Royal Papworth Hospital NHS Foundation Trust

Evidence appendix

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18 June to 26 July 2019

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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

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

Royal Papworth Hospital is a regional centre for the diagnosis and treatment of cardiothoracic disease, it is also a national centre for a range of specialist services including pulmonary endarterectomy (PEA), balloon pulmonary angioplasty (BPA), heart and lung transplant and extra corporeal membrane oxygenation (ECMO). Royal Papworth Hospital has the largest respiratory support and sleep centre (RSSC) in the UK.

The hospital is a purpose-built hospital on the Cambridge Biomedical Campus and treats more than 100,000 patients each year from across the UK.

(Source: Trust Website / Acute RPIR – Context acute tab)

Patient numbers

Between March 2018 and February 2019, the trust saw:

- 20,727 inpatient admissions
- 107,402 outpatient appointments
- 168 deaths

(Source: Hospitals Episode Statistics)
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 consistently above the England average for recommending the trust as a place to receive care from April 2018 to March 2019.

(Source: Friends and Family Test)

Inpatient survey

This survey looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018.

Between August 2018 and January 2019, a questionnaire was sent to 1,250 recent inpatients at each trust.

Responses were received from 766 patients at Royal Papworth Hospital NHS Foundation Trust. Royal Papworth Hospital NHS Foundation Trust scored better than other trusts for 31 out of 60 questions, and about the same as other trusts for 29 out of 60 questions in the 2018 inpatient survey.

(Source: Inpatient survey 2018)
Is this organisation well-led?

To rate this organisation and write this well-led report, we interviewed members of the trust board, both the executive and non-executive directors, and a range of senior staff across the trust including clinical and non-clinical service and specialty directors.

We spoke with a wide range of staff to ask their views on the leadership 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, investigations, and feedback from patients, local people and stakeholders.

Leadership
The trust board, executives and senior leadership team had the skills, knowledge, integrity and experience needed to provide high quality services on appointment and throughout their employment.

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 the chief executive officer, chief nurse, medical director and the chief operating officer and four non-executive directors to determine whether the necessary fit and proper person checks had been undertaken. Board members completed annual self-declaration forms to confirm that they complied with the regulation. All files had an annual declaration within them in line with FPPR. We found all files to be fully compliant with the FPPR.

Board Members

Of the executive board members at the trust, none were Black and Minority Ethnic (BME) and 43% were female.

Of the non-executive board members 14% were BME and 29% 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%</td>
<td>43%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>14%</td>
<td>29%</td>
</tr>
<tr>
<td>All board members</td>
<td>7%</td>
<td>36%</td>
</tr>
</tbody>
</table>

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

There was a lack of diversity amongst the board members. This was not representative of the local population. However, the trust was aware of this and were undertaking work to develop a more diverse senior leadership team.

The trust board of directors managed the trust’s services and developed plans and strategies for the future. The board included full-time executive directors who oversaw the day-to-day running of the trust and part-time non-executive directors (NEDs) who brought with them a blend of knowledge, experience and expertise from both the public and private sector. NEDs 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
The trust board was made up from voting members, and non-voting members, a chair, six NEDs, six executive directors and one non-voting executive director. The six NEDs had joined the trust at varying dates between 2012 and 2019.

The trust had 18 public governors, one of which was the lead governor, and seven staff governors on its council. In addition, there were four appointed governors who had been nominated from local organisations. The council of governors helped to shape the strategic direction of the trust. Their role was to hold the NEDs 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 annually.

We met with five of the governors; they told us the trust had open and communicative NEDs and an accessible executive team. They felt they could raise any concerns with the NEDs, chair and the executive directors.

The board of directors managed the trust’s services and developed plans and strategies for the future. The board included full-time executive directors who oversaw the day-to-day running of the trust and part-time non-executive directors (NEDs) who brought with them a blend of knowledge, experience and expertise from both the public and the private sector. They help to ensure the trust is accountable to the people it serves.

Executive directors and non-voting directors were employed by and worked in the trust daily and had management of set areas of the trust’s business. Non-executive directors were not full-time employees of the trust. They were individuals who had shown an interest in the provision of health services for the local people and brought with them specialist experience and independent oversight of the board’s activities. NEDs helped ensure the trust remained accountable to the people it served.

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 supportive conversations.

The trust board and senior leadership team displayed integrity on an ongoing basis. Throughout our well-led inspection, we saw evidence of cohesive and 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.

There was clear leadership of the trust to drive and improve the delivery of high-quality person-centred care. Senior leaders were visible and were mindful of being accessible to staff across the trust.

The trust’s senior leadership team had a comprehensive knowledge of the trust’s current priorities and challenges and acted to address them. Prior to our inspection, we attended a trust board meeting, and we studied board minutes and associated papers throughout our inspection. The
board meetings were well attended, and we observed a unitary board that was open to challenge. The meeting we attended was well chaired and there were healthy discussions from and between the executive and the NEDs. 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 that sat across five divisions. These were cardiology, surgery and transplant, respiratory medicine, clinical support services and ambulatory. Each division was led by a triumvirate team, consisting of a deputy director of operations, clinical director and a head of nursing. Each division was also supported by an operational manager.

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. The trust had recently launched a culture and leadership programme of which one of the objectives was to build a leadership strategy that supported the development of compassionate leaders who fostered a high quality care culture.

In 2018, the trust had introduced the use of a talent mapping tool to assess the capability and potential of the senior leadership across the trust. The output of the review fed into the trust’s individual performance review process for the individual leaders as part of discussions around career aspiration and development.

The pharmacy department was adequately staffed and had put in place a recruitment and retention strategy to support career progression for existing staff. A restructure had taken place, whereby each specialty area had a lead pharmacist who supported junior staff, which supported succession planning and learning.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision to be the best leading hospital in the United Kingdom, providing excellence in specialist heart and lung patient care, based on research, education and innovation. The aim of the vision was to bring tomorrow’s treatments to today’s patients.

The trust’s mission was to provide excellent, specialist care to patients suffering from heart and lung disease.

The trust’s vision was underpinned by a set of deep-rooted values, which were:

- Leading with care – We put patient care at the heart of everything we do.
- Instilling innovation – We look for every opportunity to innovate and improve.
- Feeling valued – We ensure our staff members feel valued for the work they do.
- Encouraging excellence – We encourage excellence in all aspects of clinical and non-clinical services.

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.

The trust had a strategy which expired in 2019. The strategy was based around the trust moving from its premises to a new purpose-built hospital on the Cambridge Biomedical Campus which
was cohabited with other NHS providers, educational institutions and commercial pharma companies. The trust delivered this strategy in April/May 2019 and had planned for a period of optimisation, activity transfer between the trust and a neighbouring trust and active leadership through the sustainability and transformation programme (STP) in the fields of cardiology and respiratory medicine, which would enable the trust to deliver the remaining aims of the strategy. At the time of our inspection, the trust was developing a new strategy, and had been doing so since Autumn 2018. The new strategy was to encompass a clinical vision, innovation, research and education, workforce, culture and leadership, resources, facilities and technology.

The new strategy was being developed using the NHS Improvement strategy development toolkit. The trust had sought feedback from stakeholders, senior leaders within the organisation and members of the trust’s patient and public involvement committee.

The trust’s strategic objectives for 2019/20 were:

**Our patients**
- We will implement our Quality Strategy (2019-2022) and further embed our Quality Improvement methodology to deliver continuous quality improvement, supporting excellent care and outcomes.
- We will deliver our activity plan and meet our patient access targets.

**Our staff**
- We will, during this period of change, invest in our leaders to enable them to be the best they can be to support our incredible staff to deliver excellent patient care.
- We will continue to enhance our reputation as an employer and attract high quality staff to work with us in all roles and departments.

**Our resources**
- We will deliver a safe and effective move to our new Royal Papworth Hospital.
- We will deliver our financial, activity plans and recovery programme, supporting the Trust’s return to financial stability.

**Our partners**
- We will use the opportunity of our new hospital and location to innovate, develop partnerships with external organisations and further build upon our reputation as one of the world’s leading heart and lung hospitals.
- We will work closely with our STP partners to support delivery of our system plan and, through our leadership of cardiothoracic services, to refine patient pathways to improve outcomes and patient experience.

Monitoring of the trust’s progress against their strategic aims was monitored through the strategic projects committee. This was a sub committee of the board.

Throughout our core service inspection, staff were aware of the vision and strategy for the trust and had felt well engaged with in relation to this.

In addition to the trust wide vision and strategy, the trust had many other strategies that were aligned with the overarching strategy; such as an information governance strategy, quality strategy, risk management strategy, estate strategy, digital strategy, nursing strategy and a freedom to speak up strategy.

The trust’s Medicines Optimisation Strategy had been updated in July 2019 and the chief pharmacist told us that this would be reviewed again to align with the trust’s priorities once this had been agreed. A pharmacy dispensary service was provided seven days a week, with full clinical support Monday to Friday.
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.

Staff culture within the trust was positive. Staff we spoke with throughout our core service and well-led inspection told us they felt positive and proud about working for the trust and their team. Staff felt empowered to make decisions and to make changes within their service.

There was a no blame culture within the trust and staff were actively encouraged to raise concerns and report incidents without fear of retribution. Staff were encouraged to be open and honest in relation to issues arising and raising issues. Candour, openness, honesty, transparency and challenges to poor practice were encouraged by senior leaders.

Senior leaders demonstrated an understanding of the importance of enabling staff to raise concerns without fear of retribution. The trust had a whistleblowing policy and staff we spoke with knew how to raise the whistleblowing process. This was also demonstrated throughout the trust’s freedom to speak up vision and strategy, which stated the trust was committed to promoting an open and transparent culture across the organisation to ensure that all members of staff felt safe and confident to speak out. This was supported by the board and senior leadership team who supported this agenda by modelling the behaviours to promote a positive culture throughout the organisation, provided the resources required to deliver an effective Freedom to Speak Up function; and had oversight to ensure the policy and procedures were being effectively implemented.

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 a freedom to speak up guardian who was allocated one day per week to the freedom to speak up role. The trust was also in the process of recruiting 20 freedom to speak up guardian champions.

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 (FTSUG). Between January 2019 and March 2019, staff had raised 11 issues, eight of which concerned bullying and harassment.

