succeed. There were high levels of satisfaction across staff groups within the department.

Staff were proud of their department and spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and everyone’s responsibility.

Staff spoke of how they were encouraged to speak up if they saw something they were unhappy with regarding patient care. The senior team demonstrated a commitment to support the staff and team working in the department and everyone was treated the same regardless of their role or position.

Many staff told us there was a blame free culture in the department, rather a learning culture and senior leaders gave us examples of staff suggesting improvement ideas which had been acted upon. For example, medical staff wanted to plan their own off duty and staff had implemented a healthy competition on their closed media page to share how effectively they completed the sepsis-six pathway. The fastest response was less than 15 minutes.

All of the junior doctors we spoke with told us they enjoyed working in the ED, they said they felt supported and valued by their seniors and colleagues and that they had opportunities to learn and gain confidence. One doctor explained how his senior stayed to supervise him performing a new suturing technique.

The ED held a monthly new starters forum to ensure new staff felt welcome and supported. It included inviting senior members of the team to have discussions with staff, celebrate diversity by staff introducing themselves and their country of origin. Also, staff were encouraged to feedback on how the recruitment process went and what improvements could be made.

**Governance**

Governance arrangements are proactively reviewed and reflected best practice. A systematic approach was implemented to work with other organisations to improve patient experiences and outcomes.

There was an effective governance framework in place. There were monthly emergency department clinical governance meetings. Staff were involved in the trust’s shared governance system.

Staff attended monthly meetings which covered topics such as complaints, incidents and quality improvement projects. The departmental risks and compliance with the Care Quality Commission (CQC) standards were discussed, along with the outcomes and learning from incident investigations.

We reviewed Division C board minutes from three meetings and observed that the agenda included performance, patient safety, incidents, risk and quality, staffing, health and safety, safety thermometer indicators, infection control and serious incidents. We observed actions identified assigned to individuals with a tracked plan to ensure they were completed. One open action for the ED was concerns regarding Child and Adolescent Mental Health Services (CAHMS) provision we saw that this was escalated through to the Division C performance meeting with the executive team in October 2018.
We reviewed a presentation ‘ED Matters’ for staff which contained information regarding lessons learnt from serious incidents within the division to ensure learning was cascaded across the trust. For example, the theft of medication in another department, the lessons were clear and shared with staff to reduce the risk of the incident happening again.

The senior team had oversight of the management of incident within ED. At the time we inspected the service had six incidents open that were being managed.

**Management of risk, issues and performance**

There was a commitment to best practice performance and risk management processes. The department reviewed how they function and ensured all staff had the skills and knowledge to use systems effectively.

There was a system for identifying and monitoring departmental risks. There was a departmental risk register which was regularly reviewed. Senior leaders in the department were aware of and spoke confidently about their risks and how they were addressing them.

The top risk identified for the department was the insufficient capacity of the ED. This had been reviewed but remained the highest risk score until the environment plans were approved and implemented. The second highest risk related to children and adolescents. The ED was in the process of recruiting to mitigate this risk which would enable the score to be reviewed once the member of staff was in post.

The department produce a monthly newsletter called ED Matters. We reviewed the newsletter for February 2018, June 2018 and September 2018. They included good news stories, compliments, operational issues, targets and where improvements are needed, staffing updates, learning from incidents, new pathways and staff awards.

The senior leadership team recognised the ED environment was challenging. The ED was originally built in 1961 to accommodate 35,000 patients a year. Since then the ED has had four significant refurbishments and attendances have exceeded expected attendances. The board commissioned work in 2017/18 to explore how to develop the ED and it was not seen as viable to build a new department. A specialist architect had visited the trust to identify how the ED could be designed to maximise available space. This was shared with all staff through the ED matters presentation to ensure staff are aware of up to date developments.

The senior leadership team within the directorate had started winter planning in the summer months. Plans included the suspension of some planned specialty surgery through the winter months to allow more beds to be available. Two wards had been redesigned as extra capacity medical wards and medical specialty doctors will assess patients within the ED and admit them directly to a speciality bed to alleviate demands on the clinical decisions unit (CDU).

**Information Management**

The service collected, analysed, managed and used information to support its activities, using secure electronic systems with security safeguards.

The ED was paperless and staff were trained to use the electronic patient information system. The system had multifunctional screens to enable the user to access for example, risk assessment fields, safeguarding fields and speciality notes. All staff we spoke with said that it was an easy system to navigate.

The electronic system had alerts to notify staff of patients at risk of deteriorating, if there was a safeguarding concern, or if the patient was a vulnerable person.

All staff we asked about concerns regarding the system told us that changes to the system could be made to improve its functionality, but they could take up to six months to complete which was out of their control and a manufacture issue.

The bed planning system showed failed discharges, which were monitored through the daily huddles, and we observed this during our inspection. Ward dashboards were available on the trust’s electronic reporting system, which showed the ‘SAFER bundle’ a tool to make sure patients
were assessed and reviewed in the most effective way. ‘SAFER’ stands for Senior review/Anticipate/Flow/Earlier discharge/React to delays. Compliance to the SAFER bundle was reviewed on a ward by ward basis. This enabled the ED to know exactly where the bed pressures and available beds were throughout the trust.

Pharmacists effectively used the electronic patient information system ‘track board’ feature to identify patients most likely to be admitted to a ward and prioritise medicines reviews for those patients.

**Engagement**

**Leaders consistently involved staff, considered public feedback and welcomed stakeholder challenge to develop the department.**

Staff told us they enjoyed working in the department and felt listened to. Nursing staff enjoyed the variety of work and the fact they rotated throughout the departmental areas.

The department made time for staff away days, to enable staff to work together for the day and participate in developing the ED. We observed a six-month plan to ensure all staff got to attend a meeting. Topics included on the away day were, sepsis, governance, mortality and morbidity and other subjects were decided as required.

The volunteer body were a good example of focussed engagement with the local public. Members of the public who wished to give some of their free time applied to the trust to be volunteers. The volunteers in ED chose to work there and their commitment benefited the department; this was a highly valued initiative.

The trust used various social media platforms to engage with patients, the public, staff, and stakeholders such as media, annual board meetings and patient feedback and complaints.

Staff could opt in to the ED’s private dedicated social media page. This enabled the sharing of any news, updates to practice, safety alerts, staffing issues, successes, good news stories and feedback from lessons learnt from incidents or complaints.

The ED had a hub to enable patients to charge their mobile phones whilst waiting to be seen. This was an initiative that was from patients and families feedback that they needed to charge their mobile phones.

The department had a monthly employee of the month. Staff could be nominated by colleagues, of which one was chosen to become winner of the month. The employee of the month featured in the ED matters newsletter.

Within the ED matters presentation which was also displayed around the ED there was a ‘Get to Know’ page where a member of staff answered a set of questions to enable colleagues to get to know them which helped with staff relationships within the department.

Every year the trust held an Annual Public Meeting (APM). Everyone was welcome to attend and ask questions or raise concerns with the Board of Directors and Governors. One of the topics of discussion at the 2017 APM was the ED and promoting awareness of only accessing the department for emergency treatments. Discussions included where to go with minor ailments to educate the public and improve flow within the ED.

The public could join the Cambridge University Hospital foundation trust membership. Members received regular information about the latest developments in the trust. As of 31 March 2018, membership consisted of 19,425 individuals. The trust divided membership into three groups:

- Patient – for patients and carers (4,383)
- Public – for people who live in the catchment area (5,067)
- Staff – automatic membership for eligible staff, opt out was available (9,535)
Learning, continuous improvement and innovation

There was a commitment from all staff to seek and embed new ways of working to improve care and services for patients.

The trust, senior leadership team and staff were committed to the continuous learning, improvement and innovation throughout the emergency department. Staff shared with us how all senior staff were supported to complete a master’s degree, which the trust funded and they were given the time to attend the study days. Paediatric medical staff came to the department and held weekly training sessions for the junior medical staff to attend.

The ED had an initiative called the ED listeners. The ED listeners provided on-site peer support in times of need and offered advice on where to access additional specialist support. The team of listeners were identified by wearing a yellow lanyard.

Medical staff were focused on continually improving the quality of care. A number were involved in research and academic projects, some of which had been nationally recognised. For example, participation in a research study led by Cambridge University's Judge School of Management. This aimed to understand how trainee emergency department doctors were inducted safely to work in an emergency department. Senior staff told us that this would help the ED to critically evaluate the way they build their ED teams.

The ED introduced Trauma Risk Management (TRiM) Practitioner training to support staff health and wellbeing. TRiM is a peer-led process which seeks to identify and support staff who may be at risk of a psychological injury after experiencing a traumatic event.

The emergency department (ED) staff participated in outreach work in the community and had visited a pre-school nursery. Staff shared with us a picture of a teacher having their arm put in a plaster cast to demonstrate to children what happened in ED if they broke a bone.

Staff shared a presentation with us that they had delivered to older children between age 10 and 11 years old. It contained information about what treatments staff do in the ED and pictures of the areas the children may need to visit.

A healthcare assistant (HCA) who took a ‘no nonsense’ attitude (practical and only interested in achieving) towards protecting patients and staff in the ED was one of two winners of the trusts you made a difference award for January 2018. They successfully introduced a programme called ‘No Nonsense November’ for annual fit testing of respirators in the event of a major chemical incident. The fit testing identified the ED needed additional protective hoods for staff that were not clean shaven, respirators were not allowed to be worn by staff who had a beard as this did not give a safe seal on the staff members face. The HCA successfully negotiated the purchase of these hoods as well as identifying safe storage.

A paediatric HCA from the ED who coordinated an appeal for new toys for the children’s emergency waiting room won the August 2018 you made a difference award. The member of staff made a local appeal on a social media site for toys to support the children in the ED and offered to collect the donations in their own time. The social media post was seen by BBC Cambridgeshire who interviewed the member of staff for the local news which highlighted fund raising within the department.
The medical care service at Cambridge University NHS Foundation Trust sits across four divisions, with the largest group sitting within the acute services directorate (alongside the emergency department). This includes the medical decisions unit and short stay medical ward (under the care of acute medicine); and six wards under the care of the department of medicine for the elderly.

A comprehensive range of medical services is available including respiratory medicine, infectious diseases, immunology, allergy, clinical pharmacology, nephrology, hepatology, rheumatology, gastroenterology, neurology, stroke medicine (including the hyper acute stroke unit), dermatology, cardiology, diabetes and endocrinology, haematology and oncology. Dialysis services are delivered off-site in Cambridge and at satellite units in Huntingdon, King's Lynn and Bury St Edmunds.

Day case chemotherapy is provided in two-day treatment units on site (the haematology day unit and the oncology day unit), and in three local GP surgeries. Oncology or haematology patients presenting as emergencies are reviewed in a dedicated cancer assessment unit (CAU). Apheresis services are provided in the apheresis unit adjacent to the CAU.

(Source: Routine Provider Information Request AC1 – Context acute)

The medical care service at the trust has 616 medical inpatient beds located across 26 wards and units.

<table>
<thead>
<tr>
<th>Ward/unit name</th>
<th>Description of ward/unit</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Assessment Unit 4</td>
<td>Medical Short Stay Decisions Unit (MDU)</td>
<td>26</td>
</tr>
<tr>
<td>Emergency Assessment Unit 5</td>
<td>Medical Short Stay Emergency Unit (MSEU)</td>
<td>26</td>
</tr>
<tr>
<td>Hinchinbrooke Dialysis Centre</td>
<td>Dialysis unit</td>
<td>17</td>
</tr>
<tr>
<td>Lewin Stroke and rehabilitation unit</td>
<td>Stroke and rehabilitation unit</td>
<td>26</td>
</tr>
<tr>
<td>QE Hospital, King’s Lynn Dialysis Centre</td>
<td>Dialysis unit</td>
<td>17</td>
</tr>
<tr>
<td>Ward C10</td>
<td>Haematology and haematological oncology</td>
<td>16</td>
</tr>
<tr>
<td>Ward C4</td>
<td>Medicine for the elderly (DME)</td>
<td>26</td>
</tr>
<tr>
<td>Ward C5</td>
<td>General medicine and nephrology</td>
<td>27</td>
</tr>
<tr>
<td>Ward C6</td>
<td>Medicine for the elderly</td>
<td>26</td>
</tr>
<tr>
<td>Ward D10</td>
<td>Infectious diseases isolation ward</td>
<td>11</td>
</tr>
<tr>
<td>Ward D5</td>
<td>Hepatology</td>
<td>30</td>
</tr>
<tr>
<td>Ward D6</td>
<td>Haematology</td>
<td>11</td>
</tr>
<tr>
<td>Ward D7</td>
<td>Diabetes</td>
<td>31</td>
</tr>
<tr>
<td>Ward D9</td>
<td>Oncology and chemotherapy</td>
<td>33</td>
</tr>
<tr>
<td>Ward F4</td>
<td>Medicine for the elderly (DME)</td>
<td>21</td>
</tr>
<tr>
<td>Ward F6-</td>
<td>Diabetes/endocrinology</td>
<td>27</td>
</tr>
<tr>
<td>Ward G3</td>
<td>Medicine for the elderly (DME)/discharge lounge Including delayed transfers of care (DTOC)</td>
<td>25</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>Ward G4</td>
<td>Medicine for the elderly (DME)/acute medical conditions with a specialism in complex needs</td>
<td>27</td>
</tr>
<tr>
<td>Ward G6</td>
<td>Medicine for the elderly (DME)/orthogeriatrics – specialism in dementia and delirium care</td>
<td>27</td>
</tr>
<tr>
<td>Ward K3 and Coronary Care Unit (CCU)</td>
<td>Inpatient specialist medicine, acute medicine – cardiology</td>
<td>31</td>
</tr>
<tr>
<td>Ward M4</td>
<td>Digestive diseases</td>
<td>32</td>
</tr>
<tr>
<td>Ward N2</td>
<td>Isolation ward</td>
<td>22</td>
</tr>
<tr>
<td>Ward N3</td>
<td>Respiratory medicine</td>
<td>25</td>
</tr>
<tr>
<td>Ward R2</td>
<td>Hyperacute and acute stroke</td>
<td>14</td>
</tr>
<tr>
<td>West Suffolk Dialysis Centre</td>
<td>Dialysis unit</td>
<td>14</td>
</tr>
<tr>
<td>Cambridge Dialysis Centre</td>
<td>Dialysis unit</td>
<td>28</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request P2 - Sites)

The trust had 71,187 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 23,100 (32.4 %), 1,862 (2.6%) were elective, and the remaining 46,225 (64.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine, 18,549 (26.1%)
- Gastroenterology, 13,819 (19.4%)
- Medical oncology, 13,073 (18.4%)

(Source: Hospital Episode Statistics)

Throughout our inspection we visited 20 of the medical care areas and wards managed throughout the divisions. We used a variety of methods to help us gather evidence to assess and judge the medical care services. We spoke with nine patients and those important to them, 18 doctors, including junior doctors, middle grade doctors and consultants, 30 registered nurses, three health care assistants (HCAs), three allied healthcare professionals and several other support staff, such as nutritional support staff and housekeeping staff. We interviewed the clinical leads for Division C, the division under which most of the medical care services sat. We observed the care and the environment and we looked at 21 sets of records, including patient care records, on the trusts electronic recording system. We also looked at a wide range of documents, including policies, minutes of meetings, action plans, risk assessments, and audit results.

We last inspected this service in September 2016 and rated medical care (including older people’s services) as good overall. We rated safe, caring, responsive, and well-led as good and effective as requires improvement.
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 90% for the completion of all mandatory training.

A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July, 2018</th>
<th>Trust target</th>
<th>Met (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>605</td>
<td>606</td>
<td>99.8%</td>
</tr>
<tr>
<td>Infection control</td>
<td>603</td>
<td>606</td>
<td>99.5%</td>
</tr>
<tr>
<td>Information governance</td>
<td>603</td>
<td>606</td>
<td>99.5%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>159</td>
<td>160</td>
<td>99.4%</td>
</tr>
<tr>
<td>Health and safety</td>
<td>159</td>
<td>160</td>
<td>99.4%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>551</td>
<td>609</td>
<td>90.5%</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>545</td>
<td>608</td>
<td>89.6%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>537</td>
<td>607</td>
<td>88.5%</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 95.0% for qualified nursing staff in medicine. The trust’s training targets were met for six of the eight mandatory training modules for which qualified nursing staff were eligible. The module with the lowest completion rate was fire safety with 88.5%.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July, 2018</th>
<th>Trust target</th>
<th>Met (yes/no)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>139</td>
<td>142</td>
<td>97.9%</td>
</tr>
<tr>
<td>Health and safety</td>
<td>139</td>
<td>142</td>
<td>97.9%</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>340</td>
<td>365</td>
<td>93.2%</td>
</tr>
<tr>
<td>Information governance</td>
<td>335</td>
<td>365</td>
<td>91.8%</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>334</td>
<td>365</td>
<td>91.5%</td>
</tr>
<tr>
<td>Infection control</td>
<td>334</td>
<td>365</td>
<td>91.5%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>332</td>
<td>365</td>
<td>91.0%</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>248</td>
<td>371</td>
<td>66.8%</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 88.8% for medical staff in medicine at the trust. The trust’s training target was met for seven of the eight mandatory training modules for which medical staff were eligible. The module with the lowest completion rate was resuscitation
Throughout our inspection, most of the nursing, medical and health care assistant staff we spoke with told us they could access mandatory training and that training opportunities were good. However, staff said access to face to face training was sometimes difficult to access or cancelled due to operational pressures on the service, for example resuscitation training.

Training was delivered through a mix of e-learning packages, and face-to-face classroom sessions.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. However not all staff were up-to-date with safeguarding training on how to recognise and report abuse.

Staff had training on how to recognise and report abuse and they knew how to apply it.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for qualified nursing staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July, 2018</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>616</td>
<td>616</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>605</td>
<td>606</td>
<td>99.8%</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>610</td>
<td>616</td>
<td>99.0%</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>588</td>
<td>616</td>
<td>95.5%</td>
</tr>
<tr>
<td>Prevent level 3 (WRAP)</td>
<td>51</td>
<td>56</td>
<td>91.1%</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>49</td>
<td>56</td>
<td>87.5%</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 98.2% for qualified nursing staff in medicine at the trust. The trust’s 90% completion target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible. The module with the lowest completion rate was safeguarding children level 3 with 87.5%.

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in medicine at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July, 2018</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
<td>Number of eligible staff</td>
<td>Completion rate</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>332</td>
<td>365</td>
<td>91.0%</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>331</td>
<td>372</td>
<td>89.0%</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>297</td>
<td>365</td>
<td>81.4%</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>298</td>
<td>371</td>
<td>80.3%</td>
</tr>
<tr>
<td>Prevent level 3 (WRAP)</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 85.4% for medical staff in
medicine at the trust. The trust’s 90% completion target was only met for two of the six safeguarding training modules for which medical staff were eligible. The module with the lowest completion rate was Prevent level 3 (WRAP) with 75.0%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The hospital had policies in place regarding safeguarding of adults, and staff could access National Institute for Health and Clinical Excellence (NICE) guidance on identifying domestic violence and female genital mutilation (FGM). Staff accessed these policies through the trust’s intranet system.

All nursing staff we spoke with understood their responsibilities in terms of safeguarding adults and children. They could tell us how they would report a safeguarding concern and what they would report. One member of nursing staff told us they had recently raised a safeguarding concern regarding a concern for an older person’s support in the community and received feedback from safeguarding team on the referral.

The trust had a designated safeguarding lead for adults and for children. Staff we spoke with knew who the lead was and could describe how they would contact them.

The trust’s safeguarding team submitted a quarterly report to the Board, which included a summary of referrals received by the team. Medical ward staff had made 378 adult safeguarding referrals between November 2017 and October 2018. The trust’s named nurse for adult safeguarding reported the largest volume of adult safeguarding referrals were generated regarding concerns for elderly patients.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The trust had an infection control policy, which was accessible to all staff on the trust’s intranet system including agency and locum staff.

All clinical areas we visited were visibly clean. Nursing and medical staff adhered to the trust hand hygiene and ‘bare below the elbow’ policy, and wore PPE (personal protective equipment) such as gloves and aprons when undertaking personal care. However, on ward G6 we observed a member of domestic staff entering a side room of a patient that was in isolation due to infection prevention and control risks, who did not wear any PPE. In addition, we observed another room on the same ward that was being used for a patient that required isolation. We raised this as a concern with the senior nurse on the ward who confirmed a risk assessment had not been completed for either patient regarding the isolation and procedures that should be followed. The senior nurse took immediate action and this was the only ward throughout the medical services where we observed these concerns.

Staff adhered to the hand hygiene policy and ensured that their hands were decontaminated before and after contact with patients. They also used hand sanitiser where appropriate. This was in line with National Institute for Health and Care Excellence (NICE) Quality Standard 61, which states that healthcare workers should decontaminate their hands immediately before and after every episode of direct contact care.

This was also in line with the World Health Organisation’s ‘five moments for hand hygiene’ These guidelines are for all staff working within healthcare environments and define the key moments when staff should be performing hand hygiene in order to reduce risk of cross contamination between patients.

Hand sanitiser was available at the entrance to each ward area and clear signage was in place
asking all staff and visitors to wash their hands to prevent, protect, and control the spread of infection when entering or leaving wards or departmental areas.

Results from the most recent monthly hand hygiene and ward cleanliness audits were displayed in all ward areas. Hand hygiene audits for November 2017 to September 2018 showed all medical wards met the trust compliance target of 95% for all months audited, apart from ward D7, which had recently opened as the new diabetes and endocrinology ward. Ward D7 did not meet the trust target in June 2018 when it was 73.3% or in September when it was 70%. Ward managers told us that where wards had not met the hand hygiene compliance target reminders were sent to all staff on the ward and increased monitoring took place.

The trust undertook daily ward cleaning audits, which resulted in a score out of 100 for each ward audited. The frequency of the monitoring of standards was undertaken in accordance with the to risk level of each area. The document that defines the risk level for each area was also submitted, which outlines the risk based approach to auditing. The risk levels were set by the infection control department. High risk areas were monitored weekly with a pass mark of 98%, Medium risk areas were monitored fortnightly with a pass mark of 95%, and low risk areas were monitored quarterly with a pass mark 85%. The trust provided results for the previous 12 months up to our inspection that showed audits took place in line with risk levels and trust policy.

All the equipment we checked was visibly clean and displayed green ‘I am clean’ stickers with the date of cleaning to identify those which staff had cleaned and were ready for use. This ensured staff were aware of which pieces of equipment were clean and ready for use.

In the Endoscopy unit, there was a clear pathway for clean and contaminated equipment to prevent cross contamination. Staff decontaminated the equipment and stored it in line with national guidance. Records were in place that provided a full audit and traceability process.

Nursing staff screened patients for communicable diseases such as MRSA on first admission into the ward. If a patient was admitted with MRSA staff followed the Infection prevention and control policy regarding ongoing monitoring and isolation. Any patient that posed a risk of infection was nursed in a side room or on a specific isolation ward.

The trust conducted infection prevention and control audits on all medical wards. Audits included an equipment cleaning audit of 10 wards each month. The most recent audit showed staff knowledge was 100% on all medical wards audited. Results from cleaning checks on equipment ranged from 77% on ward K3 to 100% on ward F4.

Between November 2017 and September 2018, the hospital reported 53 cases of methicillin-resistant Staphylococcus aureus (MRSA), 47 cases of Clostridium Difficile (C.Difficile) and 14 cases of methicillin-sensitive Staphylococcus aureus (MSSA). Thirteen of the cases of MRSA had been on ward G6. Staff told us the number of audits had increased on the ward and it had achieved pass marks on all audits between January and October 2018.

The trust Clinical Microbiology and Public Health Laboratory was located within Addenbrooke’s Hospital, Cambridge Biomedical Campus. Biomedical scientists in the department examined specimens for the presence of bacteria, viruses, fungi or parasites, including for use in the diagnosis of Legionnaires’ disease.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

The clinical areas we visited were bright, well organised, and free from clutter.
We looked 30 pieces of equipment including airflow mattresses, blood pressure monitors, hoists and patient monitoring equipment. All equipment had been serviced and calibrated in line with manufacturer’s guidelines.

Resuscitation equipment was visibly clean and stored in an accessible location on all the wards we visited. We reviewed a sample of consumable equipment, and 16 oxygen canisters and found they were all within calibration and maintenance dates.

We reviewed records of safety checks for resuscitation equipment from August 2018 to the end of October 2018, which showed staff had completed daily checks on all wards we visited.

We inspected the storage and expiry dates of consumable items, for example syringes, personal protective equipment and catheters on all the wards we visited. All consumables we looked at were stored correctly and were within expiry dates on all the medical wards.

Patient trolleys, equipment, and curtains providing privacy, were visibly clean throughout the medical wards. Disposable curtains displayed an expiry check date and we found all curtains to be within service date and in good condition.

All wards displayed signage to identify the nurse in charge, the number of staff planned and actual staff on duty. Signage was clear and enabled staff, patients and relatives to see the number of staff on duty, identify staff roles, and see who oversaw each ward.

Staff in all areas complied with DH Health Technical Memorandum (HTM) 07/01 in relation to the Safe Management and Disposal of Healthcare Waste (2013). This meant staff segregated waste by type using appropriate colour-coded bags and stored them in secure areas. Waste bins were colour coded for the appropriate waste disposal method and we noted that domestic staff routinely emptied waste bins during our inspection.

Nursing staff correctly labelled and secured sharps bins. We inspected sharps bins on each of the wards we visited and saw that staff did not overfill any of the sharps bins.

All cleaning cupboards were kept locked when not in use and storage of cleaning materials met Control of Substances Hazardous to Health (COSHH) regulations.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

During our inspection, we reviewed a sample of 21 patient records across the wards we inspected, which showed that medical patients received a medical review every 24 hours Monday to Friday. Patients did not receive a routine medical review at weekends. However, newly admitted patients received a medical review from the on call medical team if they were admitted at the weekend. Medical staff could request that the on call medical team at weekends reviewed patients that were at risk of deterioration or that were being prepared for discharge. Nursing staff could request support or a medical review from the on-call team at weekends when required. Nursing staff told us that they received sufficient support from the on call medical team when required.

Standard risk assessment tools were completed on admission, which staff completed in all patient records we reviewed. Staff used specific tools for pressure ulcer risk, moving and handling, and bed rails risk, nutrition, falls, and dementia screening. These were completed on the trust electronic patient record using Personal Digital Assistants (PDAs), which different professional and care staff completed.

A National Early Warning System version two (NEWS2) was used for patients across the hospital
to assist staff in the early recognition of a deteriorating patient. NEWS2 is a simple scoring system in which a score is allocated to six physiological measurements taken in hospitals – respiratory rate, oxygen saturations, temperature, systolic blood pressure, pulse rate and level of consciousness. All records we reviewed showed that staff routinely completed NEWS2, calculated scores correctly, and alerted senior staff to any patient that may be deteriorating where appropriate action was taken for further monitoring or action. This meant that patients were being monitored for signs of deterioration and could be treated in a timely way.

All the wards we visited had a named sepsis champion. Sepsis champions are staff members that undertake sepsis training and in turn provide sepsis training to other staff members in their department or ward. We observed nursing staff using the sepsis six screening tool and followed three sepsis pathways, which were completed correctly and in line with standard time frames, for example by providing antibiotics or oxygen when sepsis was first identified. The trust used a ‘sepsis six’ bundle. Staff were familiar with it and confident in recognising signs of sepsis (sepsis-six is a bundle of therapies designed to reduce the risk of death for patients experiencing sepsis). Early treatment of sepsis reduced complications and improved outcomes for patients. Nursing staff identified patients at risk of developing pressure ulcers using the Waterlow risk assessment scores and recording any potential sores on a body map. These patients could wear pressure-relieving boots to protect their ankles and/or used pressure relieving air mattresses to try to reduce the risk of pressure ulcers developing. We saw evidence of the correct use of pressure relieving air mattresses where Waterlow scores identified their use was necessary.

Staff received training in basic life support, immediate life support, and advanced life support depending on their role.

Nurse staffing

The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. However, there was a high reliance on temporary non-qualified nursing staff. Patients’ needs were met at the time of our inspection. Plans were in place to improve staff recruitment.

The trust reported the following qualified nursing staff numbers in medical care from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Medical care</td>
<td>563.2</td>
<td>736.9</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of around 76% for nursing staff in medical care in both time periods.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 22.5% for qualified nursing staff in medical care. This was higher than the trust target for nursing and midwifery staff of less than or equal to 11%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)
Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 17.2% for qualified nursing staff in medical care. This was higher than the trust target of 10.56%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 3.5% for qualified nursing staff in medical care. This was higher than the trust target of 2.7%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From August 2017 to July 2018, the trust reported that 12.7% of qualified nursing full time equivalent (FTE) shifts in medical care at the trust were filled by bank staff and 1.4% of shifts were filled by agency staff. In addition, 6.1% of the qualified nursing staff FTE shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 26.3% of non-qualified nursing staff FTE shifts in medical care at the trust were filled by bank staff and none were filled by agency staff. There were 7.5% of non-qualified nursing staff FTE shifts that were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Bank FTE shifts</th>
<th>Agency FTE shifts</th>
<th>Unfilled FTE shifts</th>
<th>Total FTE shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>974.1</td>
<td>12.7%</td>
<td>108.0</td>
<td>1.4%</td>
</tr>
<tr>
<td>Non-qualified nurses</td>
<td>1,402.6</td>
<td>26.3%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>2,376.7</td>
<td>18.3%</td>
<td>108.0</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The trust used the ‘Safer Nursing’ acuity tool to allocate the number of staff based on patient acuity and dependency. This tool provides a measurement of the intensity of nursing care required by each patient.

Most of the wards we visited had vacancies for either nurses (RNs) or health care assistants (HCAs). We noted during our inspection that on most wards staffing fell below the planned establishment. In these cases, the trust used agency or bank staff.

All wards displayed a planned and actual level for nursing and healthcare assistant staff. Nursing staff moved between wards to cover for staff shortages when required. We observed a daily staffing and capacity meeting where staff discussed staffing levels and arrangements made to move nursing or HCA staff between wards to ensure the hospital maintained safe staffing levels. Ward managers were included in the discussions. Staff shared concerns that nursing staff continued to be asked to regularly move between wards to cover for staff absences and vacancies. However, staff told us they felt they had sufficient support when being asked to move between wards to cover for staffing issues and were only asked to work on other medical wards within their division.

Nursing staff completed a handover of information between each shift, which included discussion of patient care, staffing issues and any patient safety issues.
Senior managers were aware of staffing concerns across the medical wards. The trust previously used significant recruitment initiatives and these continued at the time of our inspection. Ward managers maintained a visible presence throughout the clinical areas to support staff and staffing concerns were on the trust’s risk register, which outlined ongoing actions and mitigation taken to reduce the risk.

Agency nurse staff completed an induction before they could take responsibility for providing care and treatment on the wards. This included an orientation of the ward, how to locate policies and procedures and training on how to use the electronic patient record system. The induction included intravenous (IV) training, various competencies, and safeguarding. Agency staff had access to the trust’s computer system, which enabled them to access policies and procedures and the electronic patient record system.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The trust reported the following medical staff numbers in medical care from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Medical care</td>
<td>379.6</td>
<td>427.7</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of 88.8% for medical staff in medical care from April 2017 to March 2018. This had dropped slightly to 86.3% from April to July 2018, in part due to the addition of 8.9 WTE planned staff posts.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 11.4% for medical staff in medical care. The trust does not have a target vacancy rate for medical staff.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 2.6% for medical staff in medical care. This was lower than the trust target of 10.56%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 0.9% for medical staff in medical care. This was lower than the trust target of 2.7%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Bank and locum staff usage

The table below shows the numbers and percentages of hours in medical care from August 2017 to July 2018 that were covered by medical bank or locum staff or left unfilled.

Of the 89,661.1 FTE medical staff shifts available, 2.4% were filled by bank staff and 0.5% were covered by locum staff to cover sickness, absence or vacancy for medical staff. In the same period, 0.7% of the available hours were unable to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Locum usage</th>
<th>Not filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>FTE shifts</td>
<td>%</td>
<td>FTE shifts</td>
</tr>
<tr>
<td>Medical care</td>
<td>89,661.1</td>
<td>2,160.0</td>
<td>2.4%</td>
<td>431.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical locum tab)

Staffing skill mix

In June 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

Staffing skill mix for the 386 whole time equivalent staff working in medicine at Cambridge University Hospitals NHS Foundation Trust

Despite the number of medical staff in post in some areas being lower than the establishment, there was evidence that medical staffing was providing safe patient care, for example each ward still had named consultants responsible for each team on the ward and patients we spoke with told us they had sufficient discussions with medical staff. The trust used locum doctors to fill vacant shifts.

During our inspection, we spoke with 16 medical staff including consultants, registrars, and junior doctors (FY1 and FY2). A Foundation doctor (FY1 or FY2) is a grade of medical practitioner undertaking a Foundation Programme. This is a two-year, general postgraduate medical training programme, which forms the bridge between medical school and specialist and general practice (GP) training. Medical staff told us they felt supported.
A medical handover took place every morning, seven days a week, which included discussion of clinical incidents, unwell patients, scans, and investigations requiring urgent review. The handover meeting also included a review of medical staffing gaps and agreed redistribution of doctors.

All the wards we visited had a resident consultant and several junior doctors based on the ward. During our inspection the medical staffing and skill mix was sufficient in all areas we visited in order to treat patients safely, which was confirmed by junior staff who told us they felt they had sufficient medical support and cover.

There was a middle grade rota providing 24-hour cover seven days a week for the wards that did not have overnight middle grade cover. In addition to the middle grade cover for medical inpatients, there were on-call specialty cover rotas in cardiology, infectious diseases, respiratory medicine, nephrology, hepatology and stroke. There were also weekend only full shift rotas for acute medicine, medicine for the elderly, stroke, gastroenterology and diabetes & endocrinology.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

The trust used an electronic patient record system. All nursing and medical staff had received training in the use of the system. We reviewed 21 electronic patient records across the medical wards we inspected. All patient risk assessments were completed; national early warning scores (NEWS), falls assessments, nutritional risk assessments, and VTE risk assessments were all clearly documented. The electronic recording system used data entered by staff from each patient’s initial assessment to generate risk scores, for example for sepsis or pressure ulcers and set patient observation time scales with visual alerts to prompt staff to call a doctor if a patient’s risk had increased. All additions or amendments to the records were traceable to the individual member of staff responsible for making the entry.

All staff we spoke with were confident using EPIC. Nursing staff and Allied Health Professionals used the system for recording details of each patients care plan and discharge coordination.

Staff used Personal Digital Assistants (PDAs) to record all patient interactions. PDAs were securely stored behind nurse’s stations or in locked staff rooms when not in use.

Data entered onto the electronic recording system was periodically uploaded onto a quality dashboard from each division. The data was used for divisional Clinical Outcome Audits, which could be used to identify where there were issues in record completion, which would be reported at governance meetings and shared with staff.

Medicines

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

The service had effective systems in place for the management of medicines, including the prescribing, administration, storage and security of medicines. On all the wards we inspected, staff stored medication in locked rooms and within locked cupboards, or where necessary within a locked medicines refrigerator.

Nursing staff locked medicine trolleys when not in use and secured them to the wall or stored them in the locked clean utility room in all the wards we visited.
Controlled drugs (CD) records were legible and dated by nursing staff without any omissions and CD's were stored securely in an appropriate cupboard within the medicines storage rooms. Controlled drugs are medicines controlled under the Misuse of Drugs legislation (and subsequent amendments). Examples include: morphine, pethidine, and methadone. Regulations state that controlled drugs should be secured in a lockable wall mounted cupboard with only authorised staff having access to keys.

Books used for recording medication fridge temperatures on wards we inspected were completed daily. Staff told us that if the reading was out of range they would alert the pharmacy team.

All the wards we inspected had a named pharmacist that visited the ward daily and followed up on any medication or stock query from the ward staff. A clinical pharmacist reviewed all prescription charts each weekday.

Each patient wore a wristband that had a unique bar code to identify the patient that was scanned by staff prior to the administration of medication. Nurses also asked the patients their name and date of birth. This helped staff to ensure they were giving prescribed medicines to the correct patient. Patients were encouraged to self-administer their own medications when appropriate.

We checked the expiry dates on a selection of medications on wards including CDs, bags of intravenous fluids and other medications. Medications we checked were in date and stored according to manufacturer’s storage instructions.

We reviewed 21 patient Medication Administration Records (MARs), which were recorded on the trust’s electronic recording system. Staff recorded allergies on the system, all medicine administrations were accurately recorded and dated when they were administered. Where medications were omitted or not administered, reasons were documented within the MARs.

Staff we spoke with knew how to report a medicine incident. We were also told how the team learnt and shared information from regular ward meetings. Medicine incidents were recorded onto a dedicated electronic recording system. Learning from incidents was cascaded to staff through e-mails and staff meetings.

The trust undertook a variety of medicines audits, including medication omissions, medicine storage and antibiotic prescribing. The most recent medication administration omission audit was conducted in October 2017. The main findings were that the overall medication omission rate had improved since the last audit in 2015. Work was required in ensuring appropriate clinical review of medicines not required or refused to minimise nurse workload to ensure safety of patients at discharge and reduce costs in unnecessary dispensing of drugs at discharge. Recommendations included that pharmacists of all grades should ensure they regularly reviewed omitted medicines and that in particular, analgesics and laxatives not required were stopped in consultation with medical staff. Medical staff training should stress the importance of continually reviewing medication and discontinuing medications the patient requires or changing them to “as required”.

All prescription charts we reviewed where medicines had been omitted or stopped included a documented reason by a doctor or pharmacist within the notes.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Never Events

Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each Never Event type has the potential to
cause serious patient harm or death but neither need have happened for an incident to be a Never Event.

From October 2017 to September 2018, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported 23 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from October 2017 to September 2018.

Of these, the most common types of incident reported were:

- Healthcare associated infection (HCAI)/Infection control incident meeting SI criteria with seven (30.4% of total incidents)
- Confidential information leak/information governance breach meeting SI criteria with seven (30.4% of total incidents)
- Sub-optimal care of the deteriorating patient meeting SI criteria with three (13.0% of total incidents)
- Venous thrombo embolism (VTE) meeting SI criteria with two (8.7% of total incidents)
- Slips/trips/falls meeting SI criteria with two (8.7% of total incidents)
- Medical equipment/devices/disposables incident meeting SI criteria with one (4.3% of total incidents)
- Pressure ulcer meeting SI criteria with one (4.3% of total incidents)

(Source: Strategic Executive Information System (STEIS))

The trust had an incident reporting policy that staff could access through the trust’s electronic system. All staff we spoke with knew how to report incidents on the trust electronic reporting system and told us they received feedback from any incidents by email, face to face from their line manager, or at team meetings.

On all the wards we inspected, learning from incidents included a staff communications book kept in staff rooms. Feedback on the incident included what went wrong, the method of reporting and all actions taken by the trust to prevent the incident happening again.

Senior medical staff attended mortality and morbidity meetings. Meetings were minuted, with details of the care provided, issues found, discussion and lessons learned. Where relevant, learning from meetings was shared through consultant/physician meetings or team meetings.

Staff also told us they were actively encouraged to report incidents by their managers, to enable learning and to ensure the reoccurrence of incidents could be minimised in the future.

We reviewed the root cause analysis (RCA) of three serious incidents (SIs). The trust had thoroughly investigated each SI and detailed the incident, learning, and recommendations and actions taken to minimise reoccurrence in the future. Staff could access the governance and learning folder at any time and staff discussed SIs at team meetings. One of the SIs related to a patient that experienced a delay in being diagnosed with aortic dissection. The investigation had made two recommendations, which were part of an action plan to develop comprehensive guidelines to assist doctors working in the trust in the diagnosis and management of adult patients with chest pain and that learning from the SI was to be fed in to the Trust Patient Safety Improvement Plan. Both actions had been completed in line with the action plan target completion dates.
The trust had reported a serious incident on ward N3 regarding non-invasive ventilation. All staff we spoke with on the ward were aware of the incident and learning had been shared. The trust had acted to ensure all staff had the relevant competencies and updated training to work on the ward and a review of staffing rotas was taking place to ensure there was sufficient staff to deliver one to one care when required.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All nursing and medical staff we spoke with knew what the duty of candour was and that it was about being open and transparent when things go wrong. All RCA for SIs contained evidence of the duty of candour being implemented. The trust audited its compliance with the duty of candour. The most recent audits for August and September 2018 were 100% compliant with the trusts target for exercising DOC within 10 days of a notifiable incident.

**Safety Thermometer**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 33 new pressure ulcers, 54 falls with harm and 35 new urinary tract infections in patients with a catheter from August 2017 to August 2018 for medical services.

<table>
<thead>
<tr>
<th>Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls with harm and new urinary tract infections at Cambridge University Hospitals NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Pressure ulcers</strong> (33)</td>
</tr>
</tbody>
</table>
Nursing staff collected information for the NHS safety thermometer and clearly displayed the information on notice boards on all the wards we inspected. This meant this information was readily available for members of the public to see.

Nursing staff recorded the number of avoidable and unavoidable pressure ulcers (PUs) and number of falls. Nursing staff discussed safety thermometer results as part of their team meetings.

### Is the service effective?

#### Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

Staff were aware of the National Institute for Health and Care Excellence (NICE) guidance relevant to their speciality and they could access this guidance through the trust’s intranet, for example for diabetes in adults, heart failure and kidney disease.

Local policy and procedure guidelines for all specialties were available on the trust’s intranet and were easily accessible by all members of staff. Staff completed regular audits of documentation on all wards to ensure care was following best practice and identify areas that required improvement.

Patient care was delivered in line with trust policies and pathways based on national best practice guidance and standards. For example, across the service staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE). We reviewed 21 medication prescription charts, all of which demonstrated that patients had received a VTE risk assessment and had precautionary VTE medication prescribed and administered if indicated.

Local audits were taking place across Division C, for example, hand hygiene, venous thromboembolism (VTE) and NEWS 2. We reviewed the divisional audits for infection prevention, records, and medicines and VTE. The trust had just started an audit project into VTE compliance at the time of our inspection, which was due to be completed in February 2019. This was a second cycle audit, as the first one run by the trust showed that the Deep vein thrombosis (DVT) assessment on admission was done in 100% of patients (24 out of 24). However, only five out of 13 (38.4%) patients had been formally re-assessed after 14 days of hospital stay. The trust had taken actions since the first audits, including extra training for staff and VTE assessment had become part of the summary section on the trust’s electronic recording system, specifying the type of DVT prophylaxis for each patient.

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1. Pressure ulcers levels 2, 3 and 4
2. Falls with harm levels 3 to 6
3. Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)
The trust conducted a standards of discharge documentation audit for patients admitted with fragility fractures in July 2017. The main recommendation from the audit was to improve the conciseness of discharge paperwork to GPs and include a clear action plan. The trust also planned to introduce a telephone follow up for patients who had experienced a hip fracture. Staff in the newly commissioned Fracture Liaison Service would take on this responsibility once fully staffed. Posts were being advertised at the time of our inspection.

The trust took part in national Chronic Obstructive Pulmonary Disease (COPD) audits. The trust met the Best Practice Tariff (BPT) set by the Royal College for Physicians for the most recent audit results from April 2018 to June 2018, with 86% of relevant patients receiving a respiratory review within 24 hours and 99% of patients having a discharge bundle.

Nursing and medical staff used the sepsis six screening tool, which is best practice for the early identification of sepsis. The trust took part in the 2016/17 Royal College of Emergency Medicine Severe sepsis and septic shock clinical audit. The trust shared a copy of their 2018/19 Sepsis Quality Improvement Programme Project Plan with us at the time of our inspection, which outlined four key areas of improvement; recognition and escalation, timely and effective treatment, measurement and monitoring framework, and education, engagement and innovation. All actions within the plan were completed or on track to be completed by the target date.

Consultants conducted formal ward rounds to review patients twice a day in the acute hub.

Once patients were transferred from an acute area of the hospital to a general ward, doctors reviewed patients during a consultant-delivered ward round at least once every 24 hours Monday to Friday. On call medical teams were available on site on weekends to review patients that required daily review or for newly admitted patients.

The trust had achieved The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation, which was most recently audited and confirmed in January 2018. The accreditation process assesses the endoscopy department infrastructure policies, operating procedures and audit arrangements to ensure they meet best practice guidelines. This meant that the endoscopy department was operating within this guidance.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other preferences.

All the patients and relatives we spoke with were satisfied with the quality, range and choice of food provided.

Meal times were calm and well managed. Staff used a red jug and red tray system that enabled staff to identify patients who may need additional support with eating and drinking whilst on the wards. Staff assisted patients as required and volunteers were also available to assist patients to eat and drink.

Staff assisted patients into a suitable and comfortable position prior to eating and drinking to enable them to eat and drink effectively.

Patients had water jugs left within easy reach so they could access them independently. Support staff changed water jugs regularly on wards to ensure patients had sufficient fresh water.
Nursing staff undertook a swallow assessment on admission for patients who had experienced a stroke, and then escalated those at greatest risk to the Speech and Language Therapy (SLT) team if required.

Staff completed a nutritional assessment for all patients on admission to the medical wards. The trust used the malnutrition universal screening tool (MUST) to identify patients at risk of malnutrition. We reviewed 21 sets of patient records and found that in all cases where it was appropriate the MUST score had been completed and each patient’s fluid and diet chart completed and where necessary, escalated accordingly. Staff made referrals to a dietician when patients were at high risk of malnutrition.

Staff encouraged patients to eat meals in the hospital canteen where possible to aid their recovery and increase independence. These meals were paid for by the trust.

The trust provided protected meal times. This meant that during lunch and evening meal times all non-urgent activity on the wards stopped so that nurses and health care assistants (HCAs) could help with the meal service and provide extra assistance for those patients that needed it. We observed sufficient staff to assist patients with eating and drinking at meal times.

Wards had picture food menus to aid patient understanding. We observed staff communicating well while serving food and water to elderly patients, ensuring that their choices and nutritional needs were met.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.*

Staff had documented clear pain management plans in all the records we looked at. Staff used an as-needed (PRN) medicine protocol to ensure patients had regular pain relief and we saw this was documented in the 21 prescription charts we reviewed. Staff asked patients to rate their pain each time they took their physiological observations and staff assessed whether each patient was experiencing pain. Staff completed pain charts appropriately in all patient records we reviewed.

All patients we spoke with told us that staff always asked about pain during medication administration rounds.

The services could access the specialist pain team seven days a week and staff told us they responded quickly when an assessment was required. Staff told us they could use specialist assessment tools for patients who could not communicate verbally. For example, they used the Abbey Pain Scale for people who were living with dementia or had difficulty communicating.

**Patient outcomes**

*Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.*

**Relative risk of readmission**

**Addenbrooke’s and the Rosie Hospitals**

From May 2017 to April 2018, patients at Addenbrooke’s and the Rosie Hospitals had a higher than expected risk of readmission for elective admissions when compared to the England average.
- Patients in medical oncology, clinical haematology and gastroenterology all had higher than expected risks of readmission for elective admissions.

**Elective Admissions - Addenbrooke's and the Rosie Hospitals**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

From May 2017 to April 2018, patients at Addenbrooke’s and the Rosie Hospitals had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine had a similar to expected risk of readmission for non-elective admissions.
- Patients in medical oncology had a higher than expected risk of readmission for non-elective admissions.
- Patients in clinical haematology had a lower than expected risk of readmission for non-elective admissions.

**Non-Elective Admissions - Addenbrooke's and the Rosie Hospitals**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/05/2017 - 30/04/2018))

**Sentinel Stroke National Audit Programme (SSNAP)**

Addenbrooke’s Hospital takes part in the Sentinel Stroke National Audit programme.

On a scale of A-E, where A is best, the hospital’s overall SSNAP level was B in the most recent two time periods, April to November 2017. This was an improvement from D previously.

The hospital’s scores for the patient- and team-centred stroke unit indicators improved from grade E from April 2016 to March 2017 to grade D for the most recent two time periods, April to November 2017.
The trust’s performance is shown in the tables below.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>D</td>
<td>B↑↑</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>B</td>
<td>C↓</td>
<td>B↑</td>
<td>B</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>B↑↑</td>
<td>B</td>
</tr>
</tbody>
</table>

In terms of patient-centred performance, the trust’s performance in relation to domain 1 (scanning) and domain 5 (occupational therapy) both deteriorated from grade A from April to July 2017 to grade B in the most recent time period, August to November 2017.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
<td>A↑</td>
<td>B↓</td>
</tr>
<tr>
<td>Domain 2: Stroke unit</td>
<td>D</td>
<td>E↓</td>
<td>E</td>
<td>E</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Domain 3: Thrombolysis</td>
<td>D</td>
<td>C↑</td>
<td>C</td>
<td>E↓↓</td>
<td>B↑↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 4: Specialist assessments</td>
<td>C↓</td>
<td>C</td>
<td>D↓</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
</tr>
<tr>
<td>Domain 5: Occupational therapy</td>
<td>C↓</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A↑</td>
<td>B</td>
</tr>
<tr>
<td>Domain 6: Physiotherapy</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Domain 7: Speech and language therapy</td>
<td>D↓</td>
<td>E↓</td>
<td>E</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 8: Multi-disciplinary team</td>
<td>C</td>
<td>D↓</td>
<td>E↓</td>
<td>D</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Domain 9: Standards by discharge</td>
<td>B↓</td>
<td>B</td>
<td>A↑</td>
<td>A</td>
<td>B</td>
<td>A</td>
</tr>
<tr>
<td>Domain 10: Discharge processes</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Patient-centred total key indicator</td>
<td>C</td>
<td>D↓</td>
<td>D</td>
<td>D</td>
<td>B↑↑</td>
<td>B</td>
</tr>
</tbody>
</table>

The trust’s team-centred performance for domain 1 (scanning) also deteriorated from grade A from April to July 2017 to grade B in the most recent time period, August to November 2017. In addition, performance for domain 3 (thrombolysis) and domain 8 (multi-disciplinary team working) both deteriorated from B to C.

In contrast, both patient- and team-centred performance in relation to domain 9 (standards by discharge) improved from B from April to July 2017 to grade A in the most recent time period, August to November 2017.
At the time of the inspection we requested the most up to date SSNAP audit data for the trust. From December 2017 to June 2018 the trust overall SSNAP level had deteriorated from a B to a C.

**Lung Cancer Audit**

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a Cancer Nurse Specialist was 85.0%, which did not meet the audit aspirational standard of 90%. This was an improvement from the 2016 figure, which was 51.9%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 16.3%. This was within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 55.2%. This was within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 51.6%. This was within the expected range. The 2016 figure was not significantly different to the national level.

The one year relative survival rate for the trust in 2016 was 35.5%. This was within the expected range. The 2016 figure was not significantly different to the national level.

*(Source: National Lung Cancer Audit)*

**National Audit of Inpatient Falls 2017**

The crude proportion of patients who had a vision assessment (if applicable) was 85%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 68%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 92%. This did not meet the national aspirational standard of 100%.

*(Source: Royal College of Physicians)*
The trust produced a falls action plan after the 2017 National Audit of Inpatient Falls. The target in the action plan was to reduce inpatient falls by 3% by April 2019 and by 5% by April 2020. The action plan including actions to review and amend records to reduce duplication and improve quality, improved access to staff training and education in falls prevention and management, and improve access to falls mats and specialling. At the time of our inspection 17 of 59 actions had been completed, which was in line with the trust’s improvement plan.

The trust took part in the 2016/17 National Audit of Dementia. The trust was within the top 25% of hospitals for three of the four agreed metrics: the percentage of staff responding ‘always’ or ‘most of the time’ to the question “Is your ward/service able to respond to the needs of people with dementia as they arise”; mental state assessments carried out upon or during admission; and multi-disciplinary team involvement in discussions of discharge. No data was available around the percentage of carers rating the care received by the person cared for in hospital as ‘excellent’ or ‘good’.

The trust conducted a local dementia audit in August 2017. Findings included: Not all wards had an identified Dementia Champion, lack of training across the whole MDT and of 101 staff members audited, only 56.4% had received any formal training. There appears to be gaps in training, particularly for longer serving members of staff, but despite the lack of formal training, 95% of those questioned felt confident or very confident about caring for patients with dementia and of those observed specialling staff were, overall, interacting well with the patient they were specialling with dementia. Specialling is when one to one nursing is used to reduce the risk and incidence of harm to the patient. The trust produced an action plan that included plans or corrective actions for each of the recommendations. However, at the time of the inspection the trust did not supply evidence of their completed actions.

The trust had completed an audit on the NICE guidance 137 (PRN 6412), Epilepsies: diagnosis and management in July 2017. All actions resulting from the audit had been completed by May 2018.

There were trust-wide monthly audits of sepsis screening compliance and diagnosis to treatment times, which were submitted to NHS England as part of the 2017 to 2018 Commissioning for Quality and Innovation (CQUIN).

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

**Appraisal rates**

As of July 2018, 97.7% of staff in medical care at the trust received an appraisal compared to a trust target of 90%. The appraisal target was met for six of the seven staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals</td>
</tr>
<tr>
<td></td>
<td>completed</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>55</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>30</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>70</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>543</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>36</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>322</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>138</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff</td>
<td>0</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,194</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Appraisal tab)

All the nursing staff we spoke with confirmed they had received an annual appraisal or had got one scheduled. Staff told us that as part of their appraisal, they discussed their development and any training needed for their revalidation.

The trust and individual doctors took joint responsibility to ensure their revalidation was up to date. The trust had produced a comprehensive document outlining the revalidation process.

There were systems and processes in place to ensure newly appointed staff, bank and agency staff completed local inductions. We spoke with agency nurses and health care assistants (HCAs) who told us they had received an induction to their specific ward. We saw evidence that local inductions took place on each ward we inspected and these were kept in a folder either in the office or at the nurse’s station.

Nursing staff completed competencies specific to their specialism of their wards. For example, staff in department of medicine for the elderly completed a competency document, which included specific assessment of skin integrity, falls, and use of a Specialling Scoring Tool (SST).

The trust and individual doctors and nurses took joint responsibility to ensure their revalidation was up to date. The trust had produced a comprehensive document outlining the revalidation process. The responsible officer for the process was the medical director for the trust for doctors, and the chief nurse for nursing staff.

We spoke with three student nurses who told us they had a mentor and that nurses supported them very well.

**Multidisciplinary working**

Ward teams had access to a full range of allied health professionals that were employed by the trust, for example; physiotherapists, occupational therapists and neuropsychologists. Team members described good, collaborative working practices. There was a joined-up and thorough approach to assessing the range of patient needs, and we saw a consistent approach to ensuring assessments were regularly reviewed and kept up to date while inspecting patients’ records.

Patients’ records were fully integrated through the trust’s electronic recording system. Doctors, nurses and therapists all used the system for recording patient care and treatment. This meant that that all members of the team were aware of the input of others, and that care was well co-ordinated for patients and their relatives. Staff described the system as working well.

Staff held regular multidisciplinary (MDT) meetings or board rounds on wards. There was a joined-up and thorough approach to assessing the range of patients’ needs and a consistent approach to regularly reviewing assessments to keep them up to date.
We observed the daily inpatient board rounds and routine ‘Red to Green’ patient management meeting during the daily ward governance huddles. Red to Green is an initiative that helps turn patients’ ‘red days' into value-adding ‘green days' which help to facilitate a safe discharge from hospital. A red day is when a patient does not receive an intervention to support their pathway of care.

Patients with complex needs received prompt screening by a multi-professional team, including physiotherapy, occupational therapy, nursing, pharmacy and medical staff to implement a treatment and management plan as soon as possible.

There was joint working with pharmacists, physiotherapists, and occupational therapists, based on individual wards to ensure a consistency in approach for each patient's care and discharge. Discharge staff reviewed every patient awaiting a rehabilitation bed and attended daily ward rounds to promote early intervention and discharge where possible.

The trust held regular MDT meetings for people with complex needs, for example, patients with learning difficulties that would require extra support upon discharge, which included input from local social services.

Staff shared details of each patients’ assessments and ongoing care with their local general practitioner (GP) on discharge for example about tissue viability and nutritional assessment.

**Seven-day services**

Urgent and emergency imaging was available 24 hours a day, seven days a week and the trust had an internal imaging professional standard stating that all inpatients requiring imaging services would be seen within 24 hours of referral. Records we reviewed showed patients received imaging services within 24 hours when required.

There was consultant cover, 24 hours a day, seven days a week. Two consultants supported the acute take admissions directly in the evening until 10pm with one consultant on call overnight. Consultant on call rotas covered cardiology, infectious diseases, diabetes & endocrinology, nephrology, hepatology, gastroenterology, respiratory and stroke medicine. Consultants from each specialty were routinely scheduled ward work and to receive new patients at the weekend with middle grade and junior doctor support.

The psychiatric health liaison team were available 24 hours a day, seven days a week. The trust also had access to an alcohol liaison nurse, which was provided by a neighbouring mental health trust. In addition, a learning disability nurse was available Monday to Friday, between the hours of 9am and 5pm. The trust employed one learning disabilities nurse, which meant there was no alternative cover out of hours or when the learning disabilities nurse took their annual leave.

Pharmacy services were provided Monday to Friday 9am-5pm and a dispensing service was available for non-stock items and “to take out” medications for patients being discharged at weekends (9am to 4pm on Saturday, and 10am to 4pm Sundays and Bank Holidays).

Physiotherapy staff assessed all patients based on wards on the first full working day (Monday to Friday) after their admission. If a new patient required assessment and treatment over the weekend, a nurse could contact an on-call physiotherapist between 8.30am and 4.30pm. A doctor could contact an on-call physiotherapist outside these hours. The physiotherapy staff covered the Lewin Stroke and Rehabilitation Unit on Saturdays and Sundays with one physiotherapist and physiotherapist assistant. The physiotherapy service had an on call out of hours service 24 hours a day for emergencies.

Staff reported good access to therapies such as physiotherapy, occupational therapy and speech and language therapy Monday to Friday, with reduced access at weekends for occupational therapy and speech and language therapy.
The endoscopy service was operational seven days per week 8am to 6pm. At weekends, an on-call consultant gastroenterologist was available for emergency upper gastrointestinal (GI) bleeds, which meant staff were trained and available to respond to patients experiencing urgent GI bleeds.

The chaplaincy service was available 24 hours a day, seven days a week.