We asked the trust how many how many incidences of whistleblowing have you recorded in the last 12 months? The trust responded:

<table>
<thead>
<tr>
<th>How many incidences of whistleblowing have you recorded in the last 12 months?</th>
<th>Total</th>
<th>Date Range, Start Date (DD/MM/YY):</th>
<th>Date Range, End Date (DD/MM/YY):</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>01/03/2018</td>
<td>28/02/2019</td>
<td></td>
</tr>
</tbody>
</table>

Staff we spoke with throughout our core service inspection were mostly positive about the culture throughout the organisation and told us they were proud to work at the trust. However, three members of staff within critical care told us about a bullying culture within the service. There had been several concerns and whistleblowing raised about a bullying culture within critical care. In response to whistleblowing concerns the trust had instigated a number of interventions within critical care. One such initiative included a band 7 development programme to equip leaders within critical care with the skills to deal with challenging conversations. The freedom to speak up guardian undertook walk arounds and made themselves more visible to staff. The trust was also liaising with an external provider to provide additional support for staff around identifying, highlighting and addressing bullying and other negative behaviours. As a result of the concerns raised, the matron also introduced a health and wellbeing, behavioural standards group and individual staff were offered coaching and mentoring to improve their management skills.
The trust had participated in the ‘NHS Bullying call to Action’ programme and through this had raised awareness of understanding bullying and harassment and how it could be effectively tackled.

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. The trust had a being open policy. Staff were aware of their responsibility to be open, transparent, and honest and were able to give examples of when they had offered patients and relatives an apology. Senior staff were aware of the trust’s policy and their requirement to apply duty of candour for any incident that was investigated and categorised as moderate or above and knew the thresholds for when the duty of candour process was to be triggered.

The trust monitored compliance against requirements for duty of candour through their serious incident executive review panel (SIERP) and quality and risk management group (QRMG) reporting by exception to their quality and risk committee and the board of directors. In 2018/19, the trust reported 14 serious incidents and duty of candour was completed in 100% of cases.

The trust had a guardian of safe working (GOSW). The role of the GOSW was to protect patients and doctors by making sure doctors were not working unsafe hours. The Guardian was required to produce an annual report to the board to provide assurances that trainees were working safely and highlighting any safety issues, if necessary.

There was a junior doctors forum, however, participation was low due to timing and availability. Throughout our inspection, we heard that since the move to the new hospital concerns had been raised concerns about the adequacy of desk space and computer access in their work environment; availability of on-call rooms or access to somewhere to sleep after a night shift if they felt it was not safe to travel and availability of rest space during night shifts. These issues had been raised with the hospital senior leadership team and steps were being taken to address them.

Systems and processes were in place to address behaviour and performance that was inconsistent with the trusts vision and values. The trust suspended or supervised the practice of 12 members of staff from March 2018 to February 2019.

**Staff Diversity**

The trust provided the following breakdowns of staff groups by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Nursing and midwifery registered (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>31.5%</td>
<td>50.2%</td>
<td>76.2%</td>
</tr>
<tr>
<td>White other</td>
<td>27.9%</td>
<td>21.0%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Mixed</td>
<td>2.3%</td>
<td>1.7%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Asian / Asian British</td>
<td>23.0%</td>
<td>16.2%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Black / Black British</td>
<td>2.3%</td>
<td>2.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>6.3%</td>
<td>0.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>3.6%</td>
<td>5.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Unknown / Not stated</td>
<td>3.2%</td>
<td>2.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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

The trust had a comprehensive equality and diversity policy. This set out the framework for how the trust would ensure legislative requirements such as the Equalities Act 2010 and Human

Staff at all levels were provided with equality and diversity training as part of their mandatory training. Throughout our core service inspection, we observed the trust exceeded its targets for staff completion of this training. The trust had an equality, diversity and inclusivity steering committee that met on a bi-monthly basis.

The trust used the Equality Delivery System (EDS2) as a tool to help them deliver against their statutory requirements in relation to staff and patients.

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.

The trust’s 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversity & inclusion
- Health & wellbeing

(Source: NHS Staff Survey 2018)

Each clinical area had their own staff survey action plan which was determined by their individual scores.
Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.
As of 2018, two of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BAME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (1.9% of BME staff compared to 6.9% of White staff). This decreased by 0.2% compared to the previous year, 2017, although this wasn’t a significant change over time.

2. In 2018, BAME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (17.3% of BME staff compared to 27.7% of White staff). This increased by 7.4% compared to the previous year, 2017 which was a statistically significant improvement.

Of the four indicators from the NHS staff survey 2018 shown above (indicator 5 to 8), the following indicators showed a statistically significant difference in score between White and BAME staff:

6. 36.4% of BME staff experienced harassment, bullying or abuse from staff in the past year (2018 NHS staff survey) which was significantly higher when compared to 27.5% of White staff. The score increased by 10.2% compared to the previous year, 2017, although this wasn’t a significant change over time.

7. 72.5% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 86.8% of White staff. The score decreased by 2.0% compared to the previous year, 2017, although this wasn’t a statistically significant change over time.

8. 19.9% of BAME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey which was significantly higher when compared to 7.1% of White staff. The score increased by 4.9% when compared to the previous year, 2017, although this wasn’t a significant change over time.

There were no BAME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BAME staff.

(Source: NHS Staff Survey 2018; NHS England)

At the time of our well-led inspection there were five members of staff from a BAME background who were in a band 8a position.

The trust was well sited on its strengths and weaknesses around WRES and had an action plan that was monitored through the access and facilities group which comprised members of the council of governors, staff representatives and external stakeholders as well as the senior trust managers. The trust’s WRES action plan identified the stepping up programme would be widely advertised to enable all appropriate staff members to apply for the programme.
The trust published its annual WRES report and action plan through its external trust website. This meant the report was accessible to members of the public. The action plan was reviewed on a bi-monthly basis by the equality, diversity and inclusivity steering group. Key actions on the WRES action plan were:

- Improving the diversity of the board
- Introducing unconscious bias training for line managers
- Refreshing the governance of WRES
- Setting up a BAME staff network to improve engagement with BAME staff.

**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 March 2018 to February 2019.

(Source: Friends and Family Test)

**Sickness absence rates**

The trust’s sickness absence levels from January to December 2018 were below the England average. Over the same time period, the trust’s performance followed a similar pattern to the England average.
General Medical Council – National Training Scheme Survey

In the 2018 General Medical Council Survey the trust performed the same as expected for all 18 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 effective structures, systems and processes in place to support the delivery of its strategy.

The trust board was supported by five sub committees, that met regularly to ensure trust services and systems were performing to required expectations. These include the:

- Audit committee
- Quality and risk committee
- Remuneration committee
- Performance committee
- Strategic projects committee

These board assurance committees provided assurance to the board on the performance and operation of the trust

The Trust had a clear structure to indicate further groups, such as the Quality and Risk Management Group (QRMG) as part of its governance framework to ensure a system to support the continuous improvement in the quality of care. This group approved and monitored policies and procedures to ensure patient care was safeguarded and promoted an organisational culture
that encouraged patients, visitors and staff to report any concerns they may have or make suggestions for improvement. The QRMG met on a four weekly basis and was chaired by the trust’s clinical governance Lead. A quarterly quality and risk report was produced and published on the trust’s public website.

There were clear lines of communication and accountability between the chief pharmacist and the trust’s board. Medicines risks, and incidents were raised at the medicine’s safety group, which linked to the board through the QRMG, for which there was also good pharmacy representation.

Papers for board meetings and other committees were of a good standard and contained appropriate information. We reviewed a number of papers as part of our inspection including for example, minutes from board meetings, the audit committee, the quality and risk committee and the performance committee. Minutes were found to be clear and well presented with clear actions identified.

The board of directors held public meetings monthly. The meetings covered a range of strategic as well as operational topics. Members of the public were invited to attend the board meetings. Proposed dates and times for these meetings was published on the trust’s public facing webpage.

We studied board and committee papers and attended a trust board meeting prior to our inspection. 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 act 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.

**Board Assurance Framework**

The trust had a clear board assurance framework (BAF) that formed part of the overall risk management and assurance process of the trust and enabled the board to maintain oversight of the principle risks to the delivery of the trust’s strategic objectives. This was underpinned by a BAF policy that had been updated and approved by the trust’s quality and risk committee in April 2019. BAF risks were mapped to the trust’s strategic objectives. The risks were reported through the trust’s electronic risk management system and where appropriate, were escalated to the relevant trust committee structure.

The trust provided their Board Assurance Framework, which detailed eight objectives. A summary of these is below.

1. To deliver continuous quality improvement
2. Activity plan and meet patient access targets
3. Support and engage with staff
4. Enhance trust reputation as an employer
5. Deliver a safe and effective move
6. Deliver trust financial plan
7. Work closely with STP partners to agree a high quality plan
8. Innovate at the new hospital.

(Source: Trust Board Assurance Framework – March 2019)

At the time of our well-led inspection, the key risks to delivery of the trust’s strategic objectives for 2019/20 related to:

- Workforce, and the need to focus on recruitment and retention to support the trust’s flow and ability to deliver activity.
- Failure to optimise the new hospital to deliver activity plans and meet patient demand.
- The consequent financial impact on sustainability and the trust’s contribution to the wider system.

BAF action plans were reviewed monthly and were captured through the trust’s electronic risk management system. The trust had a BAF tracker that set out the BAF risks within and above the trust’s risk appetite. The BAF tracker included an indicator for movement in month, a long term trend line for each open risk, and identified the executive lead and the committee responsible for each BAF risk.

Executive directors reviewed open BAF risks monthly and the BAF risks were brought to the relevant trust sub committee at each meeting.

At the time of our well-led inspection, there were 22 risks above the trust’s risk appetite and eight risks that were below the trust’s risk appetite.

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.

Finances Overview

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£151.4m</td>
<td>£148.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£2.6m</td>
<td>(£53.1m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>(£148.8m)</td>
<td>(£201.9m)</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£1.8m</td>
<td>(£29.2m)</td>
</tr>
</tbody>
</table>

Projections for 2018/19 indicate that the deficit will decrease compared to 2017/18.

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

Following the inspection, the trust provided their actual year-end figures for 2018/19, which showed an income of £167.9m, with a deficit of £10.2m. The full costs equated to £178.3m, giving a budget deficit of £16.8m.

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

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from one to four, where ‘four’ reflects providers receiving the most support, and ‘one’ reflects providers with maximum autonomy. A Foundation trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence. At the time of our well-led inspection, Royal Papworth Hospital NHS Foundation Trust was in Segment two. Although there was no finance committee at this trust, risks were escalated through the audit committee and the performance committee.

The trust’s financial position reflected a period of significant change which had included the implementation of an electronic patient record (EPR) system and the impact of a move to a new PFI hospital.

The movement from a bottom line surplus of a £2.61m in 2016/17 to a deficit of £53.1m was predominately driven by:

- the transition of the new hospital, with the impairment of £44.8m in 2017/18 for the new site.
- the removal of the sustainability and transformation fund (STF) of £3.0m in 2016/17 (the trust was unable to accept its control total in 2017/18).
- the decrease in activity (leading to reduced income) during the implementation of the new EPR as staff transitioned to using the new system.