**Health promotion**

Leaflets were available for patients and visitors, which promoted healthy behaviours such as smoking cessation and dietary advice.

Staff could access smoking cessation products to aid any patients who decided to give up smoking whilst in hospital. The trust was a non-smoking organisation, which helped to promote the health benefits of not smoking.

The trust falls prevention co-ordinator had established dance for health sessions on the older people’s medical wards. The sessions integrated dance into patient treatment. The sessions aimed to facilitate increased range and ability of movement through a non-medicalised approach to healing and wellbeing for older patients.

Patients could access copies of test results such as electrocardiograms (ECGs) which staff would explain to the patients to promote understanding of patients’ health conditions for self-management on discharge.

Staff informed patients of the medicines helpline that patients, relatives or carers to contact following discharge if they had concerns about their medication.

The trust offered the annual influenza vaccine to all staff employed by the trust.

**Consent, mental capacity act and deprivation of liberty safeguards**

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for the MCA and DoLS training module as of July 2018 for qualified nursing and medical staff in medical care at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>610</td>
</tr>
<tr>
<td>Medical staff</td>
<td>297</td>
</tr>
</tbody>
</table>

Nursing staff in medical care met the trust target of 90% with a completion rate of 99.0%. However, only 81.4% of medical staff had completed the MCA and DoLS training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

At the time of our inspection we requested up to date MCA and DoLS training compliance figures. As of October 2018, medical staff completion rate was 80.3% and nursing staff completion rate was 99%.
Staff could access the trust ‘Mental Capacity Act 2005 and DoLS’ policy, which was written in line with relevant legislation. It provided a clear reference for staff and cross referred to trust policies on consent and safeguarding.

Staff told us the trust provided Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory training.

Despite the service failing to meet the trust target for staff compliance with the MCA and DoLS training, medical staff carried out mental capacity assessments and DoLS appropriately throughout the medical wards. We reviewed six MCA assessments and three DoLS records. Medical staff had completed them appropriately on the trust’s electronic recording system, evidenced discussions with each patient’s family, and dated them. Nursing staff told us that members of the safeguarding team were available to provide advice and guidance relating to MCA and DoLS.

We observed nursing staff seeking patient consent verbally before undertaking aspects of care and treatment.

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 7% which was worse than the England average of 25% from August 2017 to July 2018.

A breakdown of FFT performance by ward for medical wards at the trust with total responses over 100 is below. All the wards achieved an annual recommendation rate of 90% or above.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp1,2</th>
<th>Resp. Rate</th>
<th>Percentage recommended3</th>
<th>Annual perf3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daycases</td>
<td>4,993</td>
<td>4%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward D9</td>
<td>515</td>
<td>38%</td>
<td>99%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward C10</td>
<td>278</td>
<td>77%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward C4</td>
<td>260</td>
<td>26%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward N3</td>
<td>224</td>
<td>21%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward F6</td>
<td>222</td>
<td>26%</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>Ward D5</td>
<td>220</td>
<td>17%</td>
<td>86%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward G6</td>
<td>196</td>
<td>33%</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward EAU4 MDU</td>
<td>181</td>
<td>11%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward M4</td>
<td>175</td>
<td>13%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>Ward R2</td>
<td>161</td>
<td>34%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>Ward D10</td>
<td>154</td>
<td>47%</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Ward Lewin</td>
<td>137</td>
<td>51%</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward D6 Hasen</td>
<td>134</td>
<td>36%</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Ward C5</td>
<td>128</td>
<td>13%</td>
<td>100%</td>
<td>92%</td>
</tr>
<tr>
<td>Ward D7 Medicine</td>
<td>117</td>
<td>12%</td>
<td>100%</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Key**

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above).
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

Note: sorted by total response
We spoke with nine patients and their relatives or carers. Most patients told us that staff introduced themselves when they arrived on the ward. Patients said that staff “pull out all the stops” and that the nurses were “absolutely brilliant”. Another patient described the staff as having a good rapport with patients.

Throughout our inspection we observed staff on all wards treating patients with courtesy, kindness and respect. This included reception staff, healthcare assistants, allied health professionals, nurses and doctors.

Staff showed a good understanding of the individual needs of patients, and especially of elderly patients and patients with dementia. There was a trust wide plan in place to support patients with dementia, and staff we spoke with were aware of this. For example, on ward C5 staff ensured that patients with dementia had a blue wristband and were assigned to a specific bay where possible. This meant that staff were aware of these patients’ needs and could give the one-to-one care. Staff we spoke to knew how to access sign language and translation services for patients who needed them.

We observed staff using curtains and closing side room doors to ensure privacy, and patients told us that staff always maintained their privacy and dignity. Staff also asked each patient for their permission before entering their room or curtained bed space. Several wards including ward M4 had separate family rooms for patients and those close to them, which gave additional privacy when needed.

Notice boards on wards, including C10 and M4, showed positive feedback and thank you cards from patients, and many of these comments highlighted the compassion of staff. A member of staff on ward M4 won a trust ‘You Made a Difference Award’ for going the extra mile when caring for a palliative patient. The EAU3 team won an award after helping to quickly discharge an end of life patient, so that they could be at home with their family. Staff on ward G4 won a team award for bringing together a married couple who were both under palliative care.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

All the patients we spoke with told us that staff and especially nursing staff were emotionally supportive. We observed a staff handover on ward D5, during which nursing staff displayed sensitivity to the physical and emotional needs of patients on their ward.

Chaplaincy staff were available to provide emotional support for patients and those close to them. Wards displayed information about the trust wide chaplaincy service and we observed chaplaincy staff visiting wards including ward D5. The service was available 24 hours a day, seven days a week.

Wards displayed information on specific community support services and groups such as Macmillan, Maggie’s Centres, the Alzheimer’s Society and a local Lymphoma Support Group. Ward C5 had a noticeboard dedicated to the Addenbrooke’s Kidney Patient Association. Staff on ward M4 told us they spoke with patients directly about groups such as Colitis UK.

**Understanding and involvement of patients and those close to them**

**Staff involved patients and those close to them in decisions about their care and treatment.**

Patients told us that staff responded to questions and most patients we talked with told us that doctors communicated clearly with them about their treatment. Patients told us that they would be comfortable raising any concerns or complaints directly with nursing staff.
One patient on ward C5 told us that continuity of care was good and that staff were great at keeping their relatives up-to-date. Another patient on the same ward told us that staff were very good at informing them about their ongoing treatment. There was a trust wide carer’s scheme in place to support carers at home after a patient’s return from hospital.

Staff adapted their communication style to enable better patient understanding and involvement. For example, we saw staff on ward F4 talking with a patient with poor hearing. The staff spoke gently and clearly, and kneeled to ensure good eye contact with the patient. We observed nurses on wards that specialise in care for the elderly and patients with dementia comforting patients who were confused or wanted to wander around the ward. Staff offered reassurance and support to the patients until they became less distressed and returned to their bed.

**Is the service responsive?**

**Service planning and delivery to meet the needs of the local people**

The service planned and provided services in a way that met the needs of local people.

The ambulatory care unit was specifically adapted to meet patients’ needs. The unit's operating hours were Monday to Friday from 8:00am to 8:00pm and weekends from 9:00am to 4:00pm. The unit had a large treatment room with chairs that were specially adapted for patients of varying mobility and could rise to standing position if needed. Staff had sight of all the patients from the nurses’ station and any free member of staff could offer assistance when needed.

Staff on the unit told us that they encouraged patients with dementia, learning disabilities, autism and mental health conditions to attend with a companion. If a patient was not accompanied then a member of staff would be nominated to sit with the patient or a specialist nurse was invited to attend to sit with the patient during their visit. For hearing and sight impaired patients staff would request sign language assistance. Staff told us that the “pink phone” was available to conduct telephone translations for patients who did not speak or understand English.

Staff were responsive to the specific needs of patients living with dementia. The service used ‘forget-me-not’ system to indicate patients that were living with dementia. There was a dementia link nurse, who ward staff reported to be very accessible.

The environment was suitable to meet the needs of patients with a physical and/or learning disability. Staff we spoke with told us they would request the learning disability nurse to visit if they needed support with a patient. There was one learning disability nurse for the trust available Monday to Friday 9:00 am to 5:00pm, out of hours staff would refer to the trust guidance or a senior member of the team for advice. On the general medicine and nephrology ward there was a dedicated acute dialysis area with two beds and two dedicated dialysis nurses to treat patients staying on the ward. The specialist nurses were seconded from the Cambridge Dialysis Unit and they planned patient care and set prescribing with the ward staff.

Divisional managers had recognised the increased demand for services and worked proactively with neighbouring trusts and stakeholders consider alternative pathways for patients.

**Average length of stay**

**Addenbrooke’s and the Rosie Hospitals**

From June 2017 to May 2018 the average length of stay for medical elective patients at Addenbrooke’s and the Rosie Hospitals was 6.0 days, which was the same as the England average.

- Average lengths of stay for elective patients in gynaecological oncology and medical oncology
were lower than the England averages.

- Average length of stay for elective patients in clinical haematology was higher than the England average.

**Elective Average Length of Stay - Addenbrooke's and the Rosie Hospitals**

![Graph showing Elective Average Length of Stay]

*Note: Top three specialties for specific site based on count of activity.*

For medical non-elective patients, the average length of stay was 7.2 days, which was higher than England average of 6.4 days.

- Average length of stay for non-elective patients in general medicine was higher than the England average.
- Average lengths of stay for non-elective patients in medical oncology and clinical haematology were lower than the England averages.

**Non-Elective Average Length of Stay - Addenbrooke's and the Rosie Hospitals**

![Graph showing Non-Elective Average Length of Stay]

*Note: Top three specialties for specific site based on count of activity.*

(Source: Hospital Episode Statistics)

The trust was attempting to improve average length of stay through the introduction and integration of the Red2Green days, SAFER patient flow bundle, clinical criteria for discharge (CCD) and expected date of discharge (EDD). ‘SAFER’ stands for Senior review/Anticipate/Flow/Earlier discharge/React to delays. Compliance to the SAFER bundle was reviewed on a ward by ward basis.

**Meeting people’s individual needs**

The service took account of patients’ individual needs.

Patients were assessed on admission to identify any additional support or needs and this was provided when required. For example, a skin integrity assessment identified any needs for pressure relieving equipment. We saw that patients’ needs were assessed and appropriate equipment used to ensure patient safety. Wards reported that equipment was readily available, this included mobility aids, pressure relieving cushions and mattresses, bariatric equipment and communication aids.
Daily multidisciplinary team meetings were attended by physiotherapists, occupational therapists, diabetes nurses, tissue viability nurses and consultants to discuss patient care. Patients were assessed during board rounds by the multidisciplinary clinical team to plan care and discharges. Dementia specialist nurses also attended team meetings and assisted ward staff with the complex care needed by patients living with dementia. Other specialist nurses were available to contribute to ensuring individual needs were met in respiratory, learning disabilities and autism.

There were also good links with mental health support services and referrals were signed off by doctors before the mental health team took over care for the patient.

We observed occupational and physiotherapists working closely with the nursing and medical teams to promote patient welfare and condition management. Therapists reviewed individual needs and the use of specialist equipment to promote mobility and activities of day-to-day living to support patient’s independence. Staff also had access to specialist equipment including bariatric (for use with people living with obesity) and pressure relieving equipment.

The trust had a system in place to access telephone and face to face translation and interpreter service. Staff could access these interpreting services 24 hours a day for people who did not speak English as their first language. Leaflets in other languages were available on request. Staff could access them on the intranet and print them out for a patient.

Facilities and premises were appropriate to meet people’s individual needs. Most wards had a patient day room where they could sit and eat their meals and enjoy activities such as music and movement. Some wards also had bathrooms with specially adapted baths for the elderly and patients were offered a bath or a shower each day.

Wards were split into bays and patients were cared for in same gender facilities and had access to same gender washing and toilet facilities.

Learning disability patients were flagged on the Epic system and visited by a learning disability specialist nurse. Learning disability patients had a ‘My Passport’ form that contained likes and dislikes and any special issues that staff should be aware of.

The trust offered ‘personal listener’ devices for use with or without hearing aids to assist patients with hearing difficulties to communicate with staff.

The trust was part of the Eastern Liver Network, which is a network of providers working across the region to improve the most appropriate and local access to liver care specialists for patients.

The trust employed coordinators to arrange activities for elderly patients to increase engagement and assist in their recovery.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

During our inspection we observed a multidisciplinary meeting (MDT) where staff discussed patient care. MDT meeting were held on daily with the discharge nurse, consultant, junior doctors, registrar, physiotherapist, occupational health therapist and sister in attendance. Together the team worked on predicting dates of discharge according to care needed.

We reviewed the Hospital Discharge Policy and Procedure Version Six, approved October 2017. The policy states that the discharge planning process begins at the pre-admission clinic or on admission and that all patients are given a clinically fit date within 14 hours of admission.
The service followed the Red to Green initiative to aid the discharge planning for patients. The Red to Green initiative helps turn patients' 'red days' into value-adding 'green days' which help to facilitate a safe discharge from hospital. A red day is when a patient does not receive an intervention to support their pathway of care. Staff told us and we saw evidence in care plans that discharge planning started on the first day after the patient was admitted.

Band six nurses and discharge nurses planned, managed and coordinated the discharge of patients. Staff told us that discharge nurses worked on complex discharges and sometimes feedback on their progress during MDT meetings. Staff told us that Band six staff do a lot of the discharge coordinating, which included chasing family, carers, community and district teams, GPs and transport. Senior staff told us that Band six nurses have other duties on the ward and discharge coordination was delayed during busy periods on the ward.

Staff reported that delayed transfers of care (DTOC) continued to be a concern for the trust. A DTOC occurs when a patient is ready to leave hospital or a similar care provider but is still occupying a bed. The primary causes for DTOC from the hospital were patients awaiting care package in their own home or awaiting nursing home placement or availability. Senior staff told us the trust was working with their local CCG and local authority to improve patient flow and discharge planning.

Co-ordination of patient’s discharge was taken over by the staff in the discharge lounge who arranged collection of medications and any supplements required on discharge. Once patients were moved to the discharge lounge staff there were responsible for ensuring patients travelled to their correct discharge destination safely.

Senior staff told us that medical outliers are managed by the bed managers. Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space. Bed managers used the electronic patient records system to plan bed activity and to track and trace all current inpatients. Outlier patients remained the responsibility of the relevant medical speciality who arranged for specialist input on the ward the patient was staying on. We looked at three sets of notes for outlying patients on medical wards and saw that they received the necessary medical and nursing input daily.

The ambulatory care unit worked closely with the outpatient antibiotic team to avoid admissions. Patients who did not need any other care besides a dose of intravenous (IV) antibiotics were transferred to the ambulatory care unit straight from the Emergency Department (ED). Once patients had been given the dose of antibiotics they could go home avoiding admission onto a ward and a longer stay in the hospital.

Staff told us that rapid access assessment reviews were conducted in ED and patients who met the criteria were automatically transferred to the ambulatory care unit.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From August 2017 to July 2018 the trust's referral to treatment time (RTT) for admitted pathways for medicine was similar to the England average.

In the most recent month, July 2018, 83.6% of patients were referred within 18 weeks compared to the England average of 89.2%.
Referral to treatment (percentage within 18 weeks) – by specialty

From August 2017 to July 2018, seven specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>100.0%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>97.2%</td>
<td>93.6%</td>
</tr>
<tr>
<td>Neurology</td>
<td>96.3%</td>
<td>91.0%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>95.5%</td>
<td>94.6%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>82.3%</td>
<td>81.9%</td>
</tr>
</tbody>
</table>

One specialty was below the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatology</td>
<td>41.8%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

Senior staff told us the Dermatology RTT had been affected by staffing issues in the department. However, recruitment had taken place to improve speciality cover in the service to improve the results in the future.

Patient moving wards per admission

From August 2017 to July 2018, 93.9% of individuals did not move wards during their admission, and 6.1% moved once or more. The unit with the highest proportion of ward moves for non-clinical reasons over this time period was the coronary care unit where 172 of the 936 patients (18.4%) moved one or more times.

The coronary care unit (CCU) is a hospital ward specialising in the care of patients with heart attacks, unstable angina, cardiac dysrhythmia and various other cardiac conditions that require continuous monitoring and treatment. Once patients are stable and do not require continuous monitoring they can be moved to a general cardiology ward for their continuing care.
Patient moving wards at night
From August 2017 to July 2018, there were 1,542 patient moving wards at night within medicine. The wards with the highest numbers of moves were C5 general medicine and nephrology (221 moves) and K3 cardiology (195 moves). Moving patients at night is unsafe due to the disruption in their sleep and routine. Patients with dementia, learning disabilities, and mental health needs could have an adverse reaction to waking up in an unfamiliar environment.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns
Although the service treated concerns and complaints seriously, they were not always investigated, responded to, and closed in a timely manner. Improvements had been made and service leaders were working hard to improve this.

The trust had a management of complaints and concerns policy, which outlined the responsibilities of the trust in responding to complaints. Staff could access the policy through the trust’s electronic system.

Patients and relatives could access the trust’s Patient Advice and Liaison Service (PALS). Information on how to contact PALS was available in ward areas we visited. In addition, there leaflets were available in the wards telling patients and relatives how to raise a complaint and feedback to the hospital.

Summary of complaints
From August 2017 to July 2018 the trust received 115 complaints about medical care, 15.9% of the total complaints trust-wide. For the 87 complaints that had been closed, the trust took an average of 43.4 working days to investigate and close these complaints. The trust does not have a specific target of closing complaints. However, their internal target for responding to complaints is for 50% to receive a full written response within 30 working days.

For the 28 complaints that had not been closed, the average time these complaints had been open for was 65.8 working days.

The department of medicine for the elderly received the most complaints with 30 (26.1%), followed by oncology and GI medicine with 10 each (8.7%).

The most common subjects of the complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>34</td>
<td>29.6%</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>25</td>
<td>21.7%</td>
</tr>
<tr>
<td>Patient care</td>
<td>19</td>
<td>16.5%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>12</td>
<td>10.4%</td>
</tr>
<tr>
<td>Communications</td>
<td>10</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From August 2017 to July 2018 the trust received 60 compliments about medical care.

The following specialties received five or more compliments over this time period:
<table>
<thead>
<tr>
<th>Speciality</th>
<th>No. of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Medicine for the Elderly</td>
<td>12</td>
<td>20.0%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>8</td>
<td>13.3%</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>6</td>
<td>10.0%</td>
</tr>
<tr>
<td>Oncology</td>
<td>5</td>
<td>8.3%</td>
</tr>
<tr>
<td>Urology</td>
<td>5</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Learning from complaints was shared at team meetings and consultant led monthly clinical governance meetings. We reviewed minutes of clinical governance meetings provided by the trust for the department of medical care for the elderly where complaints were regularly scheduled for discussion at meetings. Staff on the ambulatory care unit gave an example of when a patient complained after a dislodged iron infused cannula left a mark on their arm. Staff were informed of the incident during team meetings and morning huddles.

Following on as learning from this incident staff were advised to warn patients that there was a possibility that an iron infused cannula could become dislodged and if it did this could mark the skin permanently.

Is the service well-led?

Leadership

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.

The clinical departments at this trust were clustered together under five divisions. Medical care including older people’s services was spread over four divisions. These were Divisions A, B, C and D. Each division was led by a divisional director. Each divisional director was supported by a senior team comprising an associate director of operations, clinical directors and a divisional nurse who were supported by a divisional finance manager and an organisational development manager.

Staff spoke highly of ward managers, matrons, consultants, and their divisional directors. Matrons had received extra leadership training since our last inspection and staff told us they felt they were more effective and supportive leaders.

Staff shared concerns that nursing staff continued to be asked to regularly move between wards to cover for staff absences and vacancies.

Senior leaders within Division C were well sighted on the risks as well as new opportunities that were emerging. Senior leaders told us their priorities moving forward were staffing recruitment and improving the length of stay for patients. The Nephrology Service lead told us the service was due to undertake a number of improvements to the environment and equipment in the next 12 months, which was a priority for the trust. There was clear direction on the implementation of care pathways in a number of specialties to improve patient care and patient flow. Divisional leads reported into senior leadership team and held cross divisional meetings to ensure care across the trust was integrated.
Vision and Strategy

The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.

Staff were aware of the trust's vision to improve people's quality of life through innovative and sustainable healthcare. The trust's values were to work together to be safe, kind, and excellent. These values demonstrated that the trust wanted staff to provide the highest standard of care and compassion through how they cared for patients and how they worked with each other. Staff were aware of the values and we saw that staff provided a kind and compassionate service to people. The values of the trust were displayed in some areas around the hospital such as the ward areas and corridors. Information on the vision and strategy for the trust was displayed on information boards on medical wards throughout the hospital.

There was no separate strategy for medical services within the trust. However, staff we spoke with told us their individual wards embodied the values of the trust.

Senior managers told us that most medical services sat within Division C and that the current structure worked well at speciality level. However, the main disadvantage for medical services was that staff sat across several services and divisions and this could make co-ordination more difficult. The trust had started to hold speciality specific meetings to ensure the leadership of each speciality shared learning from incident and complaints across the divisions.

Culture

Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

It was evident that clinical leads and ward managers were proud of their teams in the way in which they spoke of them and celebrated their successes, for example when staff or departments won awards.

All the nursing staff we spoke with were positive about their relationship with their immediate team and line manager.

Nursing staff told us the culture throughout the medical wards was positive and that doctors were helpful and supportive.

We observed a culture of multidisciplinary team (MDT) working on the wards we inspected. Therapy staff and discharge coordinators felt included by nursing and medical staff in decisions related to patient care, treatment, and discharge planning. All staff worked together to meet the needs of patients on the wards.

Junior doctors told us they felt supported by senior medical staff and felt they had sufficient assistance for their learning and development.

All staff we spoke with told us they felt their division was a supportive and interesting place to work. Staff interacted in a supportive and friendly way within the department to ensure safety and efficiency for patient care.

We observed a positive and calm attitude within the team, even during very busy periods. Nurses felt that senior staff gave them clear leadership and feedback on their personal and team performance on a regular basis and made them feel valued as part of the team.
Governance

The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

There was an embedded governance structure within each of the divisions covered by the medicine specialities. Staff told us they knew how to escalate concerns relating to clinical governance. Ultimately, concerns would be raised with the clinical leads for each division. Clinical governance meetings took place across the divisions and within specialities.

There were regular governance meetings throughout the directorates relating to acute medicine, specialist medicine and care of the elderly. We reviewed the minutes of the meetings and saw that discussions about complaints, audit outcome, risk and incident analysis were taking place.

There were effective structures, processes and systems of accountability in place to support the delivery of the trust’s strategy and good quality, sustainable services.

There were measures in place for staff to escalate ward-based risks to the trust board. Ward managers completed monthly reports and audits that were reported to matrons. The clinical leads managed the risk profile for the wards and reported into the trust board meetings.

The ward nurse in charge led monthly ward team meetings and the matron led nurse in charge meetings and attended meetings with the head of nursing.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a risk register for each of the divisions, which included risks relating to medical care and care for the elderly. Monthly governance meetings discussed and updated the risk register. The trust had identified numerous risk areas including, demand outstripping capacity, inappropriate staffing levels and skill mix, and delays in processing blood tests. The trust had developed plans to address all items identified on the risk register but these were not yet all fully actioned. The medical specialities risk register listed the highest risks, the lead member of staff responsible for each risk, review dates, and target completion ratings.

The risk register included obsolete equipment on the nephrology ward. The register included current mitigation of the risk including regular checks on the current equipment. The trust planned a refurbishment of the nephrology ward in 2019 to bring the specification of the ward up to national standards. The register also included a risk for consultant staffing on elderly care wards. The trust was continuing to attempt to recruit into posts and planned to change rotas to provide more cover, but was mitigating the risk by increasing the cover provided by middle grade doctors and by monitoring any incidents or complaints related to medical to ascertain if medical staffing was affecting patient care.

Mortality and morbidity meetings were held across the division. Minutes showed them to have a good attendance from different professionals from across the divisions and that an appropriate mix of cases were discussed.

Information Management

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via electronic records and the staff intranet.

Staff could access test results electronically, meaning they could access this information in a timely manner.

Patient confidentiality was maintained through use of computers and PDAs, which were kept in areas inaccessible to the public. At all times during our inspection, we saw that computer terminals were locked and secure when not in use. Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via computer based and paper patient records and the staff intranet.

The bed planning system showed failed discharges, which were monitored through the daily huddles, which we observed during our inspection. Ward dashboards were available on the trust’s electronic reporting system, which showed the ‘SAFER bundle’ a tool to make sure patients were assessed and reviewed effectively.

The trust used an electronic flagging system to identify patients who were vulnerable or those who were living with complex needs.

The trust held policies and procedures in electronic format on the hospital wide intranet. All nursing and medical staff could access them.

Staff could access test results electronically, meaning they accessed this information in a timely manner.

**Engagement**

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Public engagement was primarily undertaken through the patient advice and liaison service (PALS), and the Friends and Family Test (FFT).

The trust had an online “have your say” web form to encourage members of the public to provide feedback through the trust website.

The trust had a “You made a difference” award scheme, which awarded staff who had been nominated by patients, visitors, or colleagues for making a difference to them. The most recent awards for October 2018 were awarded to two members of staff working on the medicine wards; a physiotherapist on G4 who went the extra mile to keep elderly and frail patients as active as possible to aid their recovery and a cardiology consultant who was awarded for their support to other clinicians.

Members of the public who wished to give some of their free time could apply to the trust to be volunteers. The volunteers on medicine wards helped with meal times and engaging with older patients on medicine for the elderly wards.

The trust used various social media platforms to engage with patients, the public, staff, and stakeholders such as media, annual board meetings and patient feedback and complaints.

Staff could opt in to the trust’s private dedicated social media page. This enabled the sharing of any news, updates to practice, safety alerts, staffing issues, successes, good news stories and feedback from lessons learnt from incidents or complaints.

The trust had arranged an outreach day in June 2018 with a local primary to engage with children on the work of the hospital, which was led by staff in Division C.
The trust had engaged with former stroke and cardiology patients to assist with improving and redesigning their pathways.

**Learning, continuous improvement and innovation**

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust had implemented a project for patients to learn to administer their own intravenous antibiotics (IV) at home to reduce the amount of time otherwise fit patients had to remain in hospital. Using demonstration videos and practising on a model plastic arm using expired or returned medication, patients and their relatives are taught to self-administer IV antibiotics while in hospital. The patients are then able to administer the IV antibiotics through an intravenous line in their arm from the comfort of their own home. The project won the award for Service Improvement at the Health Enterprise East Innovation Ceremony in September 2017.

The trust has become the first NHS centre to pioneer a new generation of immunotherapy for patients with an aggressive form of skin cancer. The trust was participating in a global research study to treat patients with advanced melanoma, which hadn’t responded to conventional treatments. The study involved co-ordination of multiple departments. The treatment involved surgically removing some melanoma tumour tissue, separating out the immune cells called Tumour Infiltrating Lymphocytes (TILs) and growing them in a centralised production facility. The TILs were then returned to the hospital and administered to the patient through an intravenous infusion.

The trust executive team had agreed to a winter investment plan for 2018/19, which included a planned increase in staffing for medical wards to better care for outlying patients. The intention of the plan was to reduce the length of stay for patients and ensure all medical patients in the hospital received sufficient medical input during their stay.
The divisional structure at this trust was revised in 2014, into groupings based on clinical pathways. Consequently, the surgical specialties sit within all five divisions. A cross-divisional Surgery Board was established in May 2016 to provide an over-arching forum where all aspects of quality, risk, safety, workforce, finance and performance are reviewed monthly.

The trust provides a range of surgical specialties for the local population, and is a regional centre for major trauma, cancer, neurosurgery, transplant and vascular services. The majority of surgery is undertaken on site in 37 operating theatres. Some day case work is also undertaken at Ely Hospital. Owing to capacity constraints some elective surgery is undertaken within the local independent sector.

(Source: Routine Provider Information Request (RPIR) – Acute context)

The trust has 431 surgical inpatient beds located over 17 surgical wards.

<table>
<thead>
<tr>
<th>Ward/unit name</th>
<th>Description of ward</th>
<th>Number of beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridge Eye Unit (Ward Area)</td>
<td>Day case facility</td>
<td>14 (four first stage and 10 second stage recovery beds)</td>
</tr>
<tr>
<td>Cambridge Eye Unit (Recovery)</td>
<td>Day case facility, surgical procedures</td>
<td>10</td>
</tr>
<tr>
<td>Ward C8</td>
<td>Trauma and orthopaedics</td>
<td>37 (23 elective; 14 trauma)</td>
</tr>
<tr>
<td>Ward D8</td>
<td>Trauma and orthopaedics</td>
<td>37</td>
</tr>
<tr>
<td>Ward J3</td>
<td>Contingency ward/theatre admissions unit and discharge unit including surgical ambulatory care unit.</td>
<td>30</td>
</tr>
<tr>
<td>Ward L2</td>
<td>Day of Surgery Admission Unit (DOSA)/23 hour stay facility.</td>
<td>35</td>
</tr>
<tr>
<td>Ward L4</td>
<td>Colorectal surgery</td>
<td>32</td>
</tr>
<tr>
<td>Ward F5</td>
<td>Transplant surgery and high dependency; integrated with ward G5</td>
<td>Four</td>
</tr>
<tr>
<td>Ward G5</td>
<td>Transplant surgery</td>
<td>30</td>
</tr>
<tr>
<td>Ward F6</td>
<td>Hepatobiliary and upper GI surgery; regional referral centre.</td>
<td>33</td>
</tr>
<tr>
<td>Ward A4</td>
<td>Neurology/neurosurgery</td>
<td>26</td>
</tr>
<tr>
<td>Ward A5</td>
<td>Neuro-oncology/neurosurgery</td>
<td>25</td>
</tr>
<tr>
<td>Ward D6</td>
<td>Neurosurgery</td>
<td>16</td>
</tr>
<tr>
<td>Ward J2</td>
<td>Rapid access acute specialist rehabilitation following major trauma</td>
<td>21</td>
</tr>
<tr>
<td>Ward L5</td>
<td>Plastic and reconstructive; vascular surgery</td>
<td>32</td>
</tr>
<tr>
<td>Ward M5</td>
<td>Oral and maxillofacial surgery; ENT; ophthalmology and plastics and urology</td>
<td>32</td>
</tr>
<tr>
<td>Ward A3</td>
<td>Neurosurgery/DoSA/trauma high dependency unit</td>
<td>17(11 ward; six NCCU HDU)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)
The trust had 33,458 surgical admissions from June 2017 to May 2018. Emergency admissions accounted for 9,097 (27.2%), 16,350 (48.9%) were day case, and the remaining 8,011 (23.9%) were elective.

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Compliance with mandatory training was good and staff were supported with time away from their clinical responsibilities to complete refresher training.

The trust set a target of 90% for the completion of all mandatory training. A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>152</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>682</td>
</tr>
<tr>
<td>Health and safety</td>
<td>152</td>
</tr>
<tr>
<td>Information governance</td>
<td>677</td>
</tr>
<tr>
<td>Infection control</td>
<td>675</td>
</tr>
<tr>
<td>Fire safety</td>
<td>651</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>662</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>623</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 96.9% for qualified nursing staff in surgery. The trust’s training targets were met for all eight mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>153</td>
</tr>
<tr>
<td>Health and safety</td>
<td>153</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>377</td>
</tr>
<tr>
<td>Fire safety</td>
<td>372</td>
</tr>
<tr>
<td>Infection control</td>
<td>371</td>
</tr>
<tr>
<td>Information governance</td>
<td>370</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>369</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>278</td>
</tr>
</tbody>
</table>
The trust had an overall training compliance rate of 89.2% for medical staff in surgery at the trust. The trust’s training target was met for seven of the eight mandatory training modules for which medical staff were eligible. The module with the lowest completion rate was resuscitation with 67.8%. However, by the time of our inspection there had been a drive to capture medical staff in refresher training on resuscitation.

(Source: Routine Provider Information Request (RPIR) – Training tab)

It was evident that that mandatory training was a priority for ward leads. Staff received reminders from three months in advance to inform them they were due for annual training. Staff confirmed they received sufficient time away from clinical responsibilities to attend face-to-face training or complete online modules.

Staff received training in recognising and responding to sepsis and the use of the ‘sepsis six’ pathway.

Safeguarding

Staff were aware of processes and standard procedures to keep people safe from abuse, and received training to assess, recognise and report abuse.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for qualified nursing staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>682</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>694</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>691</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>676</td>
</tr>
<tr>
<td>Prevent level 3 (WRAP)</td>
<td>52</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>49</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 98.9% for qualified nursing staff in surgery at the trust. The trust’s 90% completion target was met for five of the six safeguarding training modules for which qualified nursing staff were eligible. The module with the lowest completion rate was safeguarding children level 3 with 87.5%.

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>376</td>
</tr>
<tr>
<td>Prevent level 3 (WRAP)</td>
<td>41</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>40</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>356</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>331</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>332</td>
</tr>
</tbody>
</table>
The trust had an overall safeguarding training compliance rate of 86.5% for medical staff in surgery at the trust. The trust’s 90% completion target was not met for four of the six safeguarding training modules for which medical staff were eligible. The module with the lowest completion rate was safeguarding children level 2 with 81.4%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Management staff (band seven and above) were trained to level three in safeguarding and other staff were trained to level two.

The trust had up to date policies for safeguarding children and safeguarding adults. Staff were familiar with the safeguarding policies and knew how to access them on the trust’s electronic system. There were dedicated safeguarding teams for safeguarding children and safeguarding adults and staff we spoke with knew how to contact the safeguarding team to ask for support or to make a referral.

Cleanliness, infection control and hygiene

There were reliable systems to ensure standards of cleanliness were maintained and protect people from a healthcare-associated infection.

The trust had systems and processes in place to reduce the risk of healthcare associated infections and maintain standards of hygiene. For example, staff received training in infection prevention and control (IPC) and there was an up-to-date trust IPC policy which staff had access to on the trust’s electronic system.

All surgical areas, including surgical wards, surgical theatres, storage rooms and sluice rooms, were visibly clean and tidy. Ward nurses were responsible for the routine cleaning of medical equipment and the immediate bed-space.

Environmental cleaning was provided by an external domestic services company. There were daily and weekly cleaning schedules for each area with cleaning scores documented weekly for high risk areas, fortnightly for medium risk areas and monthly for low risk areas. We reviewed the cleaning scores for surgical areas for August, September and October 2018 and saw there was good compliance, with the lowest recorded score 93.3% on one occasion.

Staff had access to and wore personal protective equipment (PPE), such as aprons and gloves, when providing patient care, to help prevent the spread of infection. Nursing and medical staff on wards adhered to the trust’s ‘bare below the elbows’ policy.

We observed both nursing and medical staff washing their hands between patient contacts in line with the World Health Organisation’s “Five Moments of Hand Hygiene” guidance and the National Institute for Health and Care Excellence (NICE) QS61 Statement 3.

There was evidence of compliance with national guidance and best practice in relation to IPC processes. For example, theatre staff complied with national guidance in respect of the preoperative phase, intraoperative phase (including hand decontamination, incise drapes, the use of PPE, and antiseptic skin preparation) and the postoperative phase in line with the National Institute of Health and Care Excellence (NICE) on infection prevention and control (IPC) measures (CG74, published 2008 and revised 2017).

Staff working in endoscopy followed the decontamination guidance outlined in the Health Technical Memorandum 01-06: decontamination of flexible endoscopes (published 2013 and revised 2016), water safety checks were performed in line with national guidance and equipment manufacturer’s standards.

The service undertook a range of local IPC audits, which was good practice for monitoring and escalating any IPC risks. This audit schedule included fortnightly hand hygiene audits, the results for all surgical areas from August to October 2018 showed there was an average score of 99% across the service for hand hygiene compliance, in line with the trust target of over 95%.

The trust completed monthly equipment cleaning audits. This included random checks of staff...
knowledge on equipment cleanliness, cleaning processes, equipment tagging checks and cleanliness checks of 10 pieces of equipment. The results for September and October 2018 showed compliance of consistently 90% or over, in line with the trust target of 90%. There was a 100% compliance rate in most (61%) instances.

<table>
<thead>
<tr>
<th>Audit date</th>
<th>Division</th>
<th>WARD</th>
<th>STAFF KNOWLEDGE %</th>
<th>STAFF PRACTICE %</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/10/2018</td>
<td>D</td>
<td>A3</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>02/10/2018</td>
<td>D</td>
<td>A4</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>02/10/2018</td>
<td>D</td>
<td>A5</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>10/09/2018</td>
<td>A</td>
<td>C8</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>05/10/2018</td>
<td>D</td>
<td>D6</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>10/09/2018</td>
<td>C</td>
<td>D7</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>10/09/2018</td>
<td>A</td>
<td>D8</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>06/10/2018</td>
<td>C</td>
<td>F6</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>17/10/2018</td>
<td>D</td>
<td>J2</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>23/09/2018</td>
<td>A</td>
<td>L2DSU</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>17/09/2018</td>
<td>A</td>
<td>L4</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>09/10/2018</td>
<td>D</td>
<td>L5</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>17/09/2018</td>
<td>A</td>
<td>M4</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>09/10/2018</td>
<td>D</td>
<td>M5</td>
<td>100%</td>
<td>90%</td>
</tr>
</tbody>
</table>

There were escalation processes for concerns raised from audit. The service had speciality, directorate and divisional committees for IPC who had overall responsibility for reviewing and monitoring IPC concerns. Each committee reported to the trust wide Infection Prevention & Control Committee (IPCC), with additional input from the trust-wide decontamination committee, antimicrobial stewardship group and water safety committee. The IPCC was chaired by a Consultant Microbiologist and reported to the trust Quality Committee, through the Clinical Governance Monitoring Committee.

The service monitored rates of surgical site infections (SSI), in line with guidance from the National Institute for Health and Care Excellence (NICE) (Quality Standard 49 published 2013). Surgical site infections are a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. The trust provided data, as required by the Department of Health, on SSI rates for elective orthopaedic implant surgery (either hip or knee), repair of neck of femur or reduction of long bone fracture for one three-month time period. For 2016-17, the rate of SSI for total knee replacement surgery was 1.0%, compared to a national average of 0.7% (range 0 - 5.3%).

The trust also reported on SSI rates for large and small bowel surgery and bile duct surgery, which was not mandated by the Department of Health and was part of the trust’s internal safety and quality checks. Rates for small bowel surgery were 3.6% (national average 7.2%), large bowel surgery was 11.4% (national average 9.8%) and bile duct surgery was 9.8% (national average 5.6%).

There were meetings held between the relevant surgical team and the trust’s IPC team when rates were higher than the national average to identify any actions necessary. Alongside these compulsory data submissions, the service was also carrying out their own annual audits on SSI rates which was good practice for regular surveillance. Patients with SSIs were managed in line with Public Health England guidelines on surgical site surveillance, which allows hospitals to record incidents of infection after surgery, track patient results and review or change practice to avoid further infections.

We reviewed the trust wide IPC annual report for 2016 to 2017. This showed the trust had the second lowest MRSA bacteraemia rate within the Shelford Group (a group of 10 leading academic
healthcare organisations) and the third lowest rate for Clostridium difficile (C.Difficile) among this group from April 2016 to March 2017. The report for 2017 to 2018 had not been published at the time of our inspection.

Environment and equipment

The environment was generally suitable to treat patients safely and equipment was used and maintained safely, although there were some environmental and equipment risks.

All areas we inspected were generally well laid out, spacious and designed to meet patient needs and to keep patients safe. For example, wards had dedicated male and female bays and sufficient numbers of side rooms for isolating patients who required barrier nursing due to an infection risk.

There were systems and processes to ensure the safe maintenance and replacement of equipment. We checked a range of equipment in each area which included blood pressure machines, syringe drivers and blood gas machines (both in storage areas and on the wards). We found they were all within their service date, with safety testing stickers visible to show they had been tested yearly where required.

To ensure staff did not use faulty theatre sets, there was a theatre liaison officer based within sterile services who reviewed any incident reports in relation to surgical equipment issues and would then check that the relevant faulty set was not in circulation. This person then fed back to all the band seven nurse leads about the sets that were not in use. There was back up equipment meaning the service did not have to cancel patients’ appointments if there was an equipment fault.

Resuscitation equipment was stored appropriately on clearly labelled resuscitation trolleys. On all wards we visited staff checked resuscitation equipment daily, checks were documented in a daily log. In addition, weekly checks were completed to ensure oversight that the resuscitation equipment had been checked daily. We observed two nurses undertaking the daily checks on the neurosurgery rehabilitation ward and observed this was done thoroughly, with one nurse reading out each item checked and the other confirmed it against the checklist.

There were clear procedures for the management of waste and clinical specimens within the service and we observed staff managing specimens and clinical waste appropriately and safely in line with trust policy.

All sharps bins were labelled, dated, stored safely and under the fill limit in accordance with national guidance. Staff disposed of clinical waste in the correct colour coded bags in the dirty utility room. Clean and dirty utility rooms were separate and locked with keypad entry.

Patients’ bedside areas were free from clutter. Disposable privacy curtains were dated and all within the expiry date for changing. There was a routine changing schedule, curtains would also be changed if soiled or after a patient with an infection risk. This was specified in local policy and was in accordance with Health Building Note 00-09: Infection Control in the Built Environment Regulations.

There were some risks around the environment and equipment. The overnight intensive recovery (OIR) unit was a six-bedded unit with no windows and no shower facilities. It was a 22-hour stay facility for immediate recovery and an overnight stay following surgery, sometimes patients had to stay longer than one night due to bed capacity, which we have reported on in the ‘responsive’ domain. During our inspection, there were only three patients in OIR, it was evident with six patients it would be cramped and noisy. Mixed-sex accommodation breaches were frequent due to the lack of space, and this was on the risk register for the service. Staff minimised impact by allocating the beds as appropriately as possible and using screens between bed spaces.

In the day surgery unit, there were items significantly out of date including syringes, irrigation solution and safety needles in one of the two consumable equipment trolleys. We raised this with the nurse in charge, who told us this trolley was not in use and staff knew not to use it. However, it was not clear that the trolley was not to be used. staff removed this trolley from the ward immediately, as a precaution. Equipment on the second trolley were all in date and this was the trolley in use. There was a risk within neurosurgery due to insufficient portable oxygen and
suctioning units. Only eight of the 22 beds on ward A4 had this equipment, which meant there was a risk if there were more than eight patients requiring oxygen and suctioning. This was on the service risk register and there were appropriate actions in place, including that the service was in the process of purchasing an extra portable unit; movement of patients to other bed spaces that have ports available if identified as being at risk or in the event of deterioration; and escalation for discussion at governance and directorate board if there were delays to resolution of this issue.

The theatres store room where flammable liquids were stored was very warm, staff did not record the temperature of the room. We requested a temperature reading which was recorded as 26.9 degrees Celsius, which was not in line with safe practice of storing flammable liquids, which should be no higher than 25 degrees Celsius. Staff were aware the store room often became hot and staff told us it was ‘unbearable’ on the hottest days of the summer. We raised this as a concern with senior management, who said they would move them immediately. However, when we returned the next day, the flammable liquids had been moved to a main thoroughfare, which was not temperature monitored and posed a risk to people walking through this area. We raised this again and managers ensured they were moved to an appropriate storage room which was temperature controlled.

Assessing and responding to patient risk

The service responded appropriately to changing risks to patients who used the services.

Staff explained what they would do in the event of patient deterioration and consistently told us they could access senior medical reviews and escalate concerns promptly if needed. All staff knew how to contact the rapid response team and in areas with the most acute patients, such as the intermediate dependency area, there was a member of the team based on the ward. Staff reported close links with the rapid response team to address patient risk.

All patients had a comprehensive pre-operative risk assessment which was documented in the electronic patient record system and helped inform their individual care plan and minimise risk. This included a range of risk assessments including, the malnutrition universal screening tool (MUST) score, body map and pressure ulcer risk (Waterlow), body mass index (BMI), bed rail requirement, falls risk, mental capacity, and hip and knee scores for joint replacement surgery. This was in line with national good practice guidance on pre-operative assessment from the NHS Modernisation Agency. On ward F6 we observed an example of good practice, whereby the ward clerk ran a report daily from the electronic patient records system to check that all patients on the ward had Waterlow (pressure ulcer risk) scores, nutrition assessments, and VTE assessments completed in their records.

Staff used National Early Warning Scores 2 (NEWS2) to record routine observations such as blood pressure, temperature and heart rate. The NEWS2 system had been implemented in September 2018, as an advancement on the NEWS system, to help improve assessment of patient risk. Accurate and regular NEWS2 documentation supports early recognition of a patient deterioration by grading the observations and prompting nursing or medical reviews at specific trigger points. The NEWS2 scores were recorded on the electronic patient record system and there was evidence of escalation when a patient was scoring as a risk on NEWS2. It flagged up automatically on the electronic patient records system that these patients might be at risk and required a further review.

An audit published in the July 2018 patient safety report showed compliance targets with NEWS2 completion from June 2018 to July 2018. Compliance for the trust overall was 96%, against a minimum target of 90%. However, main recovery had achieved 86% compliance in June and 89% in July, and overnight intensive recovery had scored 85% in June and 86% in July, which meant they were both rated as ‘amber’ on the red/amber/green scale in this audit. Factors identified included patients that were being monitored every five minutes did not have their temperature recorded every time, so NEWS was not completed for every set of observations. As an action to improve, the service was currently reviewing a new monitoring system for the OIR to account for the processes, and improve the accuracy of the reported compliance rates.
The trust used a ‘sepsis six’ bundle which staff were familiar with it and confident in recognising signs of sepsis (sepsis-six is a bundle of therapies designed to reduce the risk of death for of patients experiencing sepsis). Early treatment of sepsis reduced complications and improved outcomes for patients. There were trust-wide monthly audits of sepsis screening compliance and diagnosis to treatment times, which were submitted to NHS England as part of the 2017 to 2018 Commissioning for Quality and Innovation (CQUIN). Results showed 100% of surgical inpatients were screened for sepsis on admission, which demonstrated good practice for assessing and reducing patient risk. The trust performed well for mortality caused by sepsis, with an observed mortality rate of 11.6%, against an expected mortality rate of 15.3%. This ranked the trust the best performing in this indicator out of eight trusts in the Shelford group of NHS trusts.

We observed good compliance with the World Health Organisation (WHO) ‘five steps to safer surgery’ checklist, designed to reduce the risks of mistakes in surgical procedures. Completion of the checklist was recorded electronically on the trust’s EPIC electronic records system. The checklist was completed with the full surgical team present, staff who filled in the checklist could not move onto the next electronic page until the previous one had been completed, this ensured errors and risk was minimised. There was an adapted WHO checklist for interventional radiology to fit local practice.

The trust carried out an observational audit of surgical procedures in theatres from November 2017 to June 2018 which assessed compliance with the WHO ‘5 Steps to Safer Surgery’ checklist. Overall the audit found good compliance and gradual improvement in compliance over the 7-month period. The main areas for improvement were discussion of all cases on theatre lists in the team brief, and the sign in process with surgeons and the registered nurse, compliance was 80-100%. All the remaining standards were 100%. Following this audit service leads implemented weekly spot checks on a different day each week across theatres to improve and maintain compliance.

We saw individualised initiatives to help staff mitigate and respond to patient risk. For example, there were comprehensive falls risk assessments, those patients identified as high risk of falls had falls alarms installed on their bed. Staff we spoke with on neurosurgery could explain the management of patients at risk of falls. This ward was high risk due to the confusion and mobility difficulties of some patients in neurosurgery. For example, in July 2017 there had been 12 falls, and in September 2017 there had been seven falls; but there had not been any falls with serious harm in the last six months. There was a bi-monthly falls and pressure ulcer steering group to oversee the framework for measuring and monitoring of falls safety and to drive the falls improvement programme. Updates and learning from this group was shared with ward staff to help them with management of patients at risk of falls.

The neurosurgery ward had a side room with specialist seizure monitoring equipment to monitor patients at risk, this enabled staff to respond at the earliest opportunity. Wards were highlighted on the patient information boards near the nurses’ station whether patients required one to one care to ensure all staff including staff were aware of the most acute patients.

There was a team of eight resuscitation officers across the trust, who completed resuscitation equipment audits monthly and fed back to staff, and provided support for staff on resuscitation and patient deterioration, to support the management and prompt response to patient risk in the service.

**Nurse staffing**

**Staffing levels were planned and reviewed to ensure patients received safe care and treatment. Although there were vacancies, there were actions to mitigate this.**

The trust reported the following qualified nursing staff numbers in surgery from April 2017 to March 2018 and for April to July 2018:
The trust reported a staffing level of 80.2% for nursing staff in surgery from April 2017 to March 2018. This had risen slightly to 84.8% from April to July 2018, in part due to the addition of 66.1 WTE staff in post, although the number of planned posts had also increased by 36.1 WTE posts.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 18.6% for qualified nursing staff in surgery. This was higher than the trust target for nursing and midwifery staff of less than or equal to 11%.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

There was evidence of improvement in recruitment to reduce vacancies, a rolling recruitment programme ensured recruitment was timely and took place before vacancies impacted on the safety of the service. There had been significant overseas recruitment drives; which took around six months to complete the process, but several nurses had just received their personal identifiable numbers (PINs) from the Nursing and Midwifery Council (NMC) to commence work in the service.

At the time of our inspection, some areas including neurosurgery and recovery were fully staffed to establishment. Service leads and ward teams were proud of this achievement. In neurosurgery, rotas used to only have four registered nurses (RNs) planned for day shifts, but in the last year they had increased this to five which meant there could always be one supernumerary nurse. The nurse in charge told us this had reduced stress on the ward, which allowed staff to dedicate more time to care for patients and meant that the ward felt a safer place to work.

There were concerns raised about nurse staffing levels in day surgery. There had recently been a reduction in their band seven establishment so there was only one part-time band seven nurse three days a week, and band six nurses were in charge at other times. When we inspected day surgery, staffing levels were sufficient, but a health care assistant (HCA) said that when it was busy staffing levels could be problematic. The unit had five nurse vacancies and four HCA vacancies at the time of inspection. The band seven lead told us that planned staffing levels had been calculated ‘years ago’ so did not reflect the current acuity and workload. Following our inspection, the trust told us the establishment had been reviewed in May 2017. In addition to a full-time band 7 nurse, a matron (band8A) was added to the establishment to provide support, leadership and safer staffing. Additional staffing had also been placed on L2 reflecting the increase in acuity and volume of patients.

On ward G5 the junior sister raised a concern about the skill mix of nursing staff at the time because several new starters had come onto the ward at the same time, although we did not observe any safety impact during our inspection.

Ward and divisional leads had identified concerns about new staff leaving after they had completed induction training. To address this, there was a significant focus driven by divisional and speciality leads about fostering a positive learning culture, promoting staff from within, and supporting staff with specialist interests to develop, to encourage retention.

Turnover rates

From August 2017 to July 2018, the trust reported a turnover rate of 14.0% for qualified nursing staff in surgery. This was higher than the trust target of 10.56%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
Sickness rates
From August 2017 to July 2018, the trust reported a sickness rate of 3.3% for qualified nursing staff in surgery. This was higher than the trust target of 2.7%.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage
From August 2017 to July 2018, the trust reported that 10.3% of qualified nursing FTE shifts in surgery at the trust were filled by bank staff and 1.2% of shifts were filled by agency staff. In addition, 4.4% of the qualified nursing staff FTE shifts were not filled by bank or agency staff to cover staff absence.

Over the same period, 23.7% of non-qualified nursing staff FTE shifts in surgery at the trust were filled by bank staff and none were filled by agency staff. There were 5.4% of non-qualified nursing staff FTE shifts that were not filled by either bank or agency staff to cover staff absence.

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Bank FTE shifts</th>
<th>Agency FTE shifts</th>
<th>Unfilled FTE shifts</th>
<th>Total FTE shifts</th>
</tr>
</thead>
<tbody>
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<td></td>
<td>Number</td>
<td>Number</td>
<td>Number</td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Qualified</td>
<td>856.2</td>
<td>99.3</td>
<td>363.8</td>
<td>8,316.1</td>
</tr>
<tr>
<td></td>
<td>10.3%</td>
<td>1.2%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>Non-Qualified</td>
<td>1,258.3</td>
<td>0.0</td>
<td>284.5</td>
<td>5,311.1</td>
</tr>
<tr>
<td></td>
<td>23.7%</td>
<td>0.0%</td>
<td>5.4%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,114.5</td>
<td>99.3</td>
<td>648.3</td>
<td>13,627.2</td>
</tr>
<tr>
<td></td>
<td>15.5%</td>
<td>0.7%</td>
<td>4.8%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Some surgical wards shared nursing staff from other areas on occasions when they were understaffed. The service mitigated any impact of this as far as possible by allocating the staff who were less familiar with the ward/speciality to patients with more general needs or less acute patients, this ensured patients were cared for as safely as possible. Other areas did not share staff across specialities and relied on in-house bank nurses. For example, in neurosurgery there was some sharing of staff between the four different neurosurgical areas to meet patient needs but not outside of their speciality, and eye surgery relied on their own bank staff to cover gaps in the staffing rota.

Medical staffing
Medical staffing levels were planned and reviewed to ensure patients received safe care and treatment.

The trust reported the following medical staff numbers in surgery from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>Surgery</td>
<td>408.6</td>
<td>461.6</td>
</tr>
</tbody>
</table>

The trust reported a similar staffing level in both time periods.
(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates
From August 2017 to July 2018, the trust reported a vacancy rate of 12.5% for medical staff in surgery. The trust does not have a target vacancy rate for medical staff.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates
From August 2017 to July 2018, the trust reported a turnover rate of 3.2% for medical staff in
surgery. This was lower than the trust target of 10.56%  
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**
From August 2017 to July 2018, the trust reported a sickness rate of 1.0% for medical staff in surgery. This was lower than the trust target of 2.7%.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and locum staff usage**
The table below shows the numbers and percentages of hours in surgery from August 2017 to July 2018 that were covered by medical bank or locum staff or left unfilled.

Of the 102,716.3 FTE shifts available, 3.0% were filled by bank staff and 1.2% were covered by locum staff to cover sickness, absence or vacancy for medical staff. In the same period, 0.9% of the available hours were unable to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total hours available</th>
<th>Bank usage</th>
<th>Locum usage</th>
<th>Not filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>FTE shifts</td>
<td>%</td>
<td>FTE shifts</td>
</tr>
<tr>
<td>Surgery</td>
<td>102,716.3</td>
<td>3,113.0</td>
<td>3.0%</td>
<td>1,254.0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Medical locum tab)

**Staffing skill mix**
In June 2018, the proportion of consultant staff reported to be working at the trust was the same as the England average and the proportion of junior (foundation year 1-2) staff was higher.

**Staffing skill mix for the whole time equivalent staff working at Cambridge University Hospitals NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>3%</td>
<td>11%</td>
</tr>
<tr>
<td>Registrar Group~</td>
<td>33%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>16%</td>
<td>11%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)
Surgery services were consultant-led. Consultant ward rounds occurred daily including at the weekends on all surgery wards. As a regional trauma centre, cover was provided as per the trauma network guidelines, including emergency lists at the weekends conducted by consultants. Nurses and HCAs consistently reported prompt access to doctors if required and we saw good medical presence in the wards we visited.

The highest medical staffing vacancy was for anaesthetists in theatres. The trust did not use agency anaesthetists but did use NHS locum and bank anaesthetists if required. However, risk was mitigated because locum staff were well supported by substantive consultants, completed the trust induction, and there was always a substantive consultant in charge. The band seven lead explained the trust were trying to recruit by having scheduled open days and offering nursing staff a six-month fast track anaesthetic training programme to support anaesthetists in theatres.

Records

Records were well managed, clear, up-to-date and easily available to all staff providing care.

Patient records were electronic and stored on the trust’s electronic patient records system. This system contributed to safe record management because all records were in the same order and format, were updated in real time as observations or procedures took place, and the system would flag up in red where an aspect of the documentation had not been completed.

Documentation of consent was paper-based but consent forms were then scanned in to be held with the rest of the patient records on the electronic system.

In theatres had a paper-based theatre register to document the patient name, anaesthetist and surgeon names and the procedure the patient was undergoing as another safety measure for records and checks prior to surgery.

On surgical the wards we observed good record keeping and all records we checked through the electronic patient records system were clear, complete and accurate. In interventional radiology, the junior sister had recently standardised the electronic post-procedural care documents to ensure that all staff were following and documenting the recovery processes in the same way.

There was an issue with record-keeping in overnight intensive recovery (OIR) because the monitors for recording patient observations were not connected to the electronic patient records system at the time of our inspection meaning staff had to transfer it manually, which was then time away from patient care. This was highlighted as an issue by two service leads separately and was on the risk register for the service. This risk was reflected in audits of the completion of care plan notes in OIR. Monthly compliance was 35.1%; 24.6%; 42.3%; and 44.1% for April, May, June and July 2018 respectively. There were actions to improve this, which included reminders to staff at daily huddles and handovers and increasing nurse staffing to full establishment. At the time of our inspection we did not identify any concerns with care plan documentation. In the long term, there were plans to integrate the IT systems in OIR to address the issue, which would save time and reduce risk of error when inputting information, although there was no set target date to achieve this.

There were concerns raised by a nurse in eye surgery because there was no facility to scan lens numbers and expiry dates onto the electronic patient records system, this meant staff had to manually enter this information onto the system which increased the risk of human error in the record keeping. However, this was not specified on the service risk register. There were no incidents reported as a result of this. Procurement were monitoring the accuracy of the implant documentation on the electronic patient record. In addition, as part of the World Health Organisation (WHO) safety checks, the information was checked with the surgeon before use and signed as accurate by the surgeon at the end of each case.

There were insufficient ‘workstations on wheels’ which was highlighted on the service’s risk register in relation to timely record keeping as records may not be updated ‘in real time’. Although we did not observe staff having difficulties accessing the workstations during our inspection, one
nurse on ward L2 raised a concern that particularly during morning ward rounds, this was challenging in terms of effective record keeping.

**Medicines**

**There were systems in place to ensure the proper and safe use of medicines, although we had concerns around the checking and escalation arrangements for fridge temperatures.**

Medicines were prescribed and administered in line with trust policy, national guidance and best practice. For instance, medicines to take away (TTAs) were written by doctors and checked by pharmacists. Pre-labelled TTA packs were available and issued by nurses as per trust policy (Dispensing and Supply Policy & Procedure (Aug 2017)). There was a self-administration policy in place.