The 2018/19 deficit position was driven by the fixed costs of around £11m the private finance initiative (PFI) contract for the new hospital, together with increased depreciation of the new buildings and equipment.

In addition to the land and buildings, the trust had a £37.3m equipping programme split between 2017/18 and 2018/19.

The trust was planning to deliver a bottom line surplus position in 2019/20. To include profits from the sale of the old hospital site, as well as delivery of a CIP of £5.0m (2.9%). On a Control Total basis, the 2019/20 position is set to be a £nil (breakeven) position.

**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 provided their board assurance framework detailing 43 open risks. The risks were linked to the trust’s strategic objectives. A summary of their highest scoring risks which scored 15 or above (out of 25) is below.
<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk appetite (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/06/2014</td>
<td>678</td>
<td>If the trust fails to meet its RTT trajectory and cancer waiting targets then this will result in a poor patient experience, could damage its reputation and reduce its income.</td>
<td>16</td>
<td>12</td>
<td>05/03/2019</td>
</tr>
<tr>
<td>01/01/2015</td>
<td>744</td>
<td>If the trust is non-compliant with regulation and national guidance due to a lack of application, process, evidence or assurance then this will result in potential challenge from patients, commissioners and regulators which may lead to failure to register the new hospital site with the CQC</td>
<td>15</td>
<td>6</td>
<td>04/02/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>833</td>
<td>If the activity within the contract base for 18/19 is not achieved, then the trust will significantly increase its deficit as the fixed costs are incurred.</td>
<td>20</td>
<td>12</td>
<td>06/03/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>835</td>
<td>If cost control measures are not heightened, then the current cost base is unsustainable contributing to an ongoing deficit.</td>
<td>20</td>
<td>10</td>
<td>06/03/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>836</td>
<td>If the trust does not meet growth targets, then this will lead to lower income/cash levels but no reductions in cost levels so a higher level of deficit is made.</td>
<td>25</td>
<td>12</td>
<td>08/02/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>837</td>
<td>If the case mix changes towards loss making procedures, then the overall profitability changes which will cause an income and expenditure and cash pressure.</td>
<td>20</td>
<td>12</td>
<td>08/02/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>841</td>
<td>If the trust does not have a board approved SIP programme of projects that extends beyond 18/19 then the likelihood of transformational change and savings is greatly reduced.</td>
<td>20</td>
<td>12</td>
<td>08/02/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>843</td>
<td>If the trust does not meet its SIP/CIP targets it then causes short term income and expenditure and cash pressure and it also widens the gap to being able to afford for the unitary payment in 18/19</td>
<td>20</td>
<td>12</td>
<td>08/02/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>865</td>
<td>If the activity transfers from local trusts as part of the transition and local health economy work are not profitable then the deficit level will be increased.</td>
<td>20</td>
<td>12</td>
<td>24/01/2019</td>
</tr>
<tr>
<td>01/02/2016</td>
<td>869</td>
<td>If the activity and capacity assumptions are not valid for the theatres and catheter labs then the consequence increased costs due to the operating areas being under utilised.</td>
<td>20</td>
<td>10</td>
<td>08/02/2019</td>
</tr>
<tr>
<td>17/02/2016</td>
<td>1021</td>
<td>Potential for cyber breach and data</td>
<td>15</td>
<td>3</td>
<td>04/03/2019</td>
</tr>
<tr>
<td>Date risk opened</td>
<td>ID</td>
<td>Description</td>
<td>Risk score (current)</td>
<td>Risk appetite (target)</td>
<td>Last review date</td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>22/09/2017</td>
<td>1695</td>
<td>If the trust was attacked by malware then the legacy system would be exposed to compromise as they are no longer patched/patchable. The ICT server estate is using older operating systems including Server 2003, 2008 and Windows 7, SQL 2008, Office 2010, which now beyond, or about to be beyond Microsoft support meaning vulnerabilities will no longer be addressed. These servers are susceptible to attack and potential compromise.</td>
<td>16</td>
<td>12</td>
<td>01/03/2019</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>1853</td>
<td>If there are insufficient workforce levels to meet the staffing requirements of the new Papworth Hospital, then planned levels of service and activity will not be achieved and temporary staffing costs will be increased.</td>
<td>16</td>
<td>6</td>
<td>25/01/2019</td>
</tr>
<tr>
<td>27/04/2018</td>
<td>1854</td>
<td>If turnover does not reduce turnover to target level then the trust will lose key skills and reduce the levels of experience in the workforce, incur additional costs in the form of recruitment costs and temporary staffing spend, see a reduction in staff engagement and satisfaction and be unable to maintain safe staffing levels and achieve activity levels.</td>
<td>16</td>
<td>6</td>
<td>25/01/2019</td>
</tr>
<tr>
<td>23/07/2018</td>
<td>1929</td>
<td>If the trust is unable to attract and recruit staff to meet its workforce plan, as defined by the gateway process, then it will be unable to ensure safe staffing levels, maintain levels of activity required by the capacity and demand plan, achieve the levels of income required by the financial improvement plan contain pay spend within budgeted levels and staff engagement and retention will be negatively impacted.</td>
<td>16</td>
<td>9</td>
<td>25/01/2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If there is not good staff engagement then staff turnover, recruitment, sickness absence, staff morale and team working will be negatively impacted. The evidence also shows that poor staff engagement negatively impacts on patient outcomes and experience and on the organisation’s financial performance. The current recommender score as a place to work is significantly lower than</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date risk opened</td>
<td>ID</td>
<td>Description</td>
<td>Risk score (current)</td>
<td>Risk appetite (target)</td>
<td>Last review date</td>
</tr>
<tr>
<td>------------------</td>
<td>----</td>
<td>-------------</td>
<td>---------------------</td>
<td>-----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the national average. The main drivers for this are the organisational change linked to the relocation of the hospital and staffing levels in some clinical areas.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: Trust Board assurance framework – March 2019)

A daily safety briefing was held across the trust to identify risks in terms of staffing, vulnerable patients and infection control. This enabled an oversight trust wide to ensure any mitigating actions could be put in place. The daily safety brief was led by the Duty Matron,

The trust carried out various audits to check their compliance against the quality standards. The pharmacy risk register was part of the trust register and was regularly reviewed. There was no clinical pharmacy service on the day wards, and there were no current plans to improve this. Medicines reconciliation rates within 24 hours were lower than the national average, we were told that this was due to the nature of the hospital where most patients received planned surgery on the first day of admission and therefore unlikely to be seen by a pharmacist. Patients were seen in pre-assessment clinics by pharmacists, where a medicines history was taken, however this was not included in the medicines reconciliation rates. There were no medicines management technicians (MMT) able to reconcile medicines, however an internal programme had been developed to train MMTs to carry out this task.

**Information management**

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

Performance throughout the trust was reviewed by the board using the Papworth integrated performance report (PIPR). Performance was assessed under seven key domains using a balanced scorecard approach. Financial performance was supplemented by a more detailed finance report to the performance committee and board each month.

Since our previous inspection, in June 2017, the trust had introduced a new electronic patient record system that had improved the trusts recording of information and captured clinical information as well as improving transparency relating to data quality and performance. The system generated an overall monthly trust performance rating and performance was tracked over time.

At the time of our well-led inspection, the trust had introduced a business intelligence function to its EPR system. The most recent example being the referral to treatment time module, which gave a near real time visibility on performance against access targets and patient pathways. This had led to the trust achieving the status of global digital exemplar.

The trust’s digital team had won an award after launching the hospital's new EPR system, where they took the top prize in the tech project of the year category at the health tech newspaper awards 2018.

The trust had an electronic prescribing and medicines administration (EPMA) system that covered all the areas except critical care which had its own specialist EPMA system.

The trust board had good oversight of pharmacy key performance indicators, which were reported through directorate meetings. Medicine reconciliation rates and discharge medicines turnaround times were reported through the directorate performance review meetings on a monthly basis.
The trust saw information governance as a high priority and this was supported by an information governance steering group. The trust had completed its submission of the data protection and security toolkit in March 2019. All standards were declared as met.

**Engagement**

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

The trust’s staff engagement score in the 2018 NHS staff survey was slightly lower than the national average 7.2 (average 7.4).

The senior leadership team saw staff and public engagement as important in driving improvements throughout the trust. There was a real focus on staff well-being and the approach to care throughout the trust was patient and family centred.

Patient feed back throughout the trust was obtained by a variety of means, including:

- Friends and family test
- Patient surveys
- PALS enquiries including compliments and complaints
- Patient stories, which were shared at the trust’s board meetings
- Patient support groups
- Patient and carer experience groups
- Patient and public involvement committee, which was governor led
- Quality and risk committee

The trust also engaged with patients through the 15 steps challenge. This is a tool that is used to help the trust understand what good quality care looks and feels like from a patient and carer perspective. This was led by a senior nursing team with input from patients and governors. The 15 steps challenge involves taking 15 steps into a clinical area and using all senses to quietly observe interactions within the area. It also involves speaking with patients and staff. Following the 15 steps challenge a report was written and where appropriate an action plan was implemented. These were reviewed at the trust’s patient and carer experience group (PCEG) which was chaired by the deputy chief nurse.

Members of the public were invited to join the trust’s board meetings and could ask questions if they wished.

Staff engagement took place through several forums including:

- A weekly staff briefing that was led by the chief executive officer
- Staff engagement champions
- Freedom to speak up guardian
- Quarterly pulse surveys
- Staff side partnership working
- Chief nurse coffee mornings and afternoon tea
- Staff governors
- Non-executive director engagement
- Executive team ‘In your shoes’ visits

During 2018, the trust had developed a formal mechanism for capturing positive feedback in recognition of any member of staff who had gone the extra mile to support their colleague or improve patient safety and or the patient experience. This was known as laudix and had been received very positively by all staff across the trust.
Staff engagement also took place through the trust’s network of ‘care makers.’ These were staff of all levels and disciplines, including students and qualified staff who acted as ambassadors for the six Cs. The six Cs are a set of values for all health and social care staff and comprise of care, compassion, competence, communication, courage and commitment. These ambassadors were passionate about inspiring people to practice person-centred care throughout the trust. Staff members who had demonstrated any of the six Cs in a positive way were nominated for a care makers certificate.

The executive directors undertook regular patient environment rounds. These were first introduced in March 2018 and included an executive director, matron, a member of the infection prevention and control team, a member of the cleaning team and a member of the estates team. These rounds enabled the team to engage with staff around risks within the environment and to take action where required.

The trust carried out staff surveys annually, however as the trust had recently moved sites results from 2018/19 related to the previous hospital environments and culture.