Medicines reconciliation (the process of accurately listing a person’s medicines) was done in line with national guidance when transferring between care providers. Multiple sources were used in the medicines reconciliation process, including patients’ own medicines and past medicines histories. Pharmacists used a separate section on the electronic records system to document and follow up on discrepancies relating to medicines reconciliation. There was a dedicated communication portal between pharmacy staff to track progress on medicines issues identified on admission, to hand over any outstanding actions in cases of patient transfers to other wards and to aid discharge planning.

There were automatic daily reports populated from medicines information on the electronic patient records system on all patients prescribed methotrexate and medicines for Parkinson’s disease, so these could be monitored especially closely. Methotrexate is a high-risk medicine and there have been several NPSA safety alerts on its use. Medicines for Parkinson’s disease are time critical and missed doses can result in serious complications. Therefore, these populated reports were helpful for pharmacists to identify and prioritise these patients to ensure the medicine has been prescribed correctly, by a doctor of the appropriate grade, that they were administered on time and clinically appropriate. Ward pharmacists checked these reports daily to review any patients on their ward.

We saw evidence on electronic charts across surgical wards that pharmacists reviewed medicines regularly. Antibiotics were reviewed regularly and documentation included the planned duration of use. We saw good compliance with this with no missed doses seen. Pharmacists could also add ‘Discharge Medical Alerts’ onto the electronic system to flag up any potential medicine issues on discharge and any key messages on monitoring for nursing and medical staff to be aware of when discharge planning.

Nurses used the Bar-Coded Medicines Administration (BMCA) system, which is a control system that uses barcodes to prevent human errors, by ensuring patients are receiving the correct medications at the correct time by electronically validating and documenting medications. The information encoded in the BMCA system allowed the comparison of the medication being administered with what was ordered for the patient.

The pharmacy team had a strong presence on wards and were an integral part of the team. They visited wards at least weekly to restock, check medicines storage and dates and were also available on an ad hoc basis if stocks were low or for advice and support. Pharmacists ran pre-operative admission clinics from Monday to Friday, where they reviewed patients on high risk medicines and provided advice on how these should be managed perioperatively.

There were appropriate, secure, storage facilities for medicines, with a dedicated medicines storage room in each ward and in theatres. Medicines storage rooms were secured by keypad access and all medicines cabinets, trolleys and fridges were locked. Medicines used for internal use and external use were stored separately, and oxygen cylinders were all in date and stored securely.
The ordering, storage and administration of controlled drugs (CD) were in accordance with the Misuse of Drugs Act 1971 and the associated regulations. We checked CD stock levels on the wards and theatres and they matched the CD record book. In eye surgery and on ward D8 (trauma), the CD cupboard was behind the nurses’ station rather than in the medicines storage room, but there were safety assurances, there was an automatic red light that came on when they were unlocked. CDs were checked and signed daily in all areas and we saw this had been done for the last month as per trust policy. This was an improvement since our previous inspection in September 2016 when they would only be checked on days when the CD store had been opened for use.

The trust had a policy, which clearly set out the monitoring, documentation and escalation process for medication fridge temperatures. This policy required staff to check the current, minimum and maximum fridge temperatures each day, to document this, reset the thermometer after the daily check and escalate any out of range temperatures to the pharmacy team. In addition to this policy, a flow chart, which included practical advice was placed on each medication fridge. This practical advice included checking if the packaging was cold to touch. The policy reflected national guidance and the flow chart had been devised in consultation with key stakeholders including senior nurses and pharmacists.

Room and medication fridge temperatures were monitored daily and were in range during our inspection. However, the escalation process had not always been followed when temperatures were recorded out of range. For example, on ward G5 we observed occasions during August to October 2018 when the maximum temperature had exceeded the 8-degree Celsius safe level and it was not clear from the temperature monitoring sheet whether this had been escalated. Similarly, in theatres, there were three occasions in October 2018 where fridges had been recorded over the maximum safe range, twice at 10 degree Celsius and once at 15 degrees Celsius with no evidence of action or escalation recorded on these occasions.

At the time of our inspection, an audit was being undertaken by the pharmacy department to determine whether out of range fridge temperatures were being escalated appropriately, and the trust was also considering changing to an automated process for temperature monitoring to address concerns about the reliance on manual processes and associated risks.

Incidents

Staff knew how to report incidents and received feedback where they had been involved; however, we had concerns that learning from incidents was not always shared between different divisions.

Never Events

Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

From October 2017 to September 2018, the trust reported two incidents classified as never events for surgery.

The first never event occurred in October 2017 and was classified as a retained foreign object (fractured guidewire) post procedure. The second never event, occurring in December 2017, related to an incorrect implant in a neurosurgical patient.

(Source: Strategic Executive Information System (STEIS))

We observed action plans in place for both never events with appropriate recommendations. For example, for the retained fractured guidewire event, there was a recommendation to ensure the integrity of the removed guidewire was always visually checked by both the urologist and scrub nurse and to communicate the importance of this with the team. However, although the action plan showed it had been shared with the urology team, there was no specific action to share learning more widely across surgery services.

All staff we spoke with did not show awareness of the retained fractured guidewire never event
when we asked about never events in the previous 12 months. Some staff, primarily those in neurosurgery and theatres who were most directly impacted, knew about the neurosurgery cranioplasty never event, but staff in other areas did not, when we asked if there had been any surgical never events in the last 12 months.

We spoke with the medical leads for surgical services (from various divisions), we asked them to outline the two never events above and explain the main actions that had been taken following them. They needed to be prompted on what these never events were. This furthered our concerns, we were not assured learning and changes in practice to reduce the risk of incidents reoccurring, were at the forefront of practice and service delivery.

Prior to our inspection, the trust had agreed, in principle that all serious incidents, including never events would be presented at the trust’s monthly surgery board meetings to facilitate shared learning across all divisions. At the time of our inspection, this had not yet been embedded.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 12 serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from September 2017 to August 2018.

Of these, the breakdown of incident types reported were:

- Confidential information leak/information governance breach meeting SI criteria with four (33.3% of total incidents).
- Sub-optimal care of the deteriorating patient meeting SI criteria with two (16.7% of total incidents).
- Surgical/invasive procedure incident meeting SI criteria with two (16.7% of total incidents).
- Pressure ulcer meeting SI criteria with two (16.7% of total incidents).
- Slips/trips/falls meeting SI criteria with one (8.3% of total incidents).
- Medical equipment/devices/disposables incident meeting SI criteria with one (8.3% of total incidents).

*(Source: Strategic Executive Information System (STEIS))*

All grades of staff we spoke with on inspection could explain how they would report an incident and give examples of when they had reported an incident and received feedback. Staff were aware of the requirements of duty of candour when giving feedback about incidents to patients and relatives.

Systems and processes for sharing learning and actions from incidents between different divisions were not always effective.

Staff on wards and in the overnight intensive recovery unit did not show awareness of the serious incidents relating to breaches of confidentiality, although five staff in main theatres were and could tell us actions shared with them. There was mixed feedback about the learning and awareness following these incidents, although we did see reminders to staff in all areas about shredding confidential paperwork and handover documents before leaving the ward areas.

There were examples of learning and actions following other incidents specific to individual wards, the concern was related to shared learning throughout the division. On ward D8 (trauma), two staff separately told us about a patient on oxygen who was being transported to theatre by a porter and became short of breath on the way. There was no harm to the patient but as a result, all patients now were escorted to theatres with a registered nurse. In eye surgery the lead nurse told us about a staff injury and as a result, there had been reminders, both verbal and written to staff about the correct manual handling procedures. In addition, all staff had received a refresher in manual handling training.

Incidents were discussed at handover, in team meetings or at the ‘daily huddle’ at the start of a shift. There was a ’10.57’ daily meeting with all band seven nurse leads where incidents were discussed. Staff in all surgical wards reported they received emails about serious incidents and would be informed verbally at daily morning huddles. However, these meetings were not always minuted and staff did not always show awareness of the serious incidents and never events...
within the division. Therefore, we were not assured there was consistent effective information sharing processes to ensure lessons learned were at the forefront of discussions and practice. Staff on ward G5 told us it was difficult to have full team meetings as the ward was busy, which reduced the opportunity to share learning from incidents regularly at ward level.

Safety Thermometer

The service monitored performance and activity to understand risks and provide a clear accurate picture of patient safety.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 21 new pressure ulcers, 13 falls with harm and two new catheter urinary tract infections from September 2017 to September 2018 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Cambridge University Hospitals NHS Foundation Trust

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

From July 2017 to July 2018 the trust performance on patient harms, in comparison to the
Shelford group national average performance, showed the trust was performing better for harm-free care compared to the national average (95.6% compared to 94.1%).

**Is the service effective?**

**Evidence-based care and treatment**

**The service used national guidance, best practice and local policy to deliver effective care and treatment.**

Surgery services provided care to patients based on national guidance including National Institute for Health and Care Excellence (NICE), Royal College of Surgeons (RCC), Association of Anaesthetists of Great Britain and Ireland (AAGBI). These were supported by local guidelines and policies; which staff could access through the trust intranet; staff were updated on any important changes through emails and daily team briefings.

There was a comprehensive local audit schedule and regular participation in national audit to measure compliance with national standards and best practice. The local audit schedule for each ward included World Health Organisation (WHO) checklist audits, environmental and hand hygiene audits, audits of patients’ length of stay and record keeping audits.

Compliance with national guidance and evidence based practice was measured through local and national audits and through presentation to the quality governance and patient safety meetings. Patient care needs were continually assessed using specific care pathways, delivering care in line with NICE quality standards and the Royal College of Nursing (RCN) guidelines.

Individual surgical specialities used evidence and innovation to improve patient outcomes and drive improvement. For example, the prostate surgery service was taking part in random national trials, led by their academic leads for the avoidance of prostate biopsies. The urology service was trialling an enhanced recovery programme to reduce the length of stay for patients and had obtained positive results so far; staff planned to roll this out to other specialities. Elective orthopaedics were involved in a project to streamline the hip and knee pathways to try and maximise recovery. This involved comprehensive assessment of the post-operative period by the service leads, who then identified areas for improvement, for example, employing more physiotherapists in the department to promote early mobilisation of patients.

In the East of England Major Trauma Centre Work Programme 2017-2020, it was reported that there was a risk of the service being non-compliant with the British Orthopaedic Association Standards for Trauma (BOAST) in relation to the management of musculoskeletal trauma. This was impacted by theatre capacity and workforce/resources. This was self-reported by the trust in 2017 and was on the surgery service’s risk register. There were appropriate mitigating actions in place and it had been downgraded from ‘significant’ to ‘high’ risk. Actions included visits to other major trauma centres to identify any good practice and learning, and the development of a specific open fractures patient list and multidisciplinary team (MDT) template on the electronic records system.

**Nutrition and hydration**

**Patients’ nutrition and hydration needs were clearly documented and met.**

Patients’ nutritional needs were documented in their care plans on the electronic patient records system and on the information boards by their beds, for example, whether the patient was diabetic, required soft food or had any food allergies. Fluid balance charts were completed fully and accurately to monitor patients’ hydration.

Staff used the malnutrition universal screening tool (MUST) to identify patients at risk of underfeeding within 24 hours of admission, in line with national guidance. We observed this consistently completed on the electronic records system. The MUST tool calculated the overall risk of malnutrition and prompted staff to complete further regular assessments when a patient was calculated as being at risk.
Staff confirmed there was good access to dietician support when needed and they contributed to MDT meetings when required to optimise patients’ nutritional intake. On the transplant ward a dietician visited every day and offered patients nutritional advice.

The service was in the process of a long-term initiative to decrease the fasting times for surgical patients. The aim was to help meet pre-operative fasting requirements safely but with minimal impact on patients. An audit result from August 2018 showed fasting times for the service were on average 5.1 hours. The service provided us with information on their pre-operative fasting audit work and performance, which included reviewing and revising guidelines for preoperative fasting, completing a pilot in urology theatres, implementation of a “Can drink until” question on the WHO team brief paperwork. There were further plans for the following months, to ensure the improvements were embedded, including re-audit and reminders to the anaesthetic department.

**Pain relief**

**Pain was managed well, in line with national guidance.**

Patients’ pain was assessed and managed in line with the Faculty of Pain Medicine’s Core Standards for Pain Management (2015). For example, a member of the pain team visited the transplant unit every day to assess patients receiving pain management via an epidural. Following surgery, appropriate pain relief was administered in theatre recovery.

Patients undergoing orthopaedic surgery had pre-planned pain relief prescriptions as part of recovery and discharge planning. Pain control was discussed with patients pre-operatively and documented in the electronic patient records system.

We saw pain charts recorded appropriately, including visual, verbal and observer scoring. Pictorial pain indicator charts were available for patients that were unable to verbalise their level of pain.

A dedicated pain team were available 24 hours a day, seven days a week and staff told us that they were very helpful and managed and reviewed patients’ pain. Staff could contact the team for advice over the phone if appropriate, or if urgent pain support and assessment was needed a member of the pain team would be on the ward within minutes. On the trauma and orthopaedics ward, the pain nurse attended ward rounds.

We asked four patients about their pain management and they all reported that it was managed well.

**Patient outcomes**

**Information about outcomes was routinely collected and monitored.**

**Relative risk of readmission**

**Addenbrooke’s and the Rosie Hospitals**

From May 2017 to April 2018, all patients at Addenbrooke's and the Rosie Hospitals had a similar to expected risk of readmission for elective admissions when compared to the England average.

- Urology patients at Addenbrooke's and the Rosie Hospitals had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Neurosurgery and general surgery patients at Addenbrooke's and the Rosie Hospitals had higher than expected risks of readmission for elective admissions when compared to the England averages.
Elective Admissions - *Addenbrooke's and the Rosie Hospitals*

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

All patients at Addenbrooke's and the Rosie Hospitals had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- General surgery and transplantation surgery patients at Addenbrooke's and the Rosie Hospitals had lower than expected risks of readmission for non-elective admissions when compared to the England averages.
- Urology patients at Addenbrooke's and the Rosie Hospitals had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

Non-Elective Admissions - *Addenbrooke's and the Rosie Hospitals*

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity

(Source: *Hospital Episode Statistics*)

**National Hip Fracture Database**

In the 2017 National Hip Fracture Database, the risk-adjusted 30-day mortality rate was 5.2% which was within the expected range. The 2016 figure was 2.5%.

The proportion of patients having surgery on the day of or day after admission was 81.5%, which failed to meet the national standard of 85% but was within the top 25% of trusts. The 2016 figure was 80.4%.

The perioperative medical assessment rate was 99.8%, which just failed to meet the national standard of 100% but was within the top 25% of trusts. The 2016 figure was 97.1%.

The proportion of patients not developing pressure ulcers was 59.7%, which failed to meet the national standard of 100% and was within the bottom 25% of trusts. The 2016 figure was 81.6%.

The length of stay was 18.1 days, which fell within the middle 50% of trusts. The 2016 figure was 15.4 days.

(Source: *National Hip Fracture Database 2017*)

We spoke with a consultant on the trauma and orthopaedic ward who told us about a trial to
improve patient outcomes for fractures. They used the Clinical Frailty Scale and had more patients receiving two physiotherapy sessions a day to see if this improved the length of stay and recovery outcomes.

**Bowel Cancer Audit**

In the 2017 Bowel Cancer Audit, 72.1% of patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national aggregate. The 2016 figure was 72.3%.

The risk-adjusted 90-day post-operative mortality rate was 1.2% which was within the expected range. The 2016 figure was 0.0%.

The risk-adjusted 2-year post-operative mortality rate was 15.1% which was within the expected range. The 2016 figure was 19.3%.

The risk-adjusted 30-day unplanned readmission rate was 7.0% which was within the expected range. The 2016 figure was also 7.0%.

The risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection was 45.4% which was within the expected range. The 2016 figure was 44.0%.

(Source: National Bowel Cancer Audit)

**National Vascular Registry**

In the 2017 National Vascular Registry (NVR) audit, the trust achieved a risk-adjusted post-operative in-hospital mortality rate of 0.6% for abdominal aortic aneurysms which was within the expected range. The 2016 figure was also 0.6%.

Within carotid endarterectomy, the median time from symptom to surgery was 20 days, which was worse than the audit aspirational standard of 14 days. The 2016 figure was 24 days.

The 30-day risk-adjusted mortality and stroke rate was 1.1%, which was within the expected range. The 2016 figure was 1.8%.

(Source: National Vascular Registry)

**National Oesophago-Gastric Cancer Audit**

In the 2017 National Oesophago-Gastric Cancer Audit, the age and sex adjusted proportion of patients diagnosed after an emergency admission was 1.7%. Patients diagnosed after an emergency admission are significantly less likely to be managed with curative intent. The audit recommends that overall rates over 15% could warrant investigation. The 2016 figure 2.4%.

The 90-day post-operative mortality rate was 2.4% which was within the expected range. The 2016 rate was 1.9%.

The proportion of patients treated with curative intent in the Strategic Clinical Network was 33.8%. This was similar to the national aggregate and the figure in 2016 of 33.9%.

This metric is defined at strategic clinical network level; the network can represent several cancer units and specialist centres); the result can therefore be used a marker for the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results.

(Source: National Oesophago-Gastric Cancer Audit 2017)

**National Emergency Laparotomy Audit**

The National Emergency Laparotomy audit awards three ratings for each indicator. Green ratings indicate performance of over 80%, amber ratings indicate performance between 50% and 80% and red ratings indicate performance under 50%.

In the 2016 National Emergency Laparotomy Audit (NELA), Addenbrooke’s Hospital achieved a red rating for the crude proportion of cases with pre-operative documentation of risk of death. This was based on 201 cases.
The site achieved an amber rating for the crude proportion of cases with access to theatres within clinically appropriate time frames. This was based on 168 cases.

The site achieved an amber rating for the crude proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. This was based on 126 cases.

The site achieved a green rating for the crude proportion of highest-risk cases admitted to critical care post-operatively. This was based on 90 cases.

The risk-adjusted 30-day mortality for the site was 7.9% which was within the expected range. This was based on 201 cases.

(Source: National Emergency Laparotomy Audit)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

- Groin hernias
- Varicose veins
- Hip replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left.

In 2016/17, fewer patients undergoing surgery for groin hernias reported they felt worse when compared to the England averages.

For hip and knee replacements, performance was better when compared to the England averages for EQ VAS and similar for the EQ-5D index and Oxford Hip Score.

For Varicose Veins, performance on the Aberdeen varicose vein questionnaire was better than the England average. In contrast, the trust’s performance on EQ-RD index was worse than the England average.

(Source: NHS Digital)
Competent staff

Staff were competent in their responsibilities and had the appropriate skills, training and knowledge to carry out their roles.

Staff consistently told us they felt they had the necessary skills and competencies for their roles and were supported to maintain and develop these.

There was a six week supernumerary period for new nursing staff, which could be extended if a member of staff felt they needed continued support. In recovery and theatres there was a three-month supernumerary period. All new starters had a mentor for direct support and in theatres there were two band six nurses with a ‘support bleep’ every day for new staff who required extra support.

There were comprehensive student nurse orientation packages for each ward. We reviewed the student nurse orientation package for ward D8 (trauma and orthopaedics) which included a list of staff names, useful contact numbers, suggestions for learning opportunities, and the most common procedures undertaken on the ward. One student nurse we spoke with on the overnight intensive recovery ward, who was on their fourth week of placement in this unit, told us they were learning a lot, were well supported, and encouraged to ask questions. A band six nurse on ward D8, who was a student nurse support lead, said the feedback from students about orientation and support had been positive.

We reviewed local induction processes for temporary staff, which were used alongside mandatory training to ensure staff had the appropriate competencies and skills to care for patients safely.

Staff were supported and encouraged to develop their competencies and/or areas of interest. Service leads focused on this to help staff retention and were proud of the development opportunities for staff. For example, some nurses in eye surgery were dual trained as anaesthetic nurse practitioners and scrub practitioners. Health care assistants (HCAs) were supported to train as theatre support workers and could progress to assistant scrub practitioners or become operating department practitioners (ODPs) or registered nurses through the trust’s apprenticeship scheme. In neurosurgery two nurses had qualified in nurse prescribing and the service had another two undertaking the course at the time of our inspection.

The service provided regular teaching sessions which nurses were encouraged to join. One recent session had been held jointly between eye surgery and maxillofacial surgery on the management of complex combined facial surgery cases. In OIR, a nurse told us they enjoyed being a resuscitation trainer as it provided variety to their own work and helped other staff improve their resuscitation skills. Physiotherapists had quarterly learning sessions to develop their knowledge and skills and joined relevant training sessions to teach nursing staff on management of patient mobility issues.

Practice development nurses supported the development and learning needs of nursing staff. There were link nurses and HCAs for different aspects of care, such as pain management, dementia and palliative care, and they received extra training for these roles.

There was a nurse apprentice scheme for HCAs who wanted to become qualified nurses. Three nurses in recovery had qualified following completion of an apprenticeship course. We were told this training was received well as it allowed staff to continue employment while they received training.

Appraisal rates

As of July 2018, 97.7% of staff in surgery at the trust received an appraisal compared to a trust target of 90%. The appraisal target was met for seven of the eight staff groups. The only staff group not meeting the target was medical staff with 89.0%, just below the 90% target.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals completed</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Page 132
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Target</th>
<th>Achieved</th>
<th>Appraisal Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>149</td>
<td>149</td>
<td>100.0%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>18</td>
<td>18</td>
<td>100.0%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>643</td>
<td>648</td>
<td>99.2%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>360</td>
<td>367</td>
<td>98.1%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>90% Yes</td>
</tr>
<tr>
<td>Medical &amp; dental staff</td>
<td>146</td>
<td>164</td>
<td>89.0%</td>
<td>90% No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,336</td>
<td>1,367</td>
<td><strong>97.7%</strong></td>
<td>90% Yes</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Appraisal tab)

All staff we spoke with had received an appraisal in the previous 12 months and felt appraisals were a meaningful process to support staff development, identify needs and monitor progress. A nurse in eye surgery also said they received ad-hoc feedback outside of appraisals.

**Multidisciplinary working**

There was effective multi-disciplinary team (MDT) working throughout the service to maximise patient experience and outcomes.

Our observations of patient care showed surgeons nursing staff and other staff communicating and working effectively to maximise patient care, including between theatres and wards.

The majority of wards had designated allied health professionals (physiotherapy and occupational therapy (OT) staff) based on the wards to assist patients along their treatment pathway. Areas without designated allied health professionals were able to access them promptly if required. We observed that allied health professionals worked as one team with the nurses and surgeons; a physiotherapist and a member of speech and language therapy (SALT) staff both said they felt valued and they had sufficient time with patients to optimise their outcomes. On ward D8 (trauma), physiotherapists and occupational therapists attended the nursing handover each morning and were involved in discharge planning.

Each ward had regular MDT meetings to assess the progress and care plans of individual patients with input from all relevant staff and teams, such as physiotherapy, OT, SALT and mental health if required. The trauma and rehabilitation wards often had attendance at MDT meetings from a representative from a brain injury charity, with whom they were linked for additional support. However, we were told social services were not always able to be present at MDT meetings to contribute in relation to care packages upon discharge.

We saw examples of effective MDT working outside of meetings; for example, physiotherapists on the trauma and rehabilitation wards worked jointly with SALT and interpreters to provide a joined-up approach to support patients whose first language was not English.

The physiotherapist on ward J2 said they often worked with the medicines team to help patients requiring blood pressure management.

**Seven-day services**

Patients could access services when they needed to.

Wards had daily consultant surgeon ward rounds. There were appropriate out-of-hours cover arrangements for medical staffing. For example, on trauma and orthopaedics, a consultant was on the ward from 8am to 4pm Monday to Friday with a consultant on call at all times for senior emergency support. On weekends and overnight the ward was covered by a foundation year two
(FY2) doctor. There was an on-call rota for surgical and anaesthetic teams so that medical review could be obtained within 30 minutes.

On the upper and lower gastrointestinal wards (L4 and M4) there was a job planned ward based role during which time the consultant had no other commitments.

Physiotherapists were available seven days a week. There were dedicated physiotherapy teams on some wards including the intermediate dependency area (IDA) and neurosurgery, and for other wards there was prompt access to physiotherapists. This was an improvement in physiotherapy cover from our previous inspection in September 2016, where there was dedicated cover Monday to Friday but only on-call physiotherapy services at weekends.

Main theatres were accessible seven days a week and were 24 hours a day for emergency procedures.

Diagnostic imaging services, including x-ray, Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) were available 24 hours a day, seven days a week.

Interventional radiology was available from Monday to Friday from 9am to 5pm with an on-call team out of hours.

Pharmacy supported the wards full-time from Monday to Saturday. There were on call arrangements for pharmacy staff out of hours, Sundays and bank holidays. Staff reported sufficient and prompt access to pharmacy support when required.

The day surgery unit was open Monday to Saturday from 6.30am to 7.30pm. Patients who could not be discharged from the unit on a Saturday afternoon due to a prolonged recovery period or complications would be transferred to a ward.

Health Promotion

Staff were proactive in supporting patients to live healthier lives.

There were systems and processes for staff to help patients manage their own health and wellbeing, and to maximise their independence following surgery. For example, there were enhanced recovery programmes to encourage patients to be actively involved in their recovery.

We saw specific examples of staff seeking to promote patients' health. For example, on ward J2 allied health professionals encouraged patients to have walks with them, talk through their therapy exercises, or have a chat over a coffee to build up their abilities in speech and movement.

The trust was a non-smoking organisation and promoted the health benefits of not smoking, and we observed information leaflets about this on the wards we visited.

Staff informed patients of the medicines helpline to contact following discharge if they had concerns about their medication.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff obtained consent to care and treatment in line with legislation.

We followed two patient pathways through theatre and witnessed that appropriate consent was taken and documented. The surgeon asked the patient to describe in their own words the procedure for which they were consenting, which was good practice. There was a standard consent form used in all areas. There was a second more detailed form staff used for patients assessed to lack capacity under the mental capacity act. Staff gave examples of when they had used this form due to a patient being assessed as lacking capacity.

We reviewed an audit of consent forms from July to September 2018. This audit covered vascular surgery, dermatology, ear, nose and throat (ENT), oral and maxillofacial surgery and plastic surgery. The results of this audit showed generally good compliance with consent principles; however, there were some areas of concern identified. Notably, within vascular surgery, no procedure-specific consent forms were used where they were available for all three procedures audited. Instead, generic forms were used. This affected the evidence of provision of patient information leaflets, which for vascular surgery, was 0%. There were appropriate actions to
address the concerns raised, for example, for service leads to encourage greater awareness and use of procedure-specific consent forms available; and for operations managers to arrange to out of date consent forms to be removed from clinical areas. At the time of our inspection we did not see any of the old consent forms in surgical areas so we were assured the service was working to improve compliance.

The service was not formally auditing mental capacity assessment documentation; however, the mental capacity assessment template was embedded in the electronic patient notes as part of the admissions process. Therefore, the service was able to record an initial mental capacity assessment pertaining to the individual’s ability to consent to care and treatment, and the electronic system would flag up if this had not been completed. Staff had good knowledge of mental capacity.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for the MCA and DoLS training module as of July 2018 for qualified nursing and medical staff in surgery at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July 2018</th>
<th></th>
<th></th>
<th>Trust</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>target</td>
<td></td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>691</td>
<td>694</td>
<td>99.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>331</td>
<td>397</td>
<td>83.4%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in surgery met the trust target of 90% with a completion rate of 99.6%. However, only 83.4% of medical staff had completed the MCA and DoLS training module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Is the service caring?

Compassionate care

Staff treated patients with compassion, dignity and respect during most interactions.

All patients we talked to spoke highly of the staff and the care they had received. For example, a patient on overnight intensive recovery (OIR) described staff as ‘sensitive’ and ‘very caring’ and said there was nothing they would change or improve about their experience. Another patient on ward F6 said ‘nothing was too much trouble’ for the staff, and another on ward A5 (neurosurgery) described staff as ‘fabulous’ and said the whole experience had been ‘kind and caring’.

All interactions we observed between staff and patients and/or relatives were caring and compassionate. For example, during a cataract operation under local anaesthetic, the staff all showed kindness to the patient, a nurse held the patient’s hand throughout the procedure and staff maintained conversation with the patient to reassure them and keep them calm. Another orthopaedic patient who was about to go to theatres was very anxious and we saw staff reassuring them. A student nurse who had built up a strong rapport with the patient accompanied them to theatres alongside the patient’s daughter and we saw this helped distract the patient from their anxiety.

Staff were highly patient focused when they talked about their work and were motivated by being able to help and care for people. It was identified in the WHO checklist observational audit results from November 2017 to June 2018 that staff consistently showed good consideration to patient comfort and dignity during procedures in theatres.

However, while on ward L2 speaking with a patient in a bay, we overheard a loud telephone conversation by a clinical lead discussing another patient. Other patients and relatives in the bay could hear the conversation clearly. We raised this at the time as it was not good practice for maintaining patient privacy, confidentiality and dignity and the member of staff acknowledged
Friends and Family test performance

The Friends and Family Test response rate for surgery at Addenbrooke’s and the Rosie Hospitals was 24% which was the same as the England average.

A breakdown of FFT performance by ward for surgical wards at the trust with total responses over 100 is below. All the wards achieved an annual recommendation rate of 90% or above.