The trust used a weekly ‘Our Big Move’ briefing to senior staff members to ensure they received regular updates on the move to the new hospital, as well as giving staff the opportunity to ask questions or raise concerns. The briefings were well-attended, and managers monitored how well these updates were being shared to wider staff groups with monthly pulse surveys of staff. The trust held exhibition-style events to update all staff on the developments with regards to the move and produced weekly NewsBites and monthly NewsBeat communications to all staff.

Pharmacy leaders regularly engaged with pharmacy staff through weekly staff meetings and the department also undertook patient satisfaction surveys.

The trust also engaged with external stakeholders through the Cambridgeshire University Health Partners (CUHP) around education and campus development. The sustainability transformation partnership (STP) around the sustainability of cardiology services and clinical commissioning groups.

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.

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

The chief pharmacist or representatives participated in the medicine’s safety network, antimicrobial stewardship and Clinical Commissioning Group (CCG) meetings. The chief pharmacist was also part of the East of England network of chief pharmacists where learning was shared.

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 a quality improvement programme that had been underway since the trust’s quality strategy was launched in 2015. This was refreshed again in 2018 and published in 2019. This also set out the quality improvement responsibilities of staff at all levels throughout the trust. The quality strategy included a focus on improving patient safety ad the trust used its quality accounts as a vehicle to identify annual quality improvement programmes.

Staff throughout the trust were encouraged to develop ideas to improve patient services and outcomes. The trust had an active quality improvement programme and a research and
development team who supported research into practice. The trust's professional practice team supported the development of training and courses that had received international recognition. For example, the extra corporeal membrane oxygenation (ECMO) course that had been delivered by staff at the trust and was being delivered throughout other organisations.

Staff were supported to celebrate innovation and the trust held staff awards on an annual basis which had a category to celebrate innovation in practice. The 2019 Awards were held prior to our inspection at the new Royal Papworth Hospital site, prior to the hospital being fully occupied.

A weekly review of the trust's patient experience tracker was undertaken by the chief nurse and the deputy chief nurse. All negative comments were reviewed and where appropriate action was taken. This was shared throughout the trust through 'you said, we did' notices. In addition, compliments were selected and shared throughout the trust. This facilitated learning from patient experience.

Learning from deaths

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.

The trust used the Royal College of Physicians' structured judgement review methodology to review deaths. Responsibility for case record reviews sat with the clinical directors, clinical leads and mortality and morbidity leads and was overseen by the clinical governance manager and associate medical director.

Deaths that had occurred in the previous week were discussed the following week at the trust’s serious incident executive review panel (SIERP) where they were linked to case record reviews and incident investigations.

The case record review process was undertaken alongside existing clinical governance processes including serious incident investigations and mortality and morbidity meetings. If a patient’s death was considered more than 50% likely to have been potentially avoidable following case record review, this was reported as a patient safety incident and triggered the investigation process.

Between April 2018 and March 2019, 163 patients had died at Royal Papworth Hospital NHS Foundation Trust. Of these 163 deaths, 61 were reviewed by case record review, five were investigated by incident investigation and one was considered more than 50% likely to have been avoidable.

This case was identified and investigated through the serious incident investigation. Lessons learnt included the need to clearly assess and communicate the introduction of new clinical equipment into a clinical area. This led to new processes being set up for the risk assessment of new clinical equipment, appropriate training, correct storage and labelling and communication within clinical teams.

At the time of our inspection, the trust had appointed a medical examiner to support the learning from deaths work being undertaken by the trust.
Incidents

The trust had a procedure for the reporting of accidents, adverse events, incidents and defects. The board of directors were ultimately responsible for the safety of patients, staff and visitors and the organisation’s assets and reputation. Delegated authority for specific issues was assigned to sub committees of the board of directors.

The trust had a clinical governance and risk management team, which included the chief nurse, lead consultant for clinical governance, assistant director for quality and risk, the risk manager and risk officer.

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.

All moderate harm incidents and above have investigations and associated action plans, which were managed by the relevant business unit and monitored by the quality and risk management group (QRMG). Lessons learnt were shared across the organisation through the trust’s quarterly lessons learnt report through the intranet, grand round presentations and locally were shared throughout the Business Units and specialist meetings.

The trust held weekly serious incident executive review panel (SIERP) meetings to review all incidents with moderate or serious harm and any deaths. Meetings were chaired by the medical director or the chief nurse and were multidisciplinary and included all specialities. Meeting minutes from the SIERP were shared across services through the business unit meetings.

The weekly SIERP provided the panel with the opportunity for review of incidents and immediate action and learning was shared the minutes and reported through the appropriate committee and the Board. The panel routinely review all moderate harm and above and listened to any concerns raised by staff or that were referred by other organisations. The Trust actively applied the ‘just culture tool’ and discusses staff support at the meetings. In the case of any serious incident the family liaison link liaised with the family to establish whether they wished to contribute to the terms of reference for the investigation.

Incident reporting was encouraged trust wide and medicines related incidents were discussed at the Medicines Safety Group. We were given examples of when learning had been shared widely and actions that had been taken to prevent a reoccurrence of similar incidents. Appropriate processes were in place to ensure changes to national guidelines were adopted in a timely manner in the trust.

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. We reviewed three incidents as part of our inspection and found the level of investigation to be robust and where appropriate duty of candour was invoked.

Complaints process overview
The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff.

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

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25</td>
<td>100%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3,018</td>
<td>(March 2018 to February 2019)</td>
</tr>
</tbody>
</table>

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

**Number of complaints made to the trust**

The trust received 56 complaints from March 2018 to February 2019. Medical care received the most complaints with 21 (37.5% of all complaints received trust wide).

A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people’s care)</td>
<td>21</td>
<td>37.5%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>17</td>
<td>30.4%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>9</td>
<td>16.1%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>6</td>
<td>10.7%</td>
</tr>
<tr>
<td>AC - Critical care</td>
<td>2</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>56</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The most common subject of the complaints was communications which accounted for 24 complaints (42.9%).

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

The trust had a clear policy framework for managing and learning from complaints. Trends and data collected from formal complaints received by the trust were reported to the quality and risk management group on a quarterly basis through the quarterly quality and risk report. Lessons learnt, and actions taken following investigation of formal complaints were detailed in the report, which also included Patient Advice and Liaison Service (PALS) feedback and patient incidents.

The quarterly Quality and Risk report was available on the trust’s intranet for staff to access and was also available to members of the public through the trust’s public website.

The inspection team reviewed three 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.

**Compliments**

From February 2018 to March 2019, the trust received a total of 5,963 compliments. The trust did not provide a breakdown of compliments at core service level.
The trust reported themes in compliments include general thank you, happy with care and support, excellent treatment and being treated with dignity and respect.

(Source: Routine Provider Information Request (RPIR) – Compliments)

The pharmacy department had set up a ‘research café’ to promote research and audits in specialist areas. Staff were supported to enhance their knowledge and learning. Ninety-six per cent of the eligible pharmacy workforce were non-medical prescribers.

The trust had taken part in national benchmarking but had found it difficult to identify similar trusts due to the nature of the specialist services they provide.

**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.

Below is a list of the trust’s services which have been awarded an accreditation or are working towards one:

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Pathology Accreditation and its successor Medical Laboratories ISO 15189*</td>
<td>Blood Sciences</td>
<td>September 2018</td>
</tr>
<tr>
<td></td>
<td>PHE</td>
<td>September 2018</td>
</tr>
<tr>
<td>Human Tissue Authority (HTA) License</td>
<td>Post mortem</td>
<td>April 2018</td>
</tr>
<tr>
<td></td>
<td>Research</td>
<td>April 2018</td>
</tr>
<tr>
<td>Medicines &amp; Healthcare products Regulatory Agency (MHRA) compliance</td>
<td>Transfusion</td>
<td>April 2018</td>
</tr>
<tr>
<td>Quality in Primary Immunodeficiency Services (QPIDS) five year accreditation</td>
<td>Immunology</td>
<td>November 2018</td>
</tr>
<tr>
<td>NHS Blood and Transplant (NHSBT) Annual Report on Cardiothoracic Organ Transplantation</td>
<td>Surgery</td>
<td>September 2018</td>
</tr>
<tr>
<td>National Institute for Cardiovascular Outcomes Research (NICOR) report</td>
<td>Royal Papworth Hospital</td>
<td>2014 to 2017</td>
</tr>
</tbody>
</table>

* Histopathology withdrew from the process as the hospital was moving and will be commissioned by another trust.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Medical care (including older people’s care)

Facts and data about this service

Royal Papworth Hospital NHS Foundation Trust is a regional centre for the diagnosis and treatment of cardiothoracic disease for patients in the East of England.

The Trust is also a national centre for a range of specialist services including heart and lung transplantation, pulmonary endarterectomy (PEA) and extra corporeal membrane oxygenation (ECMO).

The Trust has the largest specialist respiratory support and sleep service in the UK.

Core services include:

- Cardiac services - interventional cardiology (coronary intervention and structural intervention), electrophysiology and devices, diagnostics and physiology.

- Thoracic services - lung infection (cystic fibrosis, immunology and lung defence), interstitial lung disease, pulmonary vascular disease, respiratory physiology, respiratory support and sleep centre (RSSC) and thoracic oncology.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 17,547 medical admissions from January to December 2018. Emergency admissions accounted for 1,281 (7.3%), 6,030 (34.4%) were elective, and the remaining 10,236 (58.3%) were day case.

Admissions for the top three medical specialties were:

- Respiratory medicine: 9,961
- Cardiology: 7,084
- Adult cystic fibrosis service: 488

(Source: Hospital Episode Statistics)

During our inspection we spoke with 37 staff including doctors, nurses, therapists, health care assistants and non-clinical staff. We spoke with eight patients and their relatives, reviewed 16 patient records and considered other pieces of information and evidence to come to our judgement and ratings. We visited six clinical areas including wards, catheter labs, and day procedure unit.

At our last inspection (December 2014), medicine was rated requires improvement overall with effective and caring rated good; safe, responsive and well-led rated 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.

At the time of inspection, the trust had taken the decision to allow annual mandatory refresher training to be completed outside the 12-month window in order that staff could complete familiarisation training in preparation for the move to the new hospital instead.

Mandatory training completion rates

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

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and diversity</td>
<td>176</td>
<td>178</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety</td>
<td>176</td>
<td>178</td>
<td>98.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>174</td>
<td>178</td>
<td>97.8%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (Level 1)</td>
<td>173</td>
<td>178</td>
<td>97.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - 1 Year</td>
<td>161</td>
<td>178</td>
<td>90.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>160</td>
<td>178</td>
<td>89.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>160</td>
<td>178</td>
<td>89.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>156</td>
<td>174</td>
<td>89.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>141</td>
<td>178</td>
<td>79.2%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

Nursing staff received and kept up to date with their mandatory training. In medicine the 90% target was met for five of the nine mandatory training modules for which qualified nursing staff were eligible. The target was almost met for a further three modules; adult basic life support, information governance and medicine management training (89.9% and 89.7% compliance).