Emotional support

Staff supported patients and relatives to cope emotionally.

We saw that staff took the time to support patients’ emotional and holistic needs.

A theatre support worker had recently won a ‘you made a difference’ award for spending time and effort in comforting a particularly anxious patient. They had been nominated for this award by another member of staff in the department. A patient on ward G5 (transplant) said they felt well supported during their stay.

Surgical services had access to a hospital chaplain if patients or relatives requested this support and there was information about the chaplaincy service displayed on the wards. This service was available 24 hours a day, seven days a week. Staff could also access other religious services for support for patients and relatives if requested.

Understanding and involvement of patients and those close to them

There was mixed feedback about patients and relatives being kept informed of their care and treatment.

Generally, patients reported they received information they needed from staff. A patient we spoke with in the OIR said his surgeon had come to check on him at least twice since the surgery took place the previous afternoon, and the anaesthetist had visited him that morning. They said they had been told about the expected duration of their recovery period and where they would be transferred to.

A patient on ward J2 said they did not feel they were always kept informed by doctors in relation to changes to their medication and discharge planning, although they spoke positively of nurses and allied health professionals. Another patient on ward F6 said communication from some
medical staff ‘could be better’. A third patient and their relative on ward D8 felt communication could be improved because the relative was unclear as to the next stages of the patient’s care plan.

**Is the service responsive?**

**Service delivery to meet the needs of the local people**

**Services were planned and delivered to meet the needs of patients, despite significant capacity and flow challenges.**

There were initiatives across surgery to meet the needs of the local population and patient demographic. For example, the pre-operative assessment clinic ran a prime clinic for the frail and elderly on two afternoons each week and there was a courtesy bus to take patients from outpatients to the pre-operative assessment clinic.

Eye surgery and plastic surgery staff were able to do pre-assessments in the outpatient department to meet the needs of these patients and prevent patients traveling long distances between the two departments which were at each end of the hospital.

The service had implemented a system for pancreatic cancer surgery patients where the patient could stay in nearby accommodation provided by the trust. This meant patients had a different test done each day as required, such as their computerised tomography (CT), Magnetic resonance imaging (MRI) and Positron emission tomography (PET) scans, rather than having to travel back and forth to the hospital. This reduced waiting times and improved patient experience.

The orthopaedic ward ran a fracture liaison service to follow up patients 20 weeks after surgery to find out how they were recovering and to ensure they continued their physiotherapy requirements or exercises.

However, there were some concerns around service planning and delivery specific to individual specialities. In eye surgery, we were told that one consultant insisted on their patients coming in in the morning even though this consultant only ran afternoon lists, which was therefore not best planned to meet patient needs as patients had to wait several hours to be seen. We were told by a nurse on the unit that this had been escalated to divisional leads but that so far there had been no change.

There was also a concern raised that many general anaesthetic procedures in eye surgery were booked for the afternoon rather than the morning (with the local anaesthetic procedures more often done in the mornings). The nurse who spoke with us about this felt this was not the optimal use of theatre time and could impact on patient experience as those having general anaesthetic needed a longer time to recover.

There was an issue raised by orthopaedic staff that the orthopaedic unit was on the other side of the hospital (half a mile away) from the pre-assessment unit and it was not always easy for patients to travel between them due to their condition. This was not on the risk register although service leads mentioned this issue too. We were told that ideally they would be closer together but there was not enough space to accommodate this.

**Average length of stay**

**Addenbrooke’s and the Rosie Hospitals - elective patients**

From June 2017 to May 2018 the average length of stay for all elective patients at Addenbrooke's and the Rosie Hospitals was 4.1 days, which was similar to the England average of 3.9 days.

- The average length of stay for urology elective patients was 2.4 days, which was similar to the England average of 2.5 days.
- The average length of stay for trauma and orthopaedics elective patients was 4.0 days, which was similar to the England average of 3.8 days.
- The average length of stay for neurosurgery elective patients was 5.2 days, which was similar to the England average of 5.0 days.
Addenbrooke's and the Rosie Hospitals - non-elective patients

The average length of stay for all non-elective patients at Addenbrooke's and the Rosie Hospitals was 7.1 days, which was longer than the England average of 4.9 days.

- The average length of stay for general surgery non-elective patients was 5.2 days, which was longer than the England average of 3.8 days.
- The average length of stay for trauma and orthopaedics non-elective patients was 10.6 days, which was longer than the England average of 8.7 days.
- The average length of stay for neurosurgery non-elective patients was 13.3 days, which was similar to the England average of 13.1 days.

Meeting people’s individual needs

Services were planned with a focus on meeting the individual needs of patients.

There were initiatives across surgery to meet individual needs and improve patient experience. Service leads and staff were committed to achieving this. For example, in the main recovery and intermediate dependency area, there was a ‘listening ear’ on the wall which lit up in green when noise was at an acceptable level but would light up in red if the environment was becoming too loud. The nurse in charge said this had been a useful tool in reminding staff and visitors to keep noise levels down. This initiative was a result of feedback from a patient focus group, which was held yearly.

Therapy dogs were brought in by volunteers on the major trauma and rehabilitation ward (J2) and the ward ran ‘movement and music’ classes to encourage mobility and provide an activity for patients. Allied health professionals on this ward could give examples of where they had tailored their advice and assistance to meet specific needs; for example, one patient was not yet suitable for busy and loud environments so the physiotherapist was doing one-to-one ward-based...
exercises with them building up their confidence and abilities before progressing to the hospital gym.

On the trauma and orthopaedics wards (C8 and D8) they had patient packages for patients who did not have relatives to bring in belongings for them, which included a toothbrush, toiletries and pyjamas.

There were initiatives to meet the needs of patients living with dementia. These patients all received a ‘this is me’ booklet to help staff support their individual needs. There were dementia link nurses on each ward and in theatres. Carers of patients living with dementia were allowed to accompany patients into the anaesthetic room and into recovery post-operatively to help keep the patient reassured. Carers could also hold a bleep so they could be contacted if the patient requested to see them or appeared concerned. Staff on ward D8 had recently undertaken a dementia study day which had involved ‘simulation training’ for staff to understand how senses deteriorate or change when a patient is living with dementia. The sister on this ward gave an example of one patient who liked to watch the same football match every day and had arranged this on the television for them.

There was a team of learning disability nurse specialists to support staff to meet the needs of patients living with learning disabilities. There was an open referral system for staff to refer a patient to the team. One of the team reviewed the referral and discussed the patient's individual requirements with the ward team. Staff on all wards were aware of the learning disability liaison team and contacted them if they had any questions or concerns.

There was information available on all wards for patients and relatives specific to surgical specialities. Information leaflets specified that they could be produced in another language, large print or audio upon request. The service had access to interpretation services both over the phone and face-to-face if required.

There was sufficient bariatric equipment on wards to meet the needs of these patients, including bariatric beds which could accommodate up to 400kg.

**Access and flow**

**Access and flow through the service was a significant difficulty, although there were initiatives and team working to mitigate the risk of this as far as possible.**

Service leads consistently reported that capacity was their biggest challenge and we observed this during our inspection. The leads told us it was worsened because the trust was a major regional hub and received patients transferred from other trusts in the region. At weekends some local trusts had reduced services which had an impact on the demand placed on the service. External transfers were a major issue; we were given an example of a patient admitted for a straightforward interventional radiology procedure who then had to stay an additional week for non-clinical reasons, due to not being able to repatriate to their local hospital.

This was reflected by staff we spoke with on all wards and theatres and we saw this during our inspection. For example, OIR was intended to be a 22-hour stay before patients were transferred to the appropriate ward, but there were frequent delayed discharges from OIR to wards and the intermediate dependency area. This was a high risk on the service risk register and was the most frequent cause of incidents reported by staff in the unit. There were appropriate mitigating controls, which included overflow of patients into main recovery, escalation to the bed meetings through critical care bleep holder and patient flow manager, and the use of two additional beds in the intensive care unit to support OIR flow.

Staff recognised the OIR was not the ideal environment for stays of longer than one night and there were mitigating actions to try and make patients more comfortable. For example, staff escorted patients to use bathroom facilities in another nearby ward and accommodating patients with mental health difficulties or who required more space and a calmer area in another part of main recovery instead.

The table below shows the number of patients in June and July 2018 who remained in OIR for...
longer than one night, as reported in the trust’s patient safety report published in July 2018:

Despite the challenges with access and flow, there was evidence of significant mitigating actions to manage the issues as best as possible. For example, there was a bed management team consisting of patient flow managers responsible for different specialities. They worked effectively with ward teams to ensure bed use was effective and meeting patient needs as best as possible. Ward and theatre leads spoke positively of the bed management team, who listened to their needs and considered the capacity of individual areas. This was an improvement from our last inspection in September 2016 where staff on some wards felt overlooked or not always listened to by the bed management team.

We spoke with one of the patient flow managers responsible for neurosurgery, oncology and the stroke wards, their main issues were getting patients discharged in a timely manner, which included securing a psychiatric liaison bed, delays with repatriation to a patient’s local hospital, and delays of up to six months to secure a bed for a patient at a rehabilitation centre following their acute care. On the day of our inspection, this person said they had been hoping to get ward A3 closed as it had been opened for contingency but due to five new emergency referrals coming through in a short space of time it had to remain open.

There were dedicated discharge planning coordinators to help achieve a timely and appropriate discharge. Staff spoke highly of this team in mitigating some of the issues with access and flow. For example, the charge nurse in neurosurgery said that since they had a dedicated discharge planning coordinator allocated around a year ago, managing flow was easier. This was because the role freed up time for nursing staff on the ward who were previously having to spend time chasing up discharge letters and checking whether care packages were in place; and when acuity or capacity was high, they had not always been able to do this in a timely manner. This was an improvement from our previous inspection in September 2016. These staff were valued and integrated members of the team.

Ward clerks contributed to achieving timely discharge by arranging transport home for patients who needed this service.

The ‘10.57’ daily morning meeting was attended by the senior band seven nurses from each surgical speciality and the matron to provide an update on staffing, theatre lists and bed capacity concerns. The purpose of this was to optimise theatre and bed utilisation. We attended one of these and saw information was shared about anticipating potential theatre overruns, updates as to waiting lists, late finishes from the day before and delays in starting theatre lists due to not having beds confirmed.

There were daily bed management meetings at 9am on each surgical ward to discuss patient outliers (patients on wards that were not for their speciality), an overview of discharges and moves
expected that day and patients’ progression through the hospital against the agreed plan was
discussed. In addition, trust wide bed meetings took place three times daily at 9am, 12pm and
4pm attended by the patient flow managers for each area, to ensure bed capacity was being
optimised.

In each speciality there was a band seven bleep holder who worked closely with the trust
operations centre to optimise flow throughout the day. In the intermediate dependency area
(IDA), the nurse in charge reported this worked well as they could contact the operations centre
as soon as patients were ready for mobilisation and de-escalation to a less acute ward. This
helped with capacity as they were able to free up the space for more appropriate patients as
early as possible.

There were arrangements for when wards were at full capacity. For example, if there were
neurosurgery or gastrointestinal patients outlying in contingency areas or other wards, the
division allocated a speciality nurse to ensure patients care was still managed safely in line with
their care plan.

There were specific initiatives to optimise access and flow in specific areas. In gynaecological
surgery, the two-week waiting time for urgent procedures was now managed by nurses which
had improved timeliness and patient experience. For example, nurses could remove polyps in
outpatients.

Interventional radiology had dedicated porters to transfer patients to the department when
needed. Patients were accompanied by a nurse if requested. All patients were accompanied
back down to the ward with an interventional radiology nurse to complete the handover.

The eye surgery service had about 100 patients waiting for cataract operations this was primarily
caused by a reduction in consultants within the unit over the summer, but this had now improved
and the waiting lists were reducing. The eye surgery nurse lead met with the unit’s booking
secretaries and deputy operations manager every Monday to assess their bookings for the next
four weeks and review any changes to theatre lists.

There was a patient flow policy and procedure and the trust-wide strategy placed a significant
focus on patient flow, which was reflected by service leads and ward and theatre staff.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From September 2017 to August 2018 the trust’s referral to treatment time (RTT) for admitted
pathways for surgery was worse than the England average.

In the most recent month, August 2018, 64.4% of patients were referred for treatment within 18
weeks compared with the England average of 68.5%.

![Graph showing referral to treatment (percentage within 18 weeks) - admitted performance](image)

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

From September 2017 to August 2018, one speciality was above the England average for RTT
rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurosurgery</td>
<td>75.5%</td>
<td>69.9%</td>
</tr>
</tbody>
</table>
Seven specialties were below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plastic surgery</td>
<td>74.3%</td>
<td>81.4%</td>
</tr>
<tr>
<td>Urology</td>
<td>71.6%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>67.1%</td>
<td>69.0%</td>
</tr>
<tr>
<td>General surgery</td>
<td>61.5%</td>
<td>72.7%</td>
</tr>
<tr>
<td>Trauma and orthopaedics</td>
<td>48.0%</td>
<td>60.4%</td>
</tr>
<tr>
<td>ENT</td>
<td>42.4%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>25.5%</td>
<td>60.5%</td>
</tr>
</tbody>
</table>

Following our inspection, we also requested the service’s performance in waiting times for cancer. The performance is reported by speciality, so is not broken down by surgical and non-surgical patients:

<table>
<thead>
<tr>
<th>Cancer site</th>
<th>2Wk Wait</th>
<th>31 Day first definitive treatment (FDT)</th>
<th>31 Day Subs (Surgery)</th>
<th>31 Day Subs (Other)</th>
<th>62 Day from Urgent Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>95.79%</td>
<td>99.20%</td>
<td>95.16%</td>
<td>100.00%</td>
<td>93.77%</td>
</tr>
<tr>
<td>Central Nervous System/Brain</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
</tr>
<tr>
<td>Childrens</td>
<td>92.16%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>-</td>
<td>100.00%</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>84.26%</td>
<td>98.56%</td>
<td>100.00%</td>
<td>-</td>
<td>80.92%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>97.50%</td>
<td>96.94%</td>
<td>96.43%</td>
<td>100.00%</td>
<td>60.20%</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lower GI</td>
<td>56.95%</td>
<td>98.68%</td>
<td>91.67%</td>
<td>100.00%</td>
<td>66.22%</td>
</tr>
<tr>
<td>Lung</td>
<td>98.27%</td>
<td>97.92%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>85.33%</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>71.43%</td>
</tr>
<tr>
<td>Other Haem Malignancies</td>
<td>95.83%</td>
<td>99.22%</td>
<td>100.00%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sarcomas</td>
<td>92.70%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>-</td>
</tr>
<tr>
<td>Skin</td>
<td>97.56%</td>
<td>97.40%</td>
<td>96.12%</td>
<td>100.00%</td>
<td>93.56%</td>
</tr>
<tr>
<td>Testicular</td>
<td>100.00%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100.00%</td>
</tr>
<tr>
<td>Upper GI</td>
<td>86.53%</td>
<td>98.54%</td>
<td>96.43%</td>
<td>90.00%</td>
<td>72.29%</td>
</tr>
<tr>
<td>Urological</td>
<td>98.16%</td>
<td>96.51%</td>
<td>94.12%</td>
<td>100.00%</td>
<td>75.61%</td>
</tr>
</tbody>
</table>

The trust informed us that the data above included late referrals from other trusts which were reallocated to the referring trust in line with national guidance. There was an improvement plan in place to support specific areas of underperformance.

**Cancelled operations**

A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

Over the two years, the percentage of cancelled operations at the trust showed a similar pattern when compared to the England average.

In the most recent quarter, 2018/19 quarter 1 (April to June 2018), the trust cancelled 187 surgeries. Of the 187 cancellations 14% weren’t treated within 28 days.
Over the two years, the percentage of cancelled operations at the trust was higher than the England average in all quarters apart from the most recent one, 2018/19 quarter 1 (April to June 2018). Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

**Cancelled Operations as a percentage of elective admissions - Cambridge University Hospitals NHS Foundation Trust**

(Source: NHS England)

**Learning from complaints and concerns**

Staff could explain the process for when patients wanted to raise a complaint and there were examples of changes in practice or sharing of feedback resulting from complaints.

**Summary of complaints**

From August 2017 to July 2018 the trust received 155 complaints about surgery, 21.4% of the total complaints trust-wide. For the 122 complaints that had been closed, the trust took an average of 42.6 working days to investigate and close these complaints. The trust does not have a specific target of closing complaints. However, their internal target for responding to complaints is for 50% to receive a full written response within 30 working days.

For the 33 complaints that had not been closed, the average time these complaints had been open for was 53.9 working days.
Neurosurgery received the most complaints with 47 (30.3%), followed by trauma and orthopaedics with 22 (14.2%).

The most common subjects of the complaints are shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>50</td>
<td>32.3%</td>
</tr>
<tr>
<td>Admissions and discharges</td>
<td>30</td>
<td>19.4%</td>
</tr>
<tr>
<td>Communications</td>
<td>29</td>
<td>18.7%</td>
</tr>
<tr>
<td>Patient care</td>
<td>12</td>
<td>7.7%</td>
</tr>
<tr>
<td>Staff values and behaviours</td>
<td>11</td>
<td>7.1%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>10</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 2017 to July 2018 the trust received 79 compliments about surgery.

The following specialties received five or more compliments over this time period:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>No. of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theatres</td>
<td>19</td>
<td>24.1%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>11</td>
<td>13.9%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>10</td>
<td>12.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>7</td>
<td>8.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>7</td>
<td>8.9%</td>
</tr>
<tr>
<td>Plastics</td>
<td>5</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

The service followed the trust wide policy on resolving complaints, which stated that a complainant would receive written acknowledgement within three working days, which included the offer of a discussion with a complaints case manager, how long the investigation was likely to take, and a timescale for a full response. The target response time for complaints was 30 days unless the complaint was particularly complex requiring a longer investigation period.

Ward and theatre nurse leads could identify the main complaints for their individual areas. For example, in OIR, there had been a theme in complaints around communication, especially around relatives reporting they were not always kept up to date with their relative’s progress and care. One of the actions from this was that when a patient was transferred to recovery, relatives or carers would receive a card with contact information which ensured they knew how to raise any concerns or queries. The concerns around communication and actions identified had also been shared with surgeons.

Staff received feedback when they had been involved in a complaint, although not all staff could give specific examples of learning or changes in practice following a complaint.

There were information leaflets on the wards for patients and relatives on how to raise a complaint and the role of the Patient Advice and Liaison Service (PALS). There were ‘you said, we did’ boards on each surgical ward with examples of changes and improvements following feedback. For example, on ward J2 there had been feedback that relatives were not aware of reduced car parking charges for relatives of long-term patients, so a poster had been put up on the relatives’ notice board to make people aware. On ward F6, there had been patient feedback about interruptions during mealtimes, so to address this the ward staff were now making sure all meal times were protected (undisturbed).
Is the service well-led?

Leadership

There was strong, effective leadership to help deliver care to patients and support staff.

Surgical services were delivered across the trust and were under various divisions. Anaesthesia, theatres and musculoskeletal surgery were under Division A; transplant and hepatobiliary surgery were under Division C; and vascular surgery, neurosurgery, oral maxillofacial surgery, ear, nose and throat (ENT), and ophthalmology were under Division D. Paediatric surgery was under Division E and is not reported on under this core service. Each division was overseen by a divisional director, divisional head of nursing, and associate director of operations, with individual clinical directors for each speciality.

We spoke with medical and nursing leads for surgical services and it was clear they understood the challenges for quality and sustainability, and identified the actions needed to address them. For example, they were able to explain the challenges and mitigation around access and flow as explained fully in the ‘responsive’ domain. There was commitment from service leads to supporting staff and addressing the main concerns.

Staff spoke highly of the leadership and support provided at matron level; one band six nurse told us there was no hierarchical feeling and the matron had ‘helped her push a bed many times’. Another member of staff told us matrons ‘check in with the ward regularly.’ Throughout our inspection, we observed matrons had a strong presence on the wards.

There was generally positive feedback about the executive team. Staff felt that senior leads were invested in the clinical work of the service.

Vision and Strategy

There was a trust strategy which staff were aware of and engaged in, and service specific strategies within surgery to develop and improve the service.

Each surgical division had a three-year strategy which reflected the main priorities and values for the service. Divisional strategies had been structured with year-by-year targets, consultation and collaboration from staff groups.

The divisional leads for surgical services reported into the trust wide strategy. For example, one of the trust’s overall priorities for 2018-2019 was continued focus on achieving sustained reduction in Delayed Transfers of Care (DTOCs) due to the concerns around access and flow. Each division with surgical services also had their own divisional strategic plan for 2018-2019 which reflected the priorities at trust level.

There was a focus within surgery of maximising staff development opportunities to promote retention, and of working on reducing the capacity issues as outlined in the ‘responsive’ domain.

There was a specific strategy around recruiting and retaining operating department practitioners (ODPs) which was the service’s most concerning area for staffing and agency use; this included initiatives such as allocating two supernumerary ‘floor walkers’ to support ODPs so the burden on ODPs was lessened.

Service leads within each speciality were able to explain specific areas of focus; for example, in ophthalmic surgery, the focus was on reducing the backlog for cataract surgery and optimising use of their second advanced laser machine which could reduce the time taken for individual procedures. Service leads were working with consultants to encourage more productive use of the advanced laser machine, there had been some reservations and slowness from the consultant body about training and using the equipment.

The hepatopancreatobiliary (HPB) surgery service was focusing on developing robotic surgery because it was proven to be effective, efficient and resulted in improved patient outcomes and significantly reducing length of stay by up to half. The service was one of five units in the country with this technology and leads were having difficulties securing funding for a second robotic
machine but were continuing to work towards this as the evidence had shown that due to its efficiency, the cost was recouped quickly meaning it would contribute to quality and sustainability of the service.

Notices were displayed on each ward detailing the current month’s priorities, in relation to the surgical service vision and strategy to help ensure all staff were aware of current focuses and to share this with patients and relatives. For example, on ward J2, the listed priorities at the time of our inspection were achieving discharges before 10am wherever possible and keeping the ward tidy. On ward G5, the priorities were to meet patients’ nutritional needs more effectively and to improve their cleanliness score in audits to achieve over 99%.

Culture

Morale was generally high despite concerns about capacity and demand, and there was a positive, open and team-based culture.

Staff spoke highly of their teams, the service and support received from their managers and colleagues. Staff felt valued and respected and were proud to work in the organisation. There were systems in place to provide staff with development opportunities and promote their wellbeing.

A student nurse in recovery told us all staff were ‘happy to help’ and there was a good culture between different staff groups, for example the doctors often asked if they needed help with anything and they felt there was an open culture where they could ask for help or ask questions. Staff felt comfortable that when they raised concerns these would be listened to and escalated as appropriate.

There were systems in place to recognise and value the work and commitment from staff. For example, on ward F6 (HPB surgery), the team had won a ‘you made a difference’ trust award in September 2018 because service leads felt they had gone above and beyond in their care to patients. Matrons were proud of their teams and the dedication from staff despite ongoing pressures.

Service leads had visits from the human resources team regularly to discuss any issues around people management and staff sickness, which supported a focus on staff welfare. The ophthalmic surgery service had wellbeing days with support from the trust’s mental health team to discuss mental health and wellbeing issues with staff and give advice on stress management, which had been well received by staff.

There were concerns raised in some areas about poor communication impacting on staff morale. An issue was raised on day surgery that during a reconfiguration of the ward in December 2017, staff told us that changes and plans were not communicated well with them. This caused some upset and frustrations and there was a feeling that this led to a number of staff leaving at the same time. A healthcare assistant told us this had resulted in poor morale. However, following our inspection, the trust told us this had been a planned move with planned consultation and engagement taking place with staff.

To improve morale the service held a team building day and they felt morale was gradually improving, which was reflected by the nursing lead for the service. Similarly, matrons were aware that there had been an impact on staff morale in urology because they had recently moved into the treatment centre, which was their fourth move in a relatively short time period and led to frustration among staff. Service leads were now focusing on supporting and recognising urology staff to improve morale.

Following our inspection, the trust told us the concerns raised were in relation to a planned move with a planned
Governance

There were effective structures, processes and systems of accountability to support the delivery and oversight of services.

There was an effective ‘ward to board’ governance process and a systematic programme of clinical audit to monitor the quality, operational and financial processes. The divisional structure at the trust was based on clinical pathways, meaning that surgical specialities sat across various divisions. There was a cross-divisional Surgery Board to provide an over-arching forum where all aspects of quality, risk, safety, workforce, finance and performance were reviewed monthly.

There was a quality governance framework for each division, whereby each surgical speciality had a quality governance group; which reported into the Directorate Quality Governance Committee; this reported into the divisional quality governance committee. From there, information was escalated to the Divisional Executive Performance Committee; to the management executive; the trust quality committee; and to the trust board. Medical and nursing leads for surgery could explain how issues were escalated through the framework.

We reviewed the minutes of the October divisional senior team meetings for Divisions A, C and D. There was appropriate consideration of the frequent or ongoing key issues including safety check audits, bed use, and a review of staffing, vacancies and recruitment. There was also discussion of specific concerns; for example, in the Division A meeting minutes, it was highlighted that some theatre support workers had been seen using their mobile phones while pushing patients to and from theatres and that this was unacceptable. In response, band seven leads raised this at their daily briefings with their teams. There were also actions categorised using a red/amber/green system to show actions that were new, ongoing, or completed so that the matron and band seven leads could monitor progress.

Staff at all levels were clear about their roles and responsibilities and knew who they could escalate concerns to. Staff were involved in and at the forefront of the trust’s shared governance system and attended monthly team meetings which covered topics such as complaints, incidents and quality improvement projects.

Management of risk, issues and performance

There were systems and processes to ensure risks were monitored and mitigated wherever possible, and performance was monitored.

There was a comprehensive risk register for the surgical service which included 82 live risks. The most significant risks included difficulty in recruiting to, clinical fellow roles in urology; risk of delayed or inferior treatment due to a lack of robotic capacity; risk of cancellations in theatre lists due to significant shortages in operating department practitioners and anaesthetic nurses; and inadequate fire exit routes from the neurosurgical theatres on the sixth floor which could pose a risk to patients and staff in the event of a fire. However, the fire risk had been improved by the time of our inspection, due to the building of another corridor with lift access from the ward. This was an example of practical risk mitigation and management.

Risks on the register had named owners, were reviewed regularly and had target dates for compliance and mitigating actions to help reduce the level of risk.

The clinical leads showed good awareness of the main risks within their service, such as the environmental and space issues in overnight intensive recovery (OIR), and what they were doing to mitigate them. Both medical and nursing leads showed a strong focus on the service issues with capacity and access and flow, and leads were able to explain how they were working to improve them. They worked closely with ward staff, both on the ward and between divisions to manage capacity as far as possible. Ward and theatre staff felt the clinical leads worked alongside them to improve these risks and felt their input into the capacity and flow concerns was valued.

There were arrangements in place to respond to emergencies and major incidents. Major incident and business continuity plans were in place detailing actions to be taken in the event of a utilities failure or major incident.
Information Management

The service collected, analysed, and used information to support its activities, using secure electronic systems.

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way via electronic records and the trust’s intranet. The trust held policies and procedures in electronic format on the hospital wide intranet and all staff knew how to access them.

Key performance measures were monitored and reported through the governance structure. The ward managers and matrons had access to a quality and safety dashboard at all times, which displayed performance measures. The information was displayed on ward noticeboards so staff were informed of up-to-date performance information for their service.

Staff could access test results electronically, which meant they could access this information in a timely manner.

There was evidence of lessons learned in relation to data security breaches, for example, in relation to the three data breaches reported under the ‘safe’ domain, there had been appropriate actions taken to minimise risk of this reoccurring.

Engagement

Staff were engaged in their work and there were examples of where initiatives from staff had been used to develop and improve the service.

Each ward and the theatres department held monthly team meetings and there were staff huddles or team briefs at the beginning of each shift for sharing and learning purposes. At these huddles, staff were encouraged to ask any questions or raise any issues.

Staff were engaged with the development and performance of the service and there were several examples of where staff initiatives, experiences and views had been used to shape and improve service and culture. For example, a band six nurse in eye surgery had made suggestions for an in-house structured training programme for new starters in the service, and had come up with an initiative to train everyone in the department on the use of anaesthetic drops with the help of a specific local anaesthetic guidance document. This aimed to improve timeliness of procedures as everyone would be able to start the process of local anaesthetic without having to factor into the theatre lists someone who was trained in this. They had raised this with their manager who had supported the idea and it was currently being rolled out.

In theatres, service leads had introduced a ‘good day, bad day’ app onto an iPad that was secured in the corridor area, where staff could note down any positive or negative points they had experienced, anonymously. This information was sent to the director of operations for theatres, the band seven lead told us it had been well received by staff because they felt they had an opportunity to contribute to improvement of the service.

Ward F6 (HPB surgery) was trialling a ‘staff suggestion box’ where staff could write down suggestions to improve the service. As part of the trial they held a daily ‘improvement huddle board meetings’ and discussed the initiatives that could be implemented in either the short term or long term. One initiative that had been implemented as a result and received good feedback was the monthly ward newsletter. We observed one of these huddles, which involved all types of staff including the ward sister, five nurses, a student nurse, pharmacy technician, ward clerk, a member of domestic staff, a doctor and the trust transformation lead who always attended.