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

Senior leaders told us the trust had made a decision to promote familiarisation training at the new site ahead of yearly refresher mandatory training. Band 6 staff and above achieved 97% and band 5 staff and below achieved 90% in a three month period against the trust’s target of 75%. The service had a plan to bring mandatory training compliance back in line with trust target now staff were settled at their new site.

Whilst data provided ahead of the inspection showed that nursing staff training for conflict resolution was not at trust target, data seen on site showed that staff training levels now met the trust target of 90%.

The mandatory training was comprehensive and met the needs of patients and staff. It covered core areas such as infection control, adult basic life support and medicines management amongst others. Training was provided as online learning and face to face sessions. Staff told us that it was usually easy to access training, though on occasion, training was cancelled at short notice.

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for medical staff in medicine is shown below:
In medicine the 90% target was met for two of the nine mandatory training modules for which medical staff were eligible.

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

Medical staff received mandatory training but not all of them had kept up to date. The trust were aware of this and had an action plan to address the shortfall. We requested more recent data, this showed medical staff in the medicine division were still failing to meet trust target although there had been a small improvement.

Managers monitored mandatory training and alerted staff when they needed to update their training. We spoke with one of the trust’s training leads who was able to demonstrate how the trust’s electronic system recorded the dates of when staff training was due to expire.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. 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 the completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>175</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>175</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>174</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>173</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>3</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>3</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff were eligible. The only courses not to meet the target were the two level 3 modules, which also had a low number of eligible staff.
A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>103</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>103</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>94</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>94</td>
</tr>
</tbody>
</table>

In medicine the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible. Level 2 children’s and adult’s safeguarding were the modules in which medical staff didn’t meet the 90% target.

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

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Most staff were trained to the appropriate level for safeguarding adults and children. On inspection, we saw that staff requiring safeguarding level 3 training were now at trust target completion rate.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. All the staff we spoke with were able to describe their responsibilities if they had a safeguarding concern and how they were able to escalate their concerns to safeguarding leads or where appropriate, make a referral to the local authority.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A safeguarding policy supported staff to protect people’s welfare. The policy was electronic, in date for review and included the definitions of abuse as well as recognising patients’ rights under equality and diversity legislation.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff showed us how they could access safeguarding referral information through the trust’s intranet. The chief nurse was the named safeguarding adults lead.

Staff followed safe procedures for children visiting the ward. Staff we spoke with were aware of child safeguarding procedures including those children who were visiting the wards and other clinical areas. Staff were aware of who the trust’s safeguarding leads were, where to go for advice and how to make a referral if they needed to.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. All clinical areas including the wards and cardiac catheter labs were visibly clean and free from clutter. There were schedules detailing the cleaning regime in each clinical area and environmental audits were also completed in each area.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Data we saw in inspection showed that all the medical areas we visited achieved or exceeded the trust wide cleaning target.
Staff followed infection control principles including the use of personal protective equipment (PPE). There was enough PPE on wards and in other clinical areas and it was readily available. In high risk areas such as in the cystic fibrosis ward, staff wore full length disposable gowns that covered their entire uniform as well as disposable gloves and masks if needed, to protect patients from health care associated infections. These were discarded immediately before they left the patients room. We saw staff observing the trust’s ‘bare below the elbow’ policy and they washed hands between all patient contacts.

There was hand sanitiser placed around the wards and other public areas and we observed staff using this.

In the cardiac catheter labs, staff completed scrub washing as required ahead of procedures. Staff used sterile gowns and gloves for interventions.

Hand hygiene audits met or exceeded the trust’s target for compliance in all the medical areas we visited.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff cleaned equipment according to trust’s policy. ‘I am clean’ stickers were affixed to equipment that had been properly decontaminated and indicated to staff that they were ready to use for other patients.

Staff used a specialist ultraviolet cleaning device to undertake a deep clean of each room between each patient. Staff labelled rooms as clean.

The housekeeping team carried out weekly audits on each ward in the presence of the matrons. Audit scores met or exceeded trust targets.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Medical care was provided across three floors. Third floor; respiratory support and sleep centre (RSSC) and the cardiology ward. Fourth floor; lung defence, respiratory and cystic fibrosis (CF) ward. The catheterisation laboratories (Cath labs) and bronchoscopy rooms were located on the ‘hot floor’; floor one.

The design of the environment followed national guidance. The hospital had opened approximately six weeks prior to our inspection. It was a new build and had been specifically designed to meet the needs of patients and enable staff to deliver and further develop specialist services. As such, the building was in an exceptional state of repair.

Staff had been engaged throughout the design process, over some years, to enable an understanding of the needs of patients were to receive care and treatment in the new building. Except for two four-bed bays, all rooms were single rooms. Large glass doors ensured visibility of patients by staff, with curtains and designs on the glass to afford patient privacy.

All of the rooms were spacious enabling enough room to use specialist equipment such as hoists and medical devices. All rooms had an en-suite and were completely accessible for patients with restricted mobility.

Each room had health monitoring equipment such as blood pressure machines, observation machines for patients’ heart rate and rhythm and pulse oximetry. Data from these readings were recorded directly into patient records as well as informing the alert team if there were concerns. The readings were also displayed in real time if required on screens at the nurses’ station.
The cardiac catheter labs had also been designed in such a way as to facilitate patient care and improve outcomes. It was clear that the patient pathway had been designed to maximise patient safety and reduce risk. For example, the primary percutaneous coronary intervention (PCI) pathway meant patients were taken from an ambulance and into a catheter lab in under two minutes.

There had been a significant investment in new equipment in all clinical areas. Staff told us they had enough equipment to safely care for patients and to do their job. This was the same in ward areas as well as the cardiac catheter lab. Equipment was purchased to ensure patients were as safe as possible, allowed staff to work effectively and offered some ‘future proofing of the organisation’. We saw that the design and fitting of one of the theatres with catheter laboratory equipment meant that there was scope for future service development and increasing the capacity and complexity of cases cared for.

Patients could reach call bells and staff responded quickly when called. Staff on the cystic fibrosis ward could speak with patients over an intercom from the nurse station. This was intended to avoid staff going into the patient’s room when it was not necessary in order to reduce risk of cross infection for those patients who were receiving barrier nursing.

Staff carried out daily safety checks of specialist equipment. Resuscitation trolleys including emergency equipment had been checked weekly or after use in line with trust policy. This included equipment in ward areas as well as in the cardiac catheter laboratories such as the difficult airway trolley.

The service had suitable facilities to meet the needs of patients’ families. The trust had an accommodation facility just a few minutes’ walk from the hospital. There were eight en-suite twin rooms and one en-suite single room available for families to book.

The trust had a multi faith space with a comfortable seating area which was always available to relatives and patients.

The service had enough suitable equipment to help them to safely care for patients. The trust had invested £40m into new medical equipment and operated an equipment replacement programme as part of its business planning processes.

Staff disposed of clinical waste safely. Staff disposed of clinical waste according to the trust’s policy. Staff used the correct bins for clinical and non-clinical waste. Clinical waste was collected regularly each day from the areas and taken to a secure area for disposal.

All the consumable stores we visited were well stocked. Each area had a stock rotation and ordering system. All consumables were stored appropriately and were within their expiry date.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and acted to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All patient observations were completed electronically. This automatically calculated the National Early Warning Score (NEWS 2). If the score met the threshold for escalation, the Alert team (a team of experienced specialist clinicians who supported ward and other staff) would be notified to review the patient. Records we reviewed showed that this process worked efficiently and that the Alert team reviewed the patients who were scored as at risk of deterioration in a timely way. The Alert team provided a twenty-four-hour, seven day a week service.
All staff we spoke with were positive about the support the Alert team provided. The Alert team also reviewed patients who were not scoring on the NEWS 2 scale but who staff were concerned about.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We reviewed 16 patient records and found that risk assessments including Braden scores, which are used to determine a patient’s risk of developing pressure damage, and malnutrition universal screening tool (MUST) and other assessments such as falls risk were all completed. Risk assessments were completed on admission, when there was a change in the patient’s condition and weekly. Wards ensured this was completed by instigating the ‘MUST Monday’ initiative. This ensured that all patients’ relative risk assessments were completed weekly. The records we reviewed confirmed this happened.

Staff knew about and dealt with any specific risk issues. Staff were very knowledgeable regarding the care and support that patients receiving specialist care would require. For example, staff were knowledgeable the sepsis six bundle and its requirements for those patients diagnosed with or at risk of sepsis.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). The trust had a service level agreement (SLA) with a neighbouring NHS provider for a psychiatric liaison service, which was accessible seven days a week by telephone and the physical presence of a psychiatrist or psychologist during weekdays.

Staff shared key information to keep patients safe when handling over their care to others. We saw two letters that were sent to GPs at patient discharge. Letters were appropriate and detailed when handing over patient care.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for medicine.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>152.8</td>
<td>193.7</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the nursing staffing rate within medicine was 76.3%.

The staffing rate has decreased from the previous period, March 2017 to February 2018, where the staffing rate was 78.9%. This is largely due to a rise in the number of planned posts as the number of staff in post has risen between the two time periods.

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

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance. Ward managers held safe care meetings three times per day. At these meetings managers reviewed staffing numbers to ensure care was provided safely.

The service had enough nursing staff of all grades to keep patients safe. The service was actively recruiting nurses and working towards establishment. Although trust wide, there were a significant number of nursing vacancies, the service had not opened all available beds to ensure there were
enough nurses to care for the number of patients. This was the case across all medical ward areas.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. In all the ward areas we visited, actual staffing was in line with planned staffing.

The service used a social media tool to communicate with nursing staff who were not on shift, this meant staff could be alerted to undertake additional shifts at short notice if they were available.

**Vacancy rates**

From March 2018 to February 2019 the trust reported a vacancy rate of 27.2% for nursing staff in medicine, this was higher than the trust target of 6.0%.

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

The service had reducing vacancy rates. There was a high vacancy rate for nursing staff although this was reducing. This was due to several factors. This included the trust’s recent move from its original site which had resulted in some staff leaving and an increase in the number of beds at the new hospital necessitating more staff.

The trust had taken mitigating actions. This included the use of bank and agency staff. The trust had also taken a decision to not open a significant number of beds on wards including the respiratory ward until there were sufficient staff to safely care for patients.

The trust had also recently employed an additional person in the recruitment team to improve the process of recruitment. Human resources personnel attended directorate meetings to ensure they were well informed of recruitment concerns for each service.

Shift fill rates were above 95% for nursing staff and healthcare support workers.

**Turnover rates**

The service had high turnover rates. From March 2018 to February 2019 the trust reported a turnover rate of 19.1% for nursing staff in medicine, this was higher than the trust target of 15.0%.

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

Turnover rates had seen an increase during the year preceding the trusts move to the new site in Cambridge. Early indications were that the turnover rate was improving.

**Sickness rates**

The service had low sickness rates. From March 2018 to February 2019 the trust reported a sickness rate of 3.0% for nursing staff in medicine, this was lower than the trust target of 4.0%.

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

**Bank and agency staff usage**

The table below shows the numbers and percentages of nursing hours in medicine at the trust from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

<table>
<thead>
<tr>
<th>Total Working Hours Available</th>
<th>Covered by Bank Staff</th>
<th>Covered by Agency Staff</th>
<th>Left Unfilled</th>
</tr>
</thead>
<tbody>
<tr>
<td>346,581</td>
<td>0.6%</td>
<td>4.8%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

Of the 346,581 total working hours available, 0.6% were filled by bank staff and 4.8% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 1.9% of the available hours were unable to be filled by either bank or agency staff.
Of the 155,160 total working hours available, 4.0% were filled by bank staff and 5.8% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, 4.4% of the available hours were unable to be filled by either bank or agency staff.

![Staffing Table]

(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

The service had low rates of bank and agency nurses on the wards and managers requested staff familiar with the service. The service used the same agency staff consistently. This meant these staff could provide continuity of care, had greater familiarity with the service, had a full induction and understood the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for medicine (including junior doctors in training posts).

![Medical Staffing Table]

From March 2018 to February 2019 the medical staffing rate within medicine was 92.4%.

The staffing rate has decreased from the previous period, March 2017 to February 2018, where there was an over-establishment of medical staff and the staffing rate was 101.8%. However, the number of planned posts has risen between the two time periods while the number of staff in post has only fallen slightly.

Excluding junior doctors in training posts the trust reported the following WTE medical staffing numbers.

![WTE Medical Staffing Table]

The fill rate rose from 108.4% to 139.4% between the two time periods. The number of planned posts remained the same whilst the number of staff in post rose by 2.5 WTE.

The trust has confirmed that they have more junior doctors in post than planned as they do not
often receive their full allocation of rotational trainees due to shortages across the region. This is mitigated by employing a mixture of locum appointments for service (LAS) and Clinical Fellows to cover these gaps and this inflates the employed junior doctor numbers. Secondly as a specialist trust they often attract experienced, senior clinical fellows who are close to or post certificate of completion of training (CCT). To avoid having lengthy vacancies the schedule takes into account that these clinical fellows may move on quickly which can lead to short periods of overlap between staff members.

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

The service had enough medical staff to keep patients safe. The service used a consultant of the week round. Consultants led daily board rounds except on Sundays. The service always had a consultant on call during evenings and weekends. In addition, the service had other consultants on call for specific parts of the service, for example, intervention and electrophysiology both had consultant of the week rotas. There was also a dual consultant on call 24 hours a day, seven days a week for cardiology and for respiratory services.

The medical staff matched the planned number on all shifts in each department we visited. We had no concerns about medical staffing numbers.

Vacancy rates

From March 2018 to February 2019 the trust reported a vacancy rate of 8.1% for medical staff in medicine (including junior doctors in training posts), this was higher than the trust target of 6.0%.

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

The service had reducing vacancy rates for medical staff. Recruitment of medical staff had increased following the move to the new location.

Turnover rates

From March 2018 to February 2019 the trust reported a turnover rate of 68.1% for medical staff in medicine (including junior doctors in training posts), this was higher than the trust target of 15.0%.

Excluding junior doctors in training posts the trust reported a turnover rate of 20.6%, this was higher than the trust target of 15.0%.

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

The service had a high turnover rate for medical staff. We were told that this was in part due to the uncertainty in the run up to the move in locations of the trust. Furthermore, as a specialist trust, many senior grade doctors worked for a period in training before gaining positions in other organisations.

Sickness rates

Sickness rates for medical staff were low. From March 2018 to February 2019 the trust reported a sickness rate of 0.2% for medical staff in medicine (including junior doctors in training posts), this was lower than the trust target of 4.0%.

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

Bank and locum staff usage
The table below shows the numbers and percentages of medical hours in medicine at the trust from March 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Of the 90,916 total working hours available, 1.5% were filled by bank staff and none were covered by locum staff to cover sickness, absence or vacancy for medical staff. In the same period, all the available hours were able to be filled by bank staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>March 2018 to February 2019</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></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Cardiology (senior)</td>
<td></td>
<td>42,979</td>
<td>368</td>
<td>0.9%</td>
<td>0</td>
</tr>
<tr>
<td>Chest medicine (junior)</td>
<td></td>
<td>31,251</td>
<td>853</td>
<td>2.7%</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory support &amp; sleep centre (junior)</td>
<td></td>
<td>16,686</td>
<td>119</td>
<td>0.7%</td>
<td>0</td>
</tr>
<tr>
<td>All medical staff</td>
<td></td>
<td>90,916</td>
<td>1,340</td>
<td>1.5%</td>
<td>0</td>
</tr>
</tbody>
</table>

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

**Staffing skill mix**

In January 2019, 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 84 whole time equivalent staff working in medicine at Royal Papworth Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>54%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>30%</td>
<td>29%</td>
</tr>
<tr>
<td>Junior*</td>
<td>15%</td>
<td>20%</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 - Medical (01/01/2019 - 31/01/2019)

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The trust used an electronic rostering system which took into consideration staff competencies, this ensured and appropriate skill mix for all shifts.

The service had upskilled nursing staff to be advanced nurse practitioners. This increased the skill mix on each shift.

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

Patient notes were comprehensive, and all staff could access them easily. The trust used an electronic patient record system and all relevant staff had unique login details to access them. We reviewed 16 sets of patient records and found them to be accurate and regularly updated. They reflected the needs of each patient and were sufficiently individualised to understand a patient’s individual needs and preferences.

When patients transferred to a new team, there were no delays in staff accessing their records. The majority of records were electronic and therefore there were no delays. However, referring hospitals often sent paper records with patients for example, consent forms.

Records were stored securely. For ease of access, staff stored patients’ comfort rounding charts in document holders outside each patient room. The record had the patient’s name only and were stored face down to protect patient confidentiality.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff stored medicines in locked rooms which were temperature controlled. Staff routinely monitored medication fridge temperatures. Medicines were prescribed electronically.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. Nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A pharmacist visited wards daily to review prescriptions and advise medical staff when doses needed to be revised. Patient information leaflets were provided with to take away (TTA) medicines. Pharmacists or nurses counselled patients on how to take their medicines prior to discharge.

The trust had a specialist pharmacist who provided daily pharmacy reviews for patients on the cystic fibrosis ward area. We observed a nurse describing to a patient what their take home medicines were, what they were for and when to take them.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Staff kept medicines in secure rooms. Controlled drugs (CDs) were reconciled daily by two nursing staff and records confirmed this.

Records showed that daily checks of medicines stock on the resuscitation trolleys had been performed to ensure they were fit for use and had not expired in accordance with trust’s policy. Medicines fridge records showed that medicines were stored within the recommended range.

Staff followed current national practice to check patients had the correct medicines. Pharmacy technicians visited medical wards every day and completed medicines reconciliation on a daily basis.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider had a medication safety officer who had an active role in national medication safety networks and a controlled drugs (CD) accountable officer who participated in the local CD intelligence network.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines. In all the records we reviewed we saw no patients who were having their behaviour controlled by medicines.

Incidents
The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Senior clinical staff 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. Senior clinical staff ensured that actions from patient safety alerts were implemented and monitored.

The trust held weekly serious incident executive review panel (SIERP) meetings to review all incidents with moderate or serious harm and any deaths. Meetings were chaired by the medical director or the chief nurse and were multidisciplinary and included all specialities. Meeting minutes from the SIERP were shared across services in the business unit meetings.

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 April 2018 to March 2019, the trust reported no incidents which were classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

At the time of our inspection the service had reported one never event which was a misplaced nasogastric tube. The service investigated the incident through their weekly serious incident executive review panel (SIERP), completed root cause analysis and acted to share the learning to prevent the incident from being repeated.

The trust had recently employed a medical examiner to investigate and review deaths and identify learning which was shared across all directorates.

Service leaders described a never event which had occurred in another directorate and how they had translated that learning to the staff within their service.

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported eight serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from April 2018 to March 2019.

A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>2</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
</tr>
<tr>
<td>Environmental incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>** HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
</tr>
<tr>
<td>** Total</td>
<td>8</td>
</tr>
</tbody>
</table>
** This incident relates to both a medical and surgical ward and has been counted under both core services.

(Source: Strategic Executive Information System (STEIS))

All staff knew what incidents to report and how to report them. Staff used an electronic incident reporting system to report incidents and near misses. This was in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. All staff we spoke with understood the requirements of the duty of candour regulation and could describe when it should be applied. The three incident investigation reports we reviewed evidenced that duty of candour had been carried out both verbally and in writing. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Senior clinical staff debriefed and supported staff after any serious incident. Staff involved in incidents were encouraged to demonstrate a reflective piece and were referred to educational leads to undertake continuing professional development. Service leaders described how a medical professional had received a debrief from their clinical lead following a never event.

Senior clinical staff investigated incidents thoroughly. Managers used the Yorkshire contributory factors framework and the Just Culture framework tools to investigate incidents and ensure investigations were thorough and appropriate. The trust provided investigation training to all those staff who were likely to be called upon to investigate incidents. The Yorkshire contributory factors framework is a tool that has an evidence base for optimising learning and addressing causes of patient safety incidents by helping clinicians, risk managers and patient safety officers identify contributory factors of patient safety incidents. Just Culture is a model used to improve the way investigators approach system safety and staff accountability. A Just Culture is one where all staff members feel safe to report near misses and human or system mistakes and know that these reports will be fairly evaluated and addressed.

All three incident investigation reports we reviewed confirmed patients and their families were kept informed during the carrying out of the investigation, had a nominated named individual as their point of contact and were invited to discuss findings.

Staff received feedback from investigation of incidents, both internal and external to the service and there was evidence that changes had been made as a result of feedback. Nursing staff told us about a recent serious incident and the changes to procedure that had been introduced as a direct result of the investigation, for example storing a specific piece of equipment in a more secure location. This confirmed there was sharing of learning from incidents.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. The ward managers were knowledgeable about the data and any recent falls.