Theatres staff had a closed (private) social media page where they shared information with each other which they thought would be beneficial. For example, on the day of our inspection there was a post on the page encouraging staff to support recycling by bringing in their own mugs from home to reduce plastic and costs.

Patients were engaged in the development of the service through annual patient focus groups and could provide feedback through the NHS Friends and Family Test (FFT). Results from the FFT were reported and discussed at the professional forums and ward meetings.
Learning, continuous improvement and innovation

Surgical services had several ongoing innovative initiatives to develop services and maximise patient experience.

Senior trust leads, divisional and ward leads and ward staff were committed to the continuous learning, improvement and innovation throughout surgery. There was evidence of initiatives and long-term strategies to ensure the sustainability of services. For example, there was a rolling recruitment programme so that there was a ‘proactive’ rather than ‘reactive’ approach to recruitment.

The use of dedicated discharge coordinators and the engagement of staff in developing the service, as above, were also examples of how the service worked towards continuous improvement.

There was evidence of staff involvement in the improvement and innovation of the service. For example, staff on the nurse mentorship programme had to come up with an initiative to improve or develop their ward. One nurse on ward F6 said they had initiated a system where student nurses created a list of the competencies they wanted to observe for experience, such as cannula use, and pin it on the notice board in the staff room. Then, if a registered nurse was going to do the particular task, they could offer the student nurse to come and observe with them. In vascular surgery, junior doctors had the opportunity to visit vascular services at other hospitals in the region to share learning, drive improvement of the service and for their own development purposes.

Surgical and nursing leads for the service could give examples of recent innovations or developments to improve and sustain the service. For example, there had been a recent refurbishment of two interventional radiology suites which was helping manage elective work in a timelier way. Service leads in interventional radiology were working on applying for funding for a second neurological intervention suite. There had also been a recent extension of hours of the plastic surgery unit to between 7am and 7pm, patients could now be transferred directly to theatres from pre-assessment which helped reduce pressure on the day surgery unit.
Facts and data about this service

The trust provides end of life care at Addenbrooke’s Hospital. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust had 1,517 deaths from June 2017 to May 2018.

(Source: Hospital Episode Statistics)

End of life care (EOLC) at this trust is not provided by one service alone but is a trust-wide responsibility. This is led by the trust’s EOLC Steering Group with local stakeholders, chaired by the Chief Nurse, and an Operational Group including the chaplaincy; department of elderly medicine (DME): mortuary; palliative care; discharge planning; and critical care representation. There is a dashboard of relevant metrics and a newly appointed EOLC nurse lead. Governance structures of the groups include reviewing incidents and audits; feedback from relatives; and close liaison with the resuscitation committee.

The specialist palliative care team supports EOLC throughout the trust, targeting the areas of most need. The team raises awareness; provides education and training and patient assessments. The team includes an EoLC trainer/facilitator and specialist nurses providing face-to-face visits with attention to safe and appropriate discharge. The team aims to provide seven-day assessments from early 2019. Palliative care champions (nursing and allied health professionals) attend in-house training to enable them to share knowledge throughout the trust.

The trust is a member of the Dying Matters Coalition and marks the Dying Matters awareness week each year. It also works closely with the local community palliative care services and has read access to the Electronic Palliative Care Co-ordination Systems (EPaCCS), which is used to record and share a patient’s care preferences and key details about their care at the end of life. Trust-wide discharge summaries include prompts regarding the Gold Standard Framework to provide information to GPs. An Emergency Care Improvement Programme (ECIP) project with Hospice UK was completed and local initiatives included work with a local hospice to provide nine beds to give patients an additional choice as an alternative to dying in hospital.

(Source: Routine Provider Information Request (RPIR) – Context acute tab)

The hospital also provides bereavement and chaplaincy services. The bereavement care team offer a comprehensive bereavement service that includes mortuary services, and alongside the chaplaincy service, provides a wide range of support to families, relatives, and friends of the dying and deceased.

Data provided by the trust for the reporting period October 2017 to September 2018, demonstrated the palliative care team received 2176 referrals, of which 56% were cancer related and 44% were noncancer related. At the time of our inspection the SPCT provided onsite service between 9am to 5pm Monday to Saturday. Out of hours, there was a rota for consultant cover.

We undertook an unannounced inspection of the end of life care service from 30 October to 1 November 2018. We visited 13 areas, including accident and emergency, medical wards, surgical wards, the mortuary, bereavement suite and the hospital’s chapel. We spoke with one patient and one relative. We spoke with 56 members of staff including the non-executive director with responsibility for end of life care, deputy chief nurse the assistant director of nursing, clinical lead,
medical and nursing staff, allied health professionals, the palliative care team, portering staff, mortuary staff and bereavement and chaplaincy staff.

We reviewed six sets of patient care records, six prescription charts, 36 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms and information including policies, procedures and audits.

**Is the service safe?**

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service provided the specialist palliative care team (SPCT) with mandatory training. Compliance was monitored; however, the trust target was not consistently met.

The trust employed an end of life education facilitator who coordinated education in the trust with involvement from the end of life care steering group. This meant that staff within the trust were offered targeted, specific training sessions in relation to end of life care. The end of life care facilitator created an e-learning package for newly qualified nurses which had become part of their mandatory training going forward.

Mortuary staff received training in safeguarding children level 1. Some members of bereavement and chaplaincy staff received training in safeguarding adults and children at level 2. All of those eligible to receive this training had completed it as part of their mandatory training.

**Mandatory training completion rates**

The trust set a target of 90% for the completion of all mandatory training.

A breakdown of compliance for mandatory training courses as of July 2018 for qualified nursing staff in the specialist palliative care team at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information governance</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection control</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>7</td>
<td>8</td>
<td>87.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>6</td>
<td>7</td>
<td>85.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>90%</td>
<td>n/a</td>
</tr>
<tr>
<td>Health and safety</td>
<td>0</td>
<td>0</td>
<td>n/a</td>
<td>90%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 95.3% for qualified nursing staff in end of life care. The trust’s training targets were met for four of the six mandatory training modules for which qualified nursing staff were eligible. The module with the lowest completion rate was
moving and handling, with 85.7%; however, these relates to only one member of eligible staff not having completed the training. The trust indicated that no nursing staff were eligible for equality and diversity or health and safety training.

A breakdown of compliance for mandatory training courses as of July 2018 for medical staff in end of life care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rates (%)</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety</td>
<td>1</td>
<td>2</td>
<td>50.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust had an overall training compliance rate of 80.0% for medical staff in end of life care at the trust. The trust’s training targets were not met for any of the eight mandatory training modules for which medical staff were eligible. The modules with the lowest completion rate were equality and diversity and health and safety, with 50.0%; however, this relates to only one member of staff not having completed the training in each case.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

The trust implemented safeguarding practices and procedures to help keep patients safe, however not all staff were up to date with the safeguarding training they were required to complete.

The trust investigated adult safeguarding concerns in collaboration with the patients’ local authority. All safeguarding concerns were shared with Cambridgeshire County Council to support patients’ safety. The trust liaised with the relevant external agencies, including representation at the Safeguarding Adults Board, and had internal processes for the regular review of safeguarding concerns including a joint safeguarding committee.

All members of staff we spoke with understood their responsibilities for safeguarding patients and reporting any potential safeguarding concerns. There were clear processes in place and staff were able to describe the necessary steps they would take to address concerns. The electronic records system, epic, supported this process enabled staff to securely send the relevant safeguarding information to the central trust safeguarding team.

Safeguarding training was included in the training for new members of staff at the trust and was also incorporated into the mandatory training package.

Mortuary and bereavement staff who were eligible to complete safeguarding training were fully compliant. All members of mortuary and bereavement staff had completed training in
safeguarding children level one.

**Safeguarding training completion rates**

The trust set a target of 90% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses as of July 2018 for qualified nursing staff in end of life care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>7</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 96.8% for qualified nursing staff in end of life care at the trust. The trust’s 90% completion target was met for three of the four safeguarding training modules for which qualified nursing staff were eligible. The module with the lowest completion rate was safeguarding children level 2, with 87.5%; however, this relates to only one member of staff not having completed the training.

A breakdown of compliance for safeguarding training courses as of July 2018 for medical staff in end of life care at the trust is shown below:

<table>
<thead>
<tr>
<th>Name of course</th>
<th>As of July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of staff trained</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>4</td>
</tr>
</tbody>
</table>

The trust had an overall safeguarding training compliance rate of 79.2% for medical staff in end of life care at the trust. The trust’s 90% completion target was not met for any of the four safeguarding training modules for which medical staff were eligible. The module with the lowest completion rate was safeguarding children level 2, with 66.7%; this equates to two of the six members of eligible staff not having completed the training.

*(Source: Routine Provider Information Request (RPIR) – Training tab)*

**Cleanliness, infection control and hygiene**

The service was clean and controlled infection risk well.

The service had effective infection prevention and control (IPC) procedures in place. Safety systems, processes and practices were implemented and communicated to staff. Mortuary staff were required to complete a competency log to ensure safe and effective practice which was reviewed annually.
There were reliable systems in place to maintain standards of cleanliness. We reviewed the cleaning and disinfection standard operating procedure and the mortuary safety code of practice. There were comprehensive systems in place to prevent and protect people from a healthcare-associated infection.

Personal protective equipment (PPE) such as gloves and aprons, was available throughout the mortuary area and we observed staff using it appropriately. The mortuary was visibly clean.

The mortuary had systems and processes in place to manage the risk of infection. All deceased patients who entered the mortuary were treated as a potential infection control risk. Once an infection risk had been confirmed, mortuary staff documented it and highlighted it to ensure all staff were aware. The mortuary had a separate area for storing deceased patients who had been confirmed to be an infection control risk.

We reviewed records of the daily cleaning schedule for all areas of the mortuary which were up to date. We reviewed records from July to October 2018 which were fully completed.

**Environment and equipment**

**The service had suitable premises and equipment and looked after them well.**

Patients receiving end of life care were cared for throughout the hospital.

The maintenance of equipment supported staff to keep people safe. Staff had access to syringe drivers to provide end of life patients with anticipatory medication. The trust used syringe drivers that met national safety standards. The trust had a planned maintenance schedule to ensure that syringe drivers were serviced. Data provided by the trust showed that syringe drivers met the trust targets for completion of planned preventative maintenance (PPM). This was managed by the medical equipment library.

Equipment within the mortuary was subject to a PPM schedule which meant they were being tested and regularly maintained. There was clear guidance for how frequently different types of equipment should be checked. Waste was segregated and disposed of correctly.

Fridge temperatures in the mortuary were recorded consistently. Temperatures were required to be checked daily, however they were being checked twice a day Monday to Friday and once a day at weekends. An alarm sounded if the fridge temperatures dropped below the required temperature. Faults on the fridges were alerted through the hospital switchboard to the mortuary and maintenance teams, who were available 24 hours a day to respond to any problems.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient.**

The trust had effective systems in place for identifying and responding to patient risks. Risk assessments such as pressure ulcer and manual handling were undertaken in line with national guidance. The trust used their electronic records system to document risk assessments and observations of patients. The trust used the National Early Warning Score (NEWS). Regular nursing checks such as temperature, blood pressure and heart rate were completed in line with this national scoring system.
Staff completed flow sheets for patients who were considered to require end of life care. These included assessments for pain, shortness of breath, weakness, poor appetite, mouth care and poor mobility. These observations were completed every four hours so that any changes could be detected, recorded and escalated if required. If a patient deteriorated, staff would increase the frequency of their observations according to the NEWS protocol.

During our inspection we reviewed six sets of care records. Ceiling levels of care were documented in all six sets of records. Ceiling levels of care are usually agreed between healthcare teams, and where possible, the patient or their family so that if deterioration in their condition occurs suddenly, all who are involved in the care of that patient know how to proceed. A patient’s ceiling level of care could include not escalating to intensive care, not prescribing antibiotics or not performing cardiopulmonary resuscitation.

The specialist palliative care team (SPCT) were able to quickly identify patients in the last days of life and provide them with timely support and treatment. The electronic records system enabled the SPCT to have immediate access to the records of patients who had been identified as being in receipt of end of life care. Patients who required end of life care were usually identified by ward staff, however staff were able to contact the SPCT for advice if they required support with that judgement. Staff were able to mark patients as urgent on the system, and these patients would be prioritised by the SPCT. The SPCT told us their aim was to see every dying patient on a daily basis and ward staff confirmed that this was most often the case and stated that they felt well supported by the SPCT.

Nurse staffing

The service had enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

The specialist palliative care team (SPCT) had sufficient nurse staffing to ensure patients received safe care and treatment. The planned staffing rates were not met according to the data provided by the trust; however, the trust had reviewed the needs of the service and increased their planned level of staffing from April to July 2018 which impacted negatively on the fill rate. The trust was in the process of recruiting new members of staff to the SPCT at the time of our inspection which would improve the fill rate figures and their staffing levels already met national recommendations from the Association of Palliative Medicine for Great Britain and Ireland and the National Council for Palliative care, which meant that the service had sufficient numbers of suitably qualified staff to keep patients safe.

The SPCT consisted of nurses and medics and was led by the clinical lead with support from band six and band seven nurses. The team had been granted recent approval to expand the SPCT to a seven-day service, so the specialist palliative care team had vacancies at the time of our inspection that they were in the process of recruiting to. They had already appointed three out of the four vacancies. Once the new post holders commence their roles we were told there would be 9.5 whole time equivalent (WTE) nurses in the SPCT.

In addition to nursing and medical staff, the SPCT had a clinical psychologist within the team who was able to provide support to patients and their relatives.

The Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative care recommend that there should be a minimum of one specialist palliative care nurse per 250 beds in a hospital. At the time of our inspection, there were 1,375 beds at Addenbrookes hospital with 5.9 WTE nurses in post according to the trust data which meant that end of life care staffing levels met this recommendation and was appropriate for the service. This was an
improvement from the previous inspection as the service did not previously meet this guidance.

The mortuary service consisted of a mortuary service manager plus 16 staff including biomedical scientists (BMS), anatomical pathology technicians (APT) and administration staff.

The bereavement team was led by the lead chaplain. The bereavement and chaplaincy staff were interchangeable and supported each other. The chaplains were all trained to provide bereavement support.

The trust had end of life care champions. These members of staff were based across different wards within the trust. They attended training sessions and shared their learning with their colleagues. Each ward we visited had at least one end of life care champion.

**Overall staffing rates**

The trust reported the following qualified nursing WTE staff numbers in end of life care from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>End of life care</td>
<td>7.5</td>
<td>8.5</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of 88.2% for nursing staff in end of life care from April 2017 to March 2018. This had dropped to 47.0% from April to July 2018, in part due to the addition of 4.0 WTE planned staff posts within the palliative care team.

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

At the time of our inspection the service had already recruited to 9.5 WTE and were waiting for them to start their posts in 2019. This would enable the move to a seven-day service.

**Vacancy rates**

From August 2017 to July 2018, the trust reported a vacancy rate of 26.7% for qualified nursing staff in end of life care. This was higher than the trust’s target for nursing and midwifery staff of less than or equal to 11%. There was an average of 2.5 WTE vacant nursing staff posts over this time period compared with an average level at establishment of 9.7 WTE posts within the palliative care team.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From August 2017 to July 2018, the trust reported a turnover rate of 27.0% for qualified nursing staff in end of life care. This was higher than the trust target of 10.56%. This represents 1.8 WTE staff leaving the palliative care team over the 12 month period compared to an average substantive level of 6.7 WTE staff.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From August 2017 to July 2018, the trust reported a sickness rate of 2.0% for qualified nursing
staff in end of life care. This was lower than the trust target of 2.7%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

From August 2017 to July 2018, the trust reported that 0.2% of qualified nursing FTE shifts in end of life care at the trust were filled by bank staff and no shifts were filled by agency staff or left unfilled.

<table>
<thead>
<tr>
<th>Staff type</th>
<th>Bank FTE shifts</th>
<th>Agency FTE shifts</th>
<th>Unfilled FTE shifts</th>
<th>Total FTE shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>0.2</td>
<td>0.2%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>0.0</td>
<td>0.0%</td>
<td>0.0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>70.4</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The trust did not report that any non-qualified nursing staff FTE shifts were covered by bank and agency staff or left unfilled in end of life care over this time period.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing

The service did not have enough medical staff with the right mix of qualifications and skills, but were taking action to ensure sufficient staffing for the size of the service.

The specialist palliative care team (SPCT) did not have sufficient medical staffing for the size of the service. The SPCT had 2.7 WTE palliative care consultants with an additional 0.8 WTE palliative care consultant due to begin their post in February 2019. However, the Association of Palliative Medicine for Great Britain and Ireland, and the National Council for Palliative care states that there should be a minimum of one consultant per 250 beds. The trust did not meet this guideline with the additional consultant cover included.

The trust had reviewed the needs of the service and increased their planned level of staffing from April to July 2018. If the trust recruited further medical staff to meet their planned staffing levels of 5.5 WTE consultants, they would meet the national recommendation for consultant cover in specialist palliative care.

Although medical staffing levels did not meet national guidelines, there were no concerns raised during our inspection in relation to consultant cover and the SPCT were responding to referrals within 24 hours.

There was a rota for out of hours consultant cover and medical staff were able to write prescriptions out of hours as they had access to the electronic epic system.

Overall staffing rates

The trust reported the following WTE medical staff numbers for medical staff in end of life care from April 2017 to March 2018 and for April to July 2018:

<table>
<thead>
<tr>
<th>Core service</th>
<th>April 2017 to March 2018</th>
<th>April to July 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual WTE staff</td>
<td>Planned WTE staff</td>
</tr>
<tr>
<td>End of life care</td>
<td>4.5</td>
<td>4.5</td>
</tr>
</tbody>
</table>

The trust reported a staffing level of 100% for medical staff in end of life care from April 2017 to
March 2018. This had dropped to 81.8% from April to July 2018, due to the addition of 1.0 WTE planned staff posts.

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

Vacancy rates

From August 2017 to July 2018, the trust reported a vacancy rate of 3.5% for medical staff in end of life care. The trust does not have a target vacancy rate for medical staff.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

From August 2017 to July 2018, the trust reported no turnover for medical staff in end of life care. The trust has a target of 10.5%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From August 2017 to July 2018, the trust reported a sickness rate of 0.2% for medical staff in end of life care. This was lower than the trust target of 2.7%.

(Source: Routine Provider Information Request (RPIR) - Sickness tab)

Bank and locum staff usage

From August 2017 to July 2018, the trust reported no FTE shifts in end of life care that were covered by medical bank or locum staff or left unfilled.

(Source: Routine Provider Information Request (RPIR) - Medical locum tab)

Records

Staff kept detailed records of patients’ care and treatment.

Staff kept appropriate records of patients’ care and treatment. Records were clear, up to date and were managed in a way that kept people safe.

The hospital used a centralised electronic records management system. This allowed all nursing and medical staff to access patient records from hand held devices and any computer in the hospital. This also allowed patient records to be easily organised and legible. Patient records were secure as each member of staff required a log in username and password.

Last days of life flow sheets were completed for patients approaching the end of life to ensure that all the correct observations were completed and that the needs of the individual patients were met.

We reviewed six sets of records for patients who were receiving palliative and end of life care. Records were clear and easy to navigate on the system. They were completed in detail and included discussions with patients and relatives to ensure individual needs and choices were being met.

The SPCT reviewed patients regularly and were also involved in discussions with relatives.
Information was available to staff who needed to have access to it. All patient records were available on the trust’s electronic recording system. This enabled staff to access to relevant information in a timely manner. It was also secure and protected patients’ confidentiality as it required each staff members’ individual passwords to gain access.

When appropriate, records contained details of patients’ mental health, learning disability and dementia needs alongside their physical health needs. There was an electronic flagging system whereby these additional needs could be identified by staff throughout the trust. Within the assessments for patients receiving end of life care, staff were required to answer whether the patient or family were feeling anxious and whether the patient was feeling depressed which showed that the service were considering the mental wellbeing of patients and their families.

The mortuary had a system for checking the deceased patients into and out of the mortuary. They compiled a death notification form and two members of staff completed a tracking form and the corresponding tag numbers were included in patients’ paperwork.

**Medicines**

*The service followed best practice when prescribing, giving, recording and storing medicines.*

Medicines were prescribed, stored and administered to people in line with current legislation and national guidance such as the National Institute for Health and Care Excellence (NICE). Patients receiving end of life care were prescribed anticipatory medication to manage symptoms that may be present at the end of life. Anticipatory medication is prescribed to be given when it is needed, rather than on a regular basis. Medication was prescribed in advance to ensure that symptoms such as pain, agitation and nausea could be managed.

We reviewed six medication administration records which were held on the trust’s electronic recording system. We found that allergies were flagged which gave clear information to all members of staff working with those patients who had reported allergies. The system showed when medication was given if a patient’s medication was overdue and if a medicine had been discontinued. Prescribed regular medication included the prescriber’s signature, the dose and frequency of the medication. All medicines were reviewed regularly, including anticipatory medication.

The service ensured that people received their medicines as intended. The system that was used to prescribe and document the administration of medication was robust. The service used a wristband system. The wristbands were worn by the patients and were scanned prior to the administration of medication. Staff described how this system protected patients and ensured they received their prescribed medication and how this minimised the risk of medication administration errors.

Medicines were stored safely. During our previous inspection in 2016, We raised concerns about the storage of medicines in the mortuary. The mortuary stored all medication from deceased patients who were transferred from the community. At the time of our previous inspection, these medicines were kept with the patients in locked fridges. Following a post mortem, the medicines were stored in a container awaiting disposal. This was not safe management. However, during this inspection we saw the service had taken steps to ensure the safe management of medications. Any medicines that arrived in the mortuary were recorded and stored in a locked facility. Mortuary staff contacted pharmacy to notify them of the presence of the medication within the mortuary. Pharmacy staff responded and collected the medication to be disposed of appropriately.
We checked records for the storage of medication in the mortuary. At the time of our inspection, there were no medicines being stored, however the record book clearly demonstrated medication being appropriately stored and collected by pharmacy staff, usually a few hours later.

Incidents

The service managed patient safety incidents well.

Staff understood their responsibilities to raise concerns and report them appropriately to ensure patients’ safety. Incidents were raised though the trust’s electronic reporting system.

Staff we spoke with were aware of the process for reporting incidents and could describe occasions when they had raised incidents. There were processes in place for investigating incidents and staff informed us that feedback was shared at a local level by managers and through trust-wide communication when appropriate.

Staff on ward D5 (hepatology) told us that they arranged specific learning sessions for staff based on the ward following incidents that occurred there. This provided staff with direct feedback, and as they were short sessions that took place on the ward it meant that as many staff as possible were able to attend.

We reviewed four of the most recent incidents relating to end of life care services across the trust. All four incidents were recorded as causing no harm. The information provided details of the incidents, actions taken, and lessons learned.

During our inspection we were made aware of an incident that had occurred within end of life care, which involved injuries to deceased patients due to positioning errors in the mortuary. Patients had received injuries to their arms as they had been placed incorrectly and later slipped from that position. An investigation was completed and one of the outcomes was additional training. Mortuary staff had also delivered updated training throughout the wards about preparing deceased patients for the mortuary. Following the shared learning from this incident, changes were made to the way deceased patients were positioned, staff were following these procedures as a result of their training and no further incidents had been reported of this nature at the time of our inspection. The service demonstrated that shared learning from incidents had improved safety for patients.

Never Events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2017 to September 2018, the trust reported no incidents classified as never events within end of life care.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in end of life care which met the reporting criteria set by NHS England from October 2017 to September 2018.

(Source: Strategic Executive Information System (STEIS))
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness.

The trust had an adult end of life care strategy (2016-19) which referred to various national standards and guidance; such as the Department of Health, 2008. *National End of Life Care Strategy*; Leadership Alliance for the Care of Dying People (2014) *One chance to get it right* and National Institute for Health and Care Excellence (NICE) (2011) Quality standard (QS13) - *End of Life Care for Adults*.

The trust used a last days of life flow sheet, which recognised the priorities for care according to the Leadership Alliance for the Care of Dying People: *A national framework for local action 2015-2020*. The Leadership Alliance for the Care of Dying People promotes a consistent approach to end of life care through five key principles.

The last days of life flow sheet was used across the trust in all adult wards. The last days of life flow sheet guided clinicians through a series of prompts to discuss each patient’s personal and clinical needs, preferences, and the amount of intervention required. It guided clinicians to consider the emotional, psychological and spiritual support required.

We reviewed six last days of life flow sheets and electronic care records, which detailed the conversations held with patients and their family. This included recognition of dying, symptom control, and assessment of nutrition and hydration needs.

The universal form for treatment options (UFTO) was in use at the trust. This was to provide information and guidance for patients, relatives and staff to encourage discussion regarding plans of treatment including decisions about resuscitation. UFTO puts the focus on treatments to be given rather than withheld and encourages forward planning for patients in the event of them becoming acutely unwell while in hospital.

At the time of our inspection the trust was launching the national initiative, recommended summary plan for emergency care and treatment (ReSPECT), a process that creates personalised recommendations for a patient’s clinical care in a future emergency when they are unable to make or express choices, including guidance about cardiopulmonary resuscitation (CPR).

ReSPECT was being launched to replace the Universal Form of Treatment Options (UFTO) and the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) documentation, and was to be completed through the trust’s electronic recording system. Staff we spoke with were aware of this initiative and told us that training had started. We also saw information sent to all staff through the CUH Daily, the trust e-newsletter, that ReSPECT was due to go live at the trust December 2018.

The service had an audit plan in place to monitor effectiveness of the service and to ensure structures were in place to support the delivery of the end of life care strategy. This was an improvement since the last inspection.

The trust undertook audits across a variety of areas, including NICE NG 31: Prescribing in the last days of life, use of the last days of life flow sheet, specialist palliative care team (SPCT) response time to referrals and preferred place of care (PPC).
Nutrition and hydration

Staff made sure patients had enough food and drink to meet their needs and improve their health.

Nursing and medical patient records evidenced that nutrition and hydration needs were being met. The trust used a malnutrition universal screening tool (MUST) to assess each patient’s nutritional status and identify those who were at risk of malnutrition. The last days of life flow sheet included a comprehensive list of nutrition and hydration considerations. This included prompts for nutrition and hydration assessment at every review, mouth care, swallowing difficulties and respecting the dying person’s choice to eat and drink. All staff we spoke with showed a good understanding of the importance of nutrition and hydration.

Throughout our inspection, we saw patients had drinks within easy reach and were routinely offered fluids throughout the day. Patients were encouraged to eat and drink for as long as they were able to in their last days of life.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

The trust had guidelines for the management of pain for patients in the last days of life. These guidelines were available as flow charts on the wards we inspected. They were also available through the trust’s intranet so staff had easy access to them.

We reviewed six medication administration records, all had anticipatory medication prescribed as per NICE guidelines. Anticipatory medications are those that are prescribed for use on an ‘as required’ basis to manage common symptoms that can occur at the end of life.

Pain was assessed using the prompts on the last days of life flow sheet. Throughout our inspection, we saw evidence that patient’s pain was assessed and appropriate pain relief was prescribed and administered to patients in receipt of palliative and end of life care.

Staff on all the wards we inspected told us, the Specialist Palliative Care Team (SPCT) consultants and nurses were able to provide guidance on the most effective and appropriate treatments and care at the end of life, which included pain relief and management of anxiety, nausea and vomiting.

Where appropriate, patients had a syringe driver, which delivered measured doses of medication over 24 hours. On all the wards we visited, all qualified nursing staff were trained in using syringe drivers and symptom management.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

The trust had taken part in the End of Life Care Audit – Dying in Hospital 2016 and had achieved three of the eight organisational Key Performance Indicators (KPIs). The trust had not achieved all the organisational KPI’s because there was a lack of formal training in relation to communication skills for doctors; nurses; health care assistants; (HCAs and allied health professionals).

The trust scored better than the England average in four of the five clinical KPI’s. Where the trust had scored worse than the England average this was because the trust did not perform well against documented evidence at the end of a person’s life.
The trust had developed an action plan to address the outcomes it was not meeting. The action plan for the audit was included within the trust’s end of life care strategy, which meant there was regular sight of the actions and performance of the service at the trust at divisional and board level. Most of the actions were completed and imbedded in the service.

The trust had submitted data to the 2018 National Audit of Care at the End of Life (NACEL) which was due to be published in May 2019. This national audit focuses on the quality and outcomes of care experienced by those in their last admission in acute, community and mental health hospitals throughout England and Wales.

The trust audited the last days of life flow sheet, which was used for all patients who had been recognised and expected to die within days. The audit data from September 2017 looked at all deaths in June 2017. The audit showed that 46% (40 out of 87) of patients had the flow sheet completed. The audit highlighted there was poor use of the last days of life flow sheet. As a result, a review of the flow sheet design was completed. The palliative care team told us this was re-audited as part of the NACEL, which will be published in May 2019.

The trust undertook a quarterly audit on the Universal Form of Treatment Options (UFTO) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. This was undertaken to ensure that all patients had their UFTO sheets completed correctly and documented on the trust’s electronic recording system within 72 hours of admission.

The June 2018 data showed that 88% of UFTO DNACPR forms were completed within 72 hours of admission. This was an improvement from 2017 data which was 80%. Discussions about resuscitation decisions with the patient were slightly lower at 98% compared to 100% in 2017. However, the reason for deciding not to resuscitate was clearly documented had increased to 98% compared to 96.5% in 2017.