Staff used the safety thermometer data to further improve services. Staff discussed safety thermometer data and had recently recruited a trust wide falls lead to further reduce the number of patient falls.
Safety thermometer harm free care was reported in the Papworth integrated performance (PIPR) report, which was presented to the trust board on a monthly basis.

The July 2019 PIPR showed that in June 2019, the trust provided 98% harm free care across all services. This was better than the target of 97%.

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 eight new pressure ulcers, two falls with harm and four new urinary tract infections in patients with a catheter from March 2018 to March 2019 for medical services.

### Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Papworth Hospital NHS Foundation Trust

1. **Total Pressure ulcers** (8)

2. **Total Falls** (2)

3. **Total CUTIs** (4)

(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)
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were stored on the trust wide intranet and all staff we spoke with were able to access them. For example, the policy for infection prevention and control – *hand hygiene*, was in date and due review in June 2020. The policy referenced the Department of Health guidelines.

Clinical leads had responsibility for ensuring that a compliance gap analysis review was undertaken for any new national institute for health and care excellence (NICE) guidelines for which they had been identified as the lead.

Clinical leads formulated an action plan to address any areas of non-compliance and shared this at the Business Unit Meetings where declarations of non-compliance were made. Action plans were then taken to the Quality and Risk Management Group (QRMG) for sign off. In addition, identified leads ensure that audits of relevant NICE guidance were added to specialty rolling annual audit plans and that those audits were registered with the Clinical Audit Department and were undertaken.

The service developed and safely used innovative and pioneering approaches to the delivery of care. For example, the clinical management programme for people with lung infections caused by non-tuberculosis mycobacteria (NTB) was developed out of research findings from the hospital and a partner organisation and was used to guide the design of the new hospital.

The service was the only service in the UK to provide endobronchial ultrasound (EBUS) and endoscopic ultrasound (EUS) during a single procedure. EBUS is a procedure used to diagnose lung cancer, infections, and other diseases causing enlarged lymph nodes in the chest. During the procedure the doctor investigates the lungs and takes samples of the lymph nodes with the aid of an ultrasound scan. Endoscopic ultrasound is a special endoscope which uses high-frequency sound waves to produce detailed images of the lining and walls of the digestive tract and chest, nearby organs such as the pancreas, liver, and lymph nodes.

The cystic fibrosis (CF) service was working with external industries to develop CF Smart Care and Project Breathe. These were projects that were looking at introducing virtual clinics for patients living with CF in order that any deterioration in the patients' health could be detected earlier.

New evidence-based techniques and technologies were used to support the delivery of high-quality care. This was evidenced in the use of the UV cleaning machines which reduce the risk of infections for CF patients.

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.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The trust wide menu was based on a two-weekly rotation. Meals included those suitable for patients who were vegetarian, vegan and those with other special dietary needs.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Nursing staff had completed the patient record accurately in the medical notes we reviewed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All the records we reviewed evidenced staff had competed the malnutrition universal screening tool risk assessment tool.
Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it. This was reflected in the notes we reviewed.

As part of ambulatory care for CF patients we saw that dieticians reviewed patients.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain and gave pain relief in line with individual needs and best practice. Staff monitored patients’ pain every two hours as part of intentional rounding. Nursing staff signed and completed records appropriately to evidence this.

Staff prescribed, administered and recorded all pain relief accurately. This was evidenced in the patient records we reviewed.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. Outcomes for people who used the service were consistently better than expected when compared with other similar services.

The service was consistently high performing, and this was recognised by credible external bodies such as The Lancet Respiratory Medicine Journal (2019).

The service actively looked for opportunities to participate in benchmarking and peer review including participation in approved accreditation schemes. The immunology service held accreditation from the Quality in Primary Immunodeficiency Services (QPIDS), which is the national accreditation scheme for primary immunodeficiency services in the UK, since November 2018.

The service provided an accredited polysomnography service which looked at complex sleep disorders. Polysomnography, also called a sleep study, is a test used to diagnose sleep disorders and records brain waves, the oxygen level in the blood, heart rate and breathing, as well as eye and leg movements during the study.

The services’ respiratory support and sleep studies service reported the highest rate of weaning success and long-term survival rate compared to any other international data for patients on the progressive care pathway who had previously received invasive ventilation in critical care. This was beneficial to patients’ quality of life and outcomes and also improved bed capacity for referring trusts.

Half of all patients with lung cancer (50%) joined research studies led by the trust with the aim of improving care and treatment for patients receiving treatment and future patients. This was better than the national average of 10%.

National cancer patient survey data showed patients treated at the trust had the second-best five-year survival rate in the country, with patients being fourth best for the one-year survival rate.

Diagnostic rates for endobronchial ultrasound (EBUS) were greater than 90% this meant patients were provided with clinically relevant disease staging enabling more specific treatments.

The service also had the highest rate of Positron emission tomography–computed tomography (PET-CT) and EBUS use for lung cancer staging. This was in line with NICE guidelines. PET-CT is a nuclear medicine technique which combines positron emission tomography (PET) and x-ray computed tomography (CT), to acquire sequential images from both devices in the same session, which are combined into a single image.
The respiratory motor neurone disease (MND) service reported greater than 50% of patients over the previous five years were treated with non-invasive ventilation (NIV), this is known to improve patient quality of life. In the respiratory support and sleep studies service (RSSC) this was over 60% of MND compared to the national average of 10%. Survival of patients receiving NIV at the hospital was 462 days compared to those treated in a prior multicentre UK clinical trial who survived on average 205 days.

**Relative risk of readmission**

From December 2017 to November 2018, all patients at the trust had a lower than expected risk of readmission for elective and non-elective admissions when compared to the England average.

**Elective Admissions – Trust Level**

![Graph showing readmission rates for different specialties](image)

*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 represents the opposite. Top three specialties for specific trust based on count of activity.*

Of the top three specialties, based on count of activity for elective admissions:

- Patients in respiratory medicine and the adult cystic fibrosis service had a lower than expected risk of readmission for elective admissions
- Patients in cardiology had a higher than expected risk of readmission for elective admissions

**Non-Elective Admissions – Trust Level**

![Graph showing readmission rates for different specialties](image)

*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 represents the opposite. Top three specialties for specific trust based on count of activity.*

Of the top specialties, based on count of activity for non-elective admissions:

- Patients in cardiology had a lower than expected risk of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

**Lung Cancer Audit**

The table below summarises Royal Papworth Hospital NHS Foundation Trust’s performance in the 2017 National Lung Cancer Audit.
<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>88.1%</td>
<td>Does not meet the audit aspirational standard</td>
<td>X</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>Not eligible</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non-Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>Not eligible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>Not eligible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>Not eligible</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

(Source: National Lung Cancer Audit)

The service was only eligible for one parameter in the National Lung cancer audit.

Managers carried out a comprehensive audit programme. Clinical leads completed re audit of any audits where improvements had been identified as required.

The service had the lowest decline rate for UK adult donation after brainstem death (DBD) bilateral lung offers, according to the Annual Report on Cardiothoracic Organ transplantation 2016-2017, NHS Blood and Transplant.

Managers used information from the audits to improve care and treatment. This was evidenced by the communication audit carried out around the NSTEMI (Non-ST-elevation myocardial infarction), a type of heart attack, pathway. Service users were asked about the information they had received.
around their transfer to the hospital. The audit identified communication was inconsistent, so the service addressed this by creating a short video, which ambulance crews played to patients during their transfer. This ensured all patients received the same correct information.

**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 development.

**Appraisal rates**

Managers supported staff to develop through yearly, constructive appraisals of their work. From April 2018 to February 2019, 92.4% of all staff within medicine department at the trust received an appraisal. This was higher than the trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff received appraisal</th>
<th>Number of required staff</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>43</td>
<td>45</td>
<td>95.6%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>119</td>
<td>127</td>
<td>93.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>157</td>
<td>170</td>
<td>92.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>34</td>
<td>38</td>
<td>89.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>39</td>
<td>45</td>
<td>86.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>3</td>
<td>4</td>
<td>75.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>414</strong></td>
<td><strong>448</strong></td>
<td><strong>92.4%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

In medicine, three staff groups, including medical staff did not meet the 90% appraisal target.

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had received training in tasks appropriate to their role. Staff competencies were signed and dated appropriately. Staff told us they were proactively supported and encouraged to acquire new skills and use their transferable skills.

Managers gave all new staff a full induction tailored to their role before they started work. Two of the nursing staff we spoke with described their inductions and how they had been supernumerary before being signed off as competent by their mentor.

There were enough clinical educators to support staff learning and development. The service had increased the numbers of clinical educators available to support staff. We spoke with one clinical educator who told us they were supported by the service leads to access additional training for their teams.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Team meeting minutes were displayed on the notice boards in the staff rooms, this meant, if staff had been unable to attend these meetings they did not miss out on any information.
Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. In the cardiac catheter labs, the service had a structured development programme for staff. This ensured staff had the right skills and were up to date.

Managers made sure staff received any specialist training for their role. In the CF service, we saw staff competencies were signed for tasks such as chest physiotherapy and administering intravenous medications. In cardiology, nursing staff were competent to perform cardioversion. Cardioversion is a procedure that restores a normal heart rhythm in people with certain types of abnormal heartbeats. Cardioversion is usually done by sending electric shocks to your heart through electrodes placed on your chest.

Managers identified poor staff performance promptly and supported staff to improve. The service performance managed staff who were not performing. Service leads provided additional supervision and support to enable staff time to improve. Equally, managers recognised and rewarded good performance. One staff member had received The Cavell award which is a national award given to nurses who demonstrate exceptional care to colleagues, patients and their families.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings (MDT) to discuss patients and improve their care. MDT meetings were held weekly on Wednesdays and included doctors, consultants, nurses and allied health professionals such as dieticians, physiotherapists and occupational therapists. Staff, teams and services were committed to working collaboratively for the best outcome for the patient.

Staff worked across health care disciplines and with other agencies when required to care for patients. The trust was the lead for an MDT with five other regional healthcare trusts in a range of specialties. The Trust provided a specialist thoracic and cardiology opinion.

Real time discussions and decisions at MDT ensured clear decision making for patients and there was a clear rationale for the decisions which were made.

We attended MDT, staff, teams and services were committed to working collaboratively to deliver joined-up care to people who use services. There was formal and informal peer review and challenge from medical staff, nursing staff and allied health professions. All staff input was respected, and views and opinions were used to plan patient care. It was clear at the MDT meetings that all staff were focussed on the individual patient and their best interest.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were aware of the process for referring patients, but at the time of our inspection there were not patients requiring referral.

Patients had their care pathways reviewed by the relevant consultants. Consultants reviewed patients daily and care plans documented patient progress on the planned care pathway. This was evidenced in all the patient records we reviewed.

The lead consultant for the pulmonary embolism pathway worked closely with the haematology service from a neighbouring provider to ensure the best possible patient care.

The service had established working groups with neighbouring providers to streamline patient pathways and services. For example, the respiratory services working group and the interstitial lung disease (ILD) service, this ensured people received the most appropriate care in the shortest time.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**
Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. We saw evidence of this in care record we reviewed. Staff could call for support from doctors and other disciplines and diagnostic tests, 24 hours a day, seven days a week. The cardiac catheter laboratory was open routinely from 8am to 8pm Monday to Friday and 9am to 5pm Saturday and Sunday. Outside these hours an on-call service was available. The trust had a service level agreement with a neighbouring trust to access mental health support when it was required.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

Staff gave patients practical support and advice to lead healthier lives. Staff encouraged those patients who were happy to do so, to continue to self-medicate. This encouraged them to maintain some independence during their hospital stay.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. Specialist nurses and previous patients encouraged patients on the CF unit to proactively manage their symptoms.

Menus, displayed in all patient rooms, encouraged patients to make healthy diet choices and provided details on the calorie content of meals.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Nursing staff completed the health assessment as part of the patient admission process. This was a holistic assessment and covered things such as family, family history, home environment and lifestyle factors for example, smoking and drinking status.

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

**Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.**

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

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for the MCA training module from April 2018 to February 2019 at trust level for qualified nursing staff and medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>174</td>
</tr>
<tr>
<td>Medical staff</td>
<td>103</td>
</tr>
</tbody>
</table>

In medicine qualified nursing staff and medical staff met the 90% target for MCA training.

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

All staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff exceeded the trust target of 90% for MCA training for the medical service.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice (AMSAT). None of the patients we saw during inspection were subject to an MCA.
Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed the consent forms of three patients which staff clearly recorded in the patients’ records. Consent forms were signed by the consenting doctor and the patient.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff described how they would assess patient mental capacity if they seemed confused. This was also part of the medical patient record process.

Staff made sure patients consented to treatment based on all the information available. In the instances where patients were too ill to sign consent medical staff acted on verbal consent, for example, those patients who were suffering a heart attack.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff were knowledgeable about the process involved in applying for a DoLS, although no patients were subject to one at the time of inspection.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff described how they could access support and advice via the trust wide intranet.

Staff implemented DoLS in line with approved documentation. None of the records we reviewed related to any patients who were subject to DoLS.

**Is the service caring?**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff knocked on patients’ room doors, called out to introduce themselves and ask permission to come in before entering.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed many caring interactions between all staff, patients and their families. Staff used appropriate humour and clearly demonstrated a good understanding of each patients’ preferences.

Patients said staff treated them well and with kindness. Thank you cards from previous patients to ward staff used phrases like “excellent and friendly care” and “loving and caring bunch” and “wonderful care, wonderful people”. One message read “Thank you for everything you have done for me. You did so much and helped me a lot. Thank you for listening to me. You went above and beyond”.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff described how they had recently contacted the chaplaincy service to attend a patient who had expressed a wish to speak with a Chaplain.

A patient feedback letter described how a family member had been allowed to stay with a partially sighted patient throughout their stay and this had prevented the patient feeling isolated.

Staff attended the East Anglian Regional Transplant Service of Remembrance and Thanksgiving service to honor those families who had donated the organs of loved ones.

Staff followed policy to keep patient care and treatment confidential. Staff closed doors and curtains when providing care to patients. Staff closed computer screens and turned papers face down to protect patient confidentiality.

**Friends and Family test performance**

Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People think that staff go the extra mile and their care and support exceeds their expectations.
Staff described a situation where a patient attended a staff leaving do to thank them for how they had cared for them as an inpatient.

From March 2018 to February 2019 the trust’s Friends and Family Test performance for medicine (% recommended) was similar to the England average, with the exception of December 2018. In this month the percentage recommended for the trust was 87.3%, compared to the England average of 95.3%, which was the lowest across the 12-month period.

![Graph showing Medicine FFT % recommended from March 2018 to February 2019 for Papworth and England. The line for Papworth drops significantly in December 2018.]

Please note: the above performance has been calculated using data for two specialties; cardiology and respiratory medicine.

(Source: NHS England Friends and Family Test)

### Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Nursing and medical staff made time to speak with relatives and patients. We heard a doctor telling a family member “If you need me come and find me and we can have a discussion”

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff took family members into a private room to have difficult conversations. Nursing staff told us they kept tissues out of sight in this room as family members often assumed they were about to receive bad news if they saw tissues.

Staff demonstrated empathy when having difficult conversations. We saw nursing staff displayed appropriate support to a family member who was clearly distressed. Offering a gentle touch as they guided them to somewhere more private.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Nursing staff on the cystic fibrosis (CF) ward were very knowledgeable about the needs of CF patients, these are typically a younger group of patients with a different set of needs both emotionally and socially. For example, these patients are more likely to struggle with being isolated from their friends.

The trust employed a team of social workers and discharge co-ordinators to provide practical and emotional support to patients prior to discharge.

The trust had brought in an artist to work with patients to spend time doing art as relaxation and to design bedding to be used in the ward areas.
Occupational therapists provided lunch time relaxation sessions, had provided board games in the day room to alleviate boredom and arranged to take patients on trips outside the hospital to address their psychosocial needs.

Two nurses had undertaken additional training to enable them to provide acupuncture to their patients. Acupuncture is a complementary medical practice that entails stimulating certain points on the body, most often with a needle penetrating the skin, to alleviate pain or to help treat various health conditions.

The Papworth Mesothelioma Social Group (PMSG) was established by the trust as a supportive, informative social group for patients living with mesothelioma and their families. The group meets monthly for support, information sharing and also for the clinical nurse specialist to spend time offering advice and support to the family.

The cystic fibrosis team sent letters of condolence to the family of every patient who has passed away. Feedback from families is that they find this very supportive and comforting.

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. We observed a doctor discussing with a patient their care plan and transfer back to their local hospital.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed a nurse talking a patient through their discharge medications. The nurse used appropriate language and allowed time for the patient to ask questions.

Staff had collaborated with patients to develop a patient information leaflet about reflux to ensure the information was what the patient wanted to have.

Staff collaborated with patients and families to develop a DVD of information for those patients diagnosed with mesothelioma. This made sure the information was relevant.

Occupational therapists always established the specific concerns and worries for each individual patient and tailored their care plan to meet those joint goals and priorities. This included collaborating with family members or carers when discharge planning.

Staff found ways to enable patients to manage their own health and remain independent. Dietetics and speech and language therapy staff had devised a booklet with input from patients to provide patient focussed information on the options around tube feeding. This meant that patients were well informed about having a fixed naso-gastric (NG) tube or learning to insert their own so they could stay at home more. Staff assessed competency of those patients who wished to place their own NG tube before allowing them to be independent with it.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw and heard about changes made to processes and facilities as a result of the trust seeking patient feedback. For example, changes to the way ambulance staff relayed information to patients. The trust regularly carried out patient surveys in order to obtain patient feedback.

Staff supported patients to make informed decisions about their care. Medical records evidenced patients had been given choices about their care and that they were included in decision making.

The service regularly carried out patient surveys in order to obtain patient feedback. A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey and this was positive for all wards. Patients consistently spoke positively about the care they had received. One patient told us “you can talk to them (nurses) and they listen”
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the population. The pulmonary vascular disease unit (PVDU) specialist nurses provided telephone clinics to monitor the progress of complex patients and reduce the risk of admission to local non-specialist hospitals.

The service had innovative approaches to providing integrated person-centred pathways of care. The service used technology innovatively to ensure people had timely access to treatment, support and care. For example, the interstitial lung disease (ILD) service held weekly virtual multi-disciplinary team (MDT) meetings to enable doctors at the service to review new patients without very poorly patients having to travel to the hospital.

The pulmonary vascular disease unit held satellite clinics to enable patients to receive highly specialist care close to their home.

Interstitial lung disease (ILD) nurses held telephone follow up clinics for medication monitoring. This enabled increased patient contact and support but without the need for the patient to travel.

The thoracic oncology service held MDT clinics, this enabled the patient to meet with the chest physician, oncologist and surgeon in one visit.

The pulmonary vascular disease unit (PVDU) had recently undergone a change in service delivery to improve the efficiency and capacity of the service in order to meet the increasing demand from patients.

The service was the only one in the UK to provide investigation and treatment for pulmonary hypertension and was also the only service to provide balloon pulmonary angioplasty. Balloon pump angioplasty is when an interventional cardiologist inserts a very fine wire into blood vessels in the lungs and guides a tiny balloon into position. The balloon is inflated, to around the size of a pea, for a few seconds to push the blockage aside and restore blood flow to the lung tissue. The balloon is then deflated and removed. This can be repeated several times in different parts of the lung during a single treatment session.

The respiratory support and sleep service held eight outreach clinics to offer treatment for patients using the service closer to their home. Audit data showed this had led to a reduced travel time of between 1.5 to two hours on average per patient.

Facilities and premises were appropriate for the services being delivered. The service had a dedicated lift and patient waiting area for emergency patients requiring cardiac catheterisation as part of a specific treatment pathway. Ambulance staff brought patients directly to the entrance lift, nursing and medical staff received each patient out of the lift and took the patient to receive their procedure.

Staff cared for patients living with cystic fibrosis (CF) in their individual rooms. Rooms had their own computers and drug cupboards and nursing, medical and MDT staff came to the patient. This aimed to reduce the risk of infection to the patient during their stay.

The hospital had an underground walk way which linked it with a neighbouring trust. Nursing staff transferred CF patients through the walk way to have peripherally inserted central catheter (PICC) lines inserted. This meant that they could receive intravenous antibiotics (IVABX) in the community. A PICC line is a thin, soft, long catheter (tube) that is inserted into a vein in your arm, leg or neck. The tip of the catheter is positioned in a large vein that carries blood into the heart. The PICC line is used for long-term intravenous IV antibiotics, nutrition or medications.

Trust wide, all patients could access free WIFI and free entertainment in the form of TV, Freeview and radio.
Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. The service had a service level agreement with a local mental health trust.

The service had systems to help care for patients in need of additional support or specialist intervention. The lung defence service offered a dedicated telephone advice line. The lung defence consultants advised patients over the phone and prevented needing to attend an emergency department for lung related concerns.

Managers ensured that patients who did not attend appointments were contacted. The service reported no concerns with patients missing elective or follow up appointments.

The service relieved pressure on other departments when they could treat patients in a day. For example, sleep studies patients and those patients living with CF could be reviewed by a MDT in a one stop clinic.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had a lead nurse for dementia. All vulnerable patients were highlighted at the daily bed