The service also audited the availability of medication for dying patients and the appropriate use of syringe drivers in each patients’ last 24 hours of life compared to NICE guidelines (NG31). The data from December 2017 showed the percentages of patients being prescribed anticipatory medication in the last days of life was similar to the 2016. Anticipatory prescriptions for agitation was 81%, prescriptions for nausea/vomiting and respiratory secretions were both at 76%, close to the 80% target. However, prescriptions for pain relief had dropped from 87% in 2016 to 78% in 2017. This did not meet the trust’s target of 90%.

The information from the audits and the action plans was presented to the end of life care steering group, which met every six months.

Referrals to the Specialist Palliative Care Team

Data supplied by the trust showed for October 2017 to September 2018, 2176 referrals were made to the Specialist Palliative Care Team (SPCT), of these referrals 56% were cancer related and 44% were noncancer related.

Competent staff

The service made sure staff were competent for their roles.

All new nursing and medical staff were provided with palliative and end of life care training during their mandatory trust induction. The end of life care educational facilitator played an active role in developing the training program as set out in the end of life care strategy.

End of life care training was also part of the nursing staff annual refresher e-learning training. Data provided by the trust showed by September 2018, 3927 members of staff had received end of life care training during induction or clinical update training. This included medical, nursing, allied health professionals, administrative and housekeeping staff.
Porters that transported deceased patients to the mortuary and funeral directors using the mortuary had a mortuary training programme and completed a set of competencies. These competencies included: the booking in process, infection control and the safe movement of deceased patients.

End of life care champions were in place on every ward. End of life champions attended formal meetings and additional trainings three times a year. This meant the champions were able to support staff on the ward clinically and update with topical issues relating to end of life care.

The trust provided communication skills training to equip staff on how to break bad news. Data provided by the trust showed for the reporting year 2017/18, 276 staff members had received training in ‘grief and loss’ and ‘breaking bad news’ communication skill training. In addition, in 2018 the trust had started to roll out a train the trainer programme to facilitate the delivery of communication skills training to all staff band 6 and below.

The palliative care team received one to one supervision and clinical supervision with a psychologist.

**Appraisal rates**

As of July 2018, 86.5% of staff in end of life care at the trust received an appraisal compared to a trust target of 90%. The appraisal target was met for six of the eight staff groups, including the medical and nursing staff groups.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>As of July 2018</th>
<th></th>
<th></th>
<th></th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals completed</td>
<td>Appraisals required</td>
<td>Completion rate</td>
<td>Trust target</td>
<td></td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified allied health professionals</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified healthcare scientists</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; dental staff - hospital</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>7</td>
<td>57.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Other qualified scientific, therapeutic &amp; technical staff</td>
<td>1</td>
<td>3</td>
<td>33.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>37</strong></td>
<td><strong>86.5%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request – Appraisal tab)

At the time of our inspection, 100% of staff in the SPCT, Mortuary and Bereavement service at trust had received an appraisal.

**Multidisciplinary working**

**Staff from different disciplines worked together as a team to benefit patients.**

The specialist palliative care team (SPCT) had multidisciplinary team (MDT) meetings weekly attended by the palliative care team consultants, nursing staff, allied health care professionals and other relevant professionals involved in the care of patients.
Ward staff we spoke with were aware of how to contact the hospital SPCT and were positive about the input and care delivered by the team.

Referrals to the SPCT came from various professionals, including nursing, medical and allied health professionals. Nursing staff felt confident to refer to the team and to ask for advice and support.

Ward staff and managers told us the palliative care team attended the ward when referrals were made formally and less formally for advice and support when requested to do so. The SPCT routinely visited the wards.

The SPCT worked closely with the chaplaincy, mortuary and bereavement teams. Staff within each team told us they had good working relationships with each other and that this benefitted the services offered to patients and their families.

**Seven-day services**

**The service was operating six days a week but plans were in place to ensure a seven day service.**

The SPCT were available for face-to-face consultations in the hospital Monday to Saturday from 9am to 5pm. Staff could access a palliative care consultant out of hours through switchboard.

At the time of our inspection, the service had secured funding and were planning to introduce a seven day service from February 2019. Staff recruitment was underway and a number of nursing posts had been filled with start dates already agreed.

In the last 12 months preceding our inspection, the SPCT saw 78% patients referred to the team within 24 hours and 84% within 48 hours. The SPCT told us they expected these rates to improve once the seven day service had started.

The multi-faith chapel was open 24 hours a day, seven days a week for staff, patients, and visitors to access. The hospital chaplaincy service had chaplains of various denominations that could be contacted to provide holistic support for staff, patients and families 24 hours a day, seven days a week.

The mortuary and bereavement team provided an 8am to 4pm service Monday to Friday. Outside normal working hours, the team had a 24-hour emergency on-call system and could be contacted through the hospital’s Switchboard.

Porters had access to the mortuary 24 hours a day, seven days a week, which, where appropriate, enabled prompt transfers of deceased patients from clinical areas to the mortuary.

The mortuary provided service to both the hospital and community. Therefore, there was a system in place for approved funeral directors to have access to the mortuary 24 hours a day, seven days a week.

**Health promotion**

**Patients were supported to live healthier lives.**

The SPCT told us they provided support to a wide range of patients in receipt of palliative care and not just those in the last days of life. These included patients who had comorbidities that affected their health and wellbeing who may need specific guidance on health promotion.

The SPCT could refer patients to other clinics across the hospital for example pain clinic, diabetes clinic, etc. The team monitored the wellbeing of any patients in receipt of palliative care and took appropriate action to promote health and wellbeing, for example by reviewing
medication, sign posting to care support networks amongst other actions.

The trust was taking part in a new national initiative aimed at promoting better access, and earlier integration of supportive care within oncology and haematology clinics. The SPCT led the enhanced supportive care services as an outpatient clinic and offered advice and support on the management of pain, anxiety, fatigue and breathlessness. In addition, the service offered advice on, well-being and quality of life and signposted patients to local services.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

Consent, care and treatment was mostly sought in line with legislation and guidance.

MCA and DoLS guidance was available on the trust’s intranet along with other associated documents such as the trust’s consent policy, dementia policy and safeguarding adults at risk policy.

Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions.

Throughout our inspection, we reviewed 36 universal form for treatment options (UFTO) do not attempt cardio pulmonary resuscitation (DNACPR) forms. Of the 36 DNACPR records reviewed, 33 (92%) were completed in line with Resuscitation Council UK guidelines. This was an improvement since the last inspection.

Of the 36 UFTO DNACPR forms we reviewed, eight had documented that the patient did not have mental capacity. This meant these patients should have had a mental capacity assessment completed. Five (62.5%) of the patients had a clearly documented MCA assessment. The other three records (37.5%) did not have a mental capacity assessment completed and evidenced in the notes which was specific to the DNACPR order. However, two of these had a mental capacity assessment for medical treatment and nursing care completed as part of the UFTO form.

The trust undertook quarterly audits of the DNACPR UFTO forms. The most recent audit results from June 2018, demonstrated 100% of the DNACPR UFTO forms that were put in place for patients lacking capacity, either had a mental capacity assessment or lack of capacity was clearly implied in the medical notes and assessment completed for medical treatment and nursing care as per the trust guidelines.

**Mental Capacity Act and Deprivation of Liberty training completion**

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of the trust’s mandatory training programme.

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training.

A breakdown of compliance for the MCA and DoLS training module as of July 2018 for qualified nursing and medical staff in end of life care at the trust is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff trained</th>
<th>Number of eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing staff</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental staff</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff in end of life care exceeded the trust target of 90% with a completion rate of 100%.
Whilst 83.3% of medical staff completed the MCA and DoLS training module; however, this equated to only one member of staff not having completed this training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

We saw no patients at the end of life or receiving palliative care that had an active DoLS in place at the time of our inspection. Staff we spoke with had a good understanding of DoLS and were able to provide rationales for not applying for a DoLS when asked.

Staff could describe and knew how to access policy on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff knew where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Compassionate care

Staff cared for patients with compassion.

We observed staff treating patients with compassion, dignity and respect throughout our inspection. Staff expressed a desire to provide patients with the best possible care at the end of their lives.

Staff told us about a married elderly couple who were both receiving care on one of the hospital’s wards. The ward team worked to ensure the couple could spend their dying days together by coordinating a bed move so that the couple could be next to each other and hold hands in those final moments. This demonstrated the desire of staff to provide compassionate care and to prioritise the individual needs of patients. The staff were recognised with a “You made a difference” team award. This was a trust awards system that aimed to reward and recognise both teams and individual staff members who had 'made a difference' for patients, visitors or colleagues.

A member of the mortuary team was also recognised in the June 2018 “You made a difference” individual award for their work in coordinating and securing funding for a service to provide a free hand and foot clay imprints, of children who had recently died, as a lasting memento for their parents.

The Bereavement Care Questionnaire Results 2017 and 2018 Comparison compiled by the trust showed a comparison of results over two years. It showed an improvement in 2018 for respondents who felt their loved ones were treated with dignity and respect and received a good quality of care in the last stages of their lives. There was also an increase in relatives and friends who considered they had been provided with emotional and/or spiritual support at the time of their loved one’s death.

During our inspection we observed staff taking time to interact with patients and demonstrating a sensitive and supportive attitude. Staff shared an example where they were caring for two patients in a bay who were both at the final stages of life. When the first patient died staff were very mindful of the sensitivity of the porters’ visit while the other patient was still receiving care. The sister coordinated the process by speaking with staff and the porters to ensure that it was managed quickly, discreetly and respectfully.

Staff ensured that people’s privacy and dignity needs were met. We observed staff closing curtains while undertaking physical care or examinations. Staff told us that as far as possible they tried to place patients receiving end of life care in side rooms to further protect their privacy and dignity. This depended on the capacity of the ward and also the views of the patients, as not all
patients wanted to be cared for in side rooms.

We saw staff responding to call bells in a timely manner, which assured us that staff responded in a timely way when patients felt pain, discomfort or distress. Staff also spoke to us about the use of syringe drivers which they used to manage pain or discomfort in patients receiving end of life care.

Mortuary staff informed us that porters had started to place pillows under the heads of deceased patients before they were brought to the mortuary. It was prompted by training that mortuary staff had delivered to the porters about last offices. This demonstrated the caring attitude that porters held towards those in their care.

**Emotional support**

**Staff provided emotional support to patients to minimise their distress.**

Staff provided emotional support to patients receiving end of life care and their relatives or friends.

The service ensured that sensitive communication took place between staff and patients and their relatives. The chaplaincy service provided education and training to staff to equip them with the skills to aid sensitive communication. One of the training sessions provided was a grief and loss course which was available to all staff within the trust.

The bereavement service offered a follow up service to the relatives of every patient who died at the hospital. The bereavement service sent a letter to relatives five weeks following the death of the patient to invite the family to attend a meeting with relevant staff at the hospital to discuss any questions or issues they may have had relating to the care of their loved one. The bereavement service had lots of examples of how these meetings had supported relatives by providing them with answers and information about their loved one, which had enabled families to experience acceptance of what had happened and come to terms with their loss.

The specialist palliative care team (SPCT) had a clinical psychologist who provided emotional support for patients and their families. The psychologist also supported patients with techniques to help them manage any pain or nausea they were experiencing. The psychological support provided to relatives included teaching them about what their loved one was experiencing.

The chaplaincy team operated an out of hours on-call service, which meant that someone was available 24 hours, seven days a week. There were approximately 100 volunteers at the trust, who provided patients with various forms of support including taking them to the chapel, sitting and talking to patients, bedside communions, reminiscence sessions and tea parties held on some of the wards. The chaplaincy team also provided emotional support for staff. They recognised that providing end of life care could have an emotional impact on staff members and provided monthly support sessions that had been well attended for three years.

The chaplaincy team told us they provided psycho-social spiritual support, highlighting they were there to support everyone, not just those who were religious. They made use of the hospital chapel, from which they held regular services. The chapel was used for Friday prayer for those practicing Islam. Staff recognised the needs of others and considered the personal, religious and spiritual needs of their patients. The chaplaincy team could access religious representatives from all denominations if required and had well established links with other faith leaders in the local community.

Mortuary staff told us that when families came in to see their deceased relative in the viewing area, nursing staff sometimes came to the viewings to provide support to the families of deceased patients.
Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. Staff made sure patients and those close to them understood their care and treatment, and spoke with patients in a way they could understand.

Staff put patients at the centre of their care and actively involved patients and their families in shared decisions about their care and treatment. We reviewed six sets of records for patients who were receiving palliative and end of life care. The records showed that discussions took place between clinicians and patients, where possible, and where appropriate with relatives of the patients.

Staff supported patients to make advanced decisions about their care. The SPCT provided patients with support and information about their options for care, and had conversations with patients about their preferred place of care. They also supported ward staff by providing guidance for the care of patients during the time they were receiving end of life care.

All wards had set visiting times, however all wards made allowances for visitors of patients in receipt of end of life care. Their visitors were allowed open visiting which gave them the flexibility to visit whenever they wanted and stay as long as they liked. The trust had on-site accommodation, which families could use, particularly if they had to travel long distances to visit their loved one. The service recognised the impact that practical support had on the wellbeing of patients’ relatives and supported them to remain involved in the care of their loved ones.

Patients and their families could give feedback on the service and staff supported them to do this.

Is the service responsive?

Service delivery to meet the needs of the local people

The trust planned and provided services in a way that met the needs of local people.

Discussion of preferred place of care (PPC) with patients and their relatives were documented on each patient’s electronic records, and was monitored by the specialist palliative care team (SPCT).

Referrals to the specialist palliative care team (SPCT) could be made any time during a patient’s treatment. This allowed early involvement of the team and time to facilitate the most appropriate care and treatment. The enhanced supportive care services promoted better access, and earlier integration of supportive care for cancer patients.

The palliative care team encouraged referrals from nursing, medical and allied health professional staff from across the trust.

Referrals could be made through the trust’s electronic recording system. Staff informed us they could also contact the palliative care team by bleep, telephone or through switchboard.

Data provided by the trusted showed from October 2017 to September 2018, 2176 referrals were made to the SPCT, of these referrals 56% were cancer related and 44% were noncancer related.

Data provided by the trust showed on average 78% of referrals to the palliative care team were responded to within 24 hours and 84% within 48 hours.

Referrals to the SPCT were prioritised and discussed at clinical meeting each morning. This was attended by palliative care consultants and nurses.

Patients requiring end of life care were cared for throughout the trust. There were no designated beds or wards for patients who required end of life care. However, staff told us that wherever
possible, side rooms would be used for patients who were in their last days of life.

The trust undertook a bereaved relatives survey. Data from January 2018, which asked relatives if they were informed that their loved ones were coming to the end of their life, 87% said yes and 13% said no.

There were no visiting restrictions on the wards for family or friends of those receiving end of life care. The wards we inspected provided portable beds and/or comfortable chairs for those relatives wishing to stay the night with their loved ones. This ensured family and friends could spend unlimited time with their loved one.

Carers and family members of patients at the end of their life had access to reduced cost parking when visiting. Staff offered relatives hot drinks throughout the day.

We saw various quiet rooms throughout the hospital with access to drinks, sofas and soft furnishings. Staff told us these were often used for families of end of life patients, for quiet time or breaking bad news.

The trust had a discharge team that facilitated fast track discharge and end of life care planning for those patients wishing to die at home.

The bereavement care team offered a follow up service. One week following a patient death they sent a condolence card to the families personally signed by the ward sister and their team.

Four to six weeks after every death in the hospital, the patient’s family were invited to attend a meeting to discuss with a senior member of the clinical team involved in the care of their loved one and the circumstances of the death of their loved one.

**Meeting people’s individual needs**

**The service took account of patients’ individual needs.**

The chaplaincy gave examples of when wedding ceremonies, baptisms and special services had been organised for patients and staff within the hospital.

The Chapel was a multi-faith space and was open 24 hours a day, seven days a week for people of any faith or none. Prayer mats for people with a Muslim faith was available. We saw copies of the Holy Bible and Koran and multi-faith books.

The hospital had a Macmillan information pod that was staffed by trust staff as well as volunteers located in the oncology outpatient area, providing advice and support for patients, including end of life and the bereaved.

A variety of leaflets were available on the wards including information about coping with dying, chaplaincy and spiritual care and what to do following bereavement. The trust could provide these leaflets in other languages, large print or audio format if required.

The trust had a system in place to access telephone and face to face translation and interpreter services.

We spoke with a patient and their family who was at the end of their life and being nursed in a side room. We asked the patient if they were comfortable and they indicated they were. They were being nursed on an air mattress. The patient was enabled to bring belongings from home and we saw the family had brought into the hospital framed pictures, along with a pillow and duvet from home. We reviewed the patients notes. We found that their care was tailored towards their preferences and took into account their coexisting conditions such as pressure ulcer assessments.
A viewing room in the mortuary provided families or friends with a private quiet space should they wish to spend time with their deceased friend or relative. The waiting room where families sat prior to viewing their loved ones was decorated and furnished with comfortable homely furniture, helping bereaved families feel at ease.

The bereavement care team gave bereaved families a guidance booklet. This outlined what to expect following the death of a loved one, and signposting to relevant information and support. The bereavement services had numerous resources available to support people of all ages, faiths, and beliefs following the death of a patient.

Visitors to the mortuary were collected from the hospital reception and accompanied to the mortuary. A call bell was used in the viewing area if visitors required assistance from staff. This enabled staff to respond quickly, whilst allowing privacy and dignity for the deceased and their family to spend time together.

The mortuary staff told us they could accommodate all faiths, and enabled families to be able to wash the deceased patient if requested. They worked closely with faith leaders and undertakers to ensure deceased patients were cared for following their cultural and religious requirements.

**Access and flow**

**People could access the service when they needed it and the trust was working with stakeholders to improve the timeliness of fast track discharges.**

There were 2176 referrals to the palliative care team for October 2017 to September 2018. The team audited the response time to referrals received and 63% of referred patients had face to face visit within the first 24 hours and another 84% of patients were seen within 48 hours. In total 78% of referrals had a response in the form of a face to face visit or advice to health care professionals within 24 hours.

Preferred place of care (PPC) and preferred place of death (PPD) was discussed with patients and documented in the medical electronic records. This was an improvement since the last inspection. Audit data from June 2017 showed that 66 out of 88 (76%) medical records audited showed that a discussion took place about dying was documented and in 40 (46%) records where PPC discussed and documented.

However, the trust did not audit what percentage of patients achieved their PPD, which was identified at the last inspection. The June 2017 audit highlighted as a recommendation to re-audit taking into account reasons why patients do not achieve their preferred place of care and death including the speed of deterioration. The SPCT told us this had been submitted as part of the National Audit of Care at the End of Life (NACEL) which was due to be reported in May 2019.

During our inspection we noticed that PPC and PPD where documented in the electronic medical notes as part of the discussion the medical team had with the patient and their family. There was no flag for PPC or PPD in the electronic records. Therefore, there was no process in place to find at a glance if PPC or PPD options had been discussed.

Because of the PPC audit, an action plan was put in place to address key areas such as further education at ward level to promote discussion about dying and PPC with the medical teams. The palliative care team were targeting wards where data indicated an increased need for training. Staff told us and the action plan confirmed that this would be re-audited to monitor compliance in 2019.

The fast track discharge of patients in the last days and weeks of life (last two to four weeks of life) was coordinated by the integrated discharge team. All the wards we visited had access to a discharge coordinator that attended the board rounds to identify any patients that require fast
track discharge and would coordinate with the integrated discharge team.

Data provided showed that in 2018, fast track referral to discharge was a median of eight days. This data suggested the trust was performing worse than the last inspection, where the average time to discharge was 3.8 days for patients living in Cambridge and 4.7 days for patients living outside Cambridge.

The trust had been proactive in trying to reduce the delay to discharge of patients by working alongside the voluntary sector. Since April 2018, the trust had commissioned nine nurse led beds in the local hospice to ensure that patients who were nearing the end of their lives (within the last two weeks of life) and had been stabilised, had the option to be cared for at the hospice.

Patients who had been assessed as suitable for transfer to the hospice were identified and assessed by the SPCT in collaboration with the hospice liaison nurse. The liaison nurse visited the trust Monday to Friday and joined the SPCTs morning handover to discuss and review the patients.

Ward staff told us that they had not had patients delayed from being discharged to their preferred place of death due to the process, but due to families changing the minds and lack of care packages being available in the community.

Senior staff told us the fast track discharge was something the trust needed to continue to work on and address.

The mortuary had 120 fridge spaces, including spaces for deceased bariatric patients and five freezer spaces. There was a system in place to monitor daily fridge capacity within the mortuary and an appropriate escalation process for the mortuary staff to follow.

Porter staff received specific training on how to transport the deceased and had access 24 hours a day seven day a week to the mortuary to maintain patient flow through the mortuary.

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

The bereavement team was available Monday to Friday 8am to 4pm. The chaplaincy team was also trained to carry out bereavement team duties. This enabled families to organise funerals within 24 hours, should it be required.

The hospital had an on-site registrar, three days a week. This allowed families to complete all paperwork at once rather than travel to the registry office.

**Learning from complaints and concerns**

The service treated concerns and complaints seriously, investigated them and learned lessons from the results and shared these with staff.

Staff told us that complaints about the service did not happen often, but if they did, they were made aware of the nature of the complaint and any actions taken by the trust team to ensure the issues that led to the complaint did not happen again.

The trust submitted data showing it had received four complaints which had an end of life care component between August 2017 and July 2018. These complaints were logged in a response data base, with descriptions of complaints and actions taken. We reviewed the investigation into the complaints. Three out of the four complaints had aspects of lack of communication between ward staff and the next of kin. We saw the action plan for the lessons learnt and the actions taken to address the complaints.
Complaints were discussed as a standing agenda item in the ward huddle, end of life care operational group monthly meetings and the end of life care steering group six monthly meetings. We were able to see from the meeting minutes recent complaints concerning end of life care discussed and key learning points shared at the meetings.

Ward staff gave an example where lessons learnt were shared following a complaint, regarding communicating with the families of a patient. The complaint was discussed at the end of life care steering group and the findings were disseminated to all staff concerned.

Summary of complaints

From August 2017 to July 2018 the trust received no complaints about end of life care. Four complaints had an EOLC component but this was not the primary specialty relating to the complaint.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust

From August 2017 to July 2018 the trust received one compliment about end of life care. This related to the bereavement care service.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

The trust had compassionate, inclusive, and effective leadership within end of life care. Leaders demonstrated high levels of experience, capacity, and capability needed to deliver excellent and sustainable care.

There was effective and professional leadership that encouraged and supported the delivery of person centred care and we saw this throughout the service we inspected, the specialist palliative care team (SPCT), the mortuary service, chaplaincy and the bereavement service.

End of life care was led at an executive level by the chief nurse and supported by the assistant director of nursing. There was also a nonexecutive director (NED) who supported the end of life care agenda within the trust.

The trust’s end of life care steering group was chaired by the chief nurse and the assistant director of nursing deputised in their absence.

Clinical leadership within the SPCT was provided by the palliative care consultant and the lead palliative care nurse. The palliative care consultants and palliative care nurses demonstrated good leadership in the clinical areas, and staff we spoke with on the wards recognised who they were.

Staff we spoke with throughout the trust were aware of the SPCT. Staff also told us they had a good working relationship with them.
**Vision and Strategy**

The service had a vision for what it wanted to achieve and workable plans to turn it into action.

The trust had an end of life care strategy (2016-2019) and an end of life care operational policy (2016) in place. The strategy and the policy both built on the Department of Health, 2008. National End of Life Care Strategy; Leadership Alliance for the Care of Dying People (2014) One chance to get it right and National Institute for Health and Care Excellence (NICE) (2011) Quality standard (QS13) - End of Life Care for Adults and the Ambitions for Palliative and End Of Life Care; A National Framework For Local Action 2015-2020. The strategy and the policy outlined the goals and aims and recognised that end of life care was everyone’s business.

The senior leadership team told us the strategy would be reviewed in 2019, following the publication of the National Audit of Care at the End of Life (NACEL), which was due in May 2019.

The trust’s end of life care strategy, supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership.

The end of life care strategy was discussed, and its progress monitored in the end of life care operational and steering group meetings.

Staff we spoke with within the SPCT understood their role in delivering the end of life care strategy and reviewed progress against key milestones set out in the strategy document.

**Culture**

Comprehensive and successful leadership strategies were in place to ensure and sustain service delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges, and priorities in their service, and beyond.

The palliative and end of life care service leads and managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

There was a recognition of the importance of ensuring patients received a good end of life care experience across all staff groups throughout the hospital. Staff were engaged with the trust and proud of the care and treatment they provided for patients at the end of their life.

Staff we spoke with showed a commitment to delivering good quality end of life care. Although they all told us staffing was an issue throughout the wards, staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff about the level of support they received from the SPCT.

Members of the SPCT, mortuary and bereavement team demonstrated a strong team ethic and a structured working relationship.

The service recognised staff success and innovation and actively encouraged staff to drive improvement.

The mortuary and bereavement team demonstrated a desire to continually improve the care and experience they gave to both the deceased and their relatives.
Governance

The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care could flourish.

There were established systems to ensure good governance and monitor performance of the end of life care service in the trust.

There was an end of life care executive, non-executive and clinical lead. We found they had an active role in end of life care and its plans for continuous improvement.

The SPCT had regular team meetings, in which issues and general communications were shared and discussed.

There was an end of life care operational group that met bimonthly and was chaired by the assistant director of nursing. We reviewed meeting minutes, which demonstrated there was a good overview of the service, with improvements, strategy and action plans discussed.

There was an end of life care steering group every six months. Chaired by the chief nurse, including representatives from stakeholders, such as local hospices, public governors.

The service produced an annual end of life care report to the quality committee which ultimately reported to the trust Board.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them.

The service kept a risk register, which was up to date and staff knew how to escalate any concerns. The risks on the risk register reflected the risks staff had told us about throughout our inspection. For example, risks listed on the register included the absence of a seven day specialist palliative care service, insufficient patient fridge space within the mortuary and reduction in administration team to support the SPCT and end of life care education throughout the trust.

Mitigation was in place for the risks and dedicated staff leads were responsible for providing updates to the governance teams on progress made towards managing or removing the risk. There was evidence that the risks were being reviewed and updated regularly. The risks that were on the register had control measures in place and a review date.

The service produced a quality assurance dashboard that monitored performance of the service. This was measured by using a matrix system on the trust’s electronic recording system. It recorded data such as where people die by ward, and time between admission and death. This was used to target education to the wards and areas that required it most.

Clinicians were engaged in service developments and worked with managers to make sure that cost improvements did not compromise patient care.

Information Management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Leaders had access to a range of performance measures about quality, operations and finances, and used it to improve the service.

The information systems facilitated the management of data in line with data security standards.

The SPCT had read access to the electronic system used by the community services and the local
hospice. This helped the SPCT to effectively encourage appropriate interaction and promote coordinated, person-centred care to palliative and end of life care patients.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

All the wards we visited had end of life care champions, who assisted with sharing information relating to end of life care and engaged the wider staff team in new developments.

The hospital had an awards system for staff. The ‘You made a difference’ award aimed to reward and recognise both teams and individual staff members who had ‘made a difference’ for patients, visitors or colleagues. The SPCT had recently won this award for working collaboratively with their local hospice to enable patients to access nurse led hospice beds quickly and efficiently. In January 2018, ward G4 was also recognised with a ‘You made a difference’ team award for their compassionate care shown in caring for a dying couple.

The June 2018 “You made a difference” individual award also recognised a member of the mortuary team for their work in coordinating and securing funding for the ‘tiny feet’ service which provides a free hand and foot clay imprints, of children who had recently died, as a lasting memento for their parents.

The hospital conducted an annual bereavement care questionnaire which gave the public an opportunity to suggest improvements. The 2018 survey was sent out to 172 bereaved relatives who accessed the bereavement care services at the hospital and had a response rate of 28%. The results from the survey showed a high level of satisfaction.

The bereavement care service, in the weeks following the death of their loved ones, offered a follow up service for bereaved families. This gave the bereaved families an opportunity to talk to hospital staff to seek support or advice.

Leaders engaged with external partners to build a shared understanding of challenges and opportunities for the service.

Learning, continuous improvement and innovation

Managers were committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The trust had been working in partnership with Emergency Care Improvement Programme (ECIP) and Hospice UK to look at service improvement for end of life care emergency pathways. This involved various initiative and outcomes, including improving the walk from reception to the mortuary, development of an end of life care (EoLC) dashboard to provide data relevant to EoLC in a single place. The trust planned to use the work from this partnership to inform the review of the end of life care strategy in 2019.

The trust provided enhanced supportive care (ESC) which is an initiative to promote the earlier implementation of supportive and palliative care within cancer care. ESC offers a holistic, active care for patients and their families who are experiencing a potentially life-threatening illness. The goal of this service is to achieve the best quality of life for patients and their families.

Since January 2018, the trust had commissioned nine nurse led beds at a local hospice. This was a project designed to ensure patients who were nearing the end of their lives (within the last two weeks) and had been stabilised, had the option to be cared for at the hospice. Patients and families had benefitted in numerous ways in the way they were supported to spend their last days
according to their choice. This had been evidenced through the very positive feedback received from the patients and their families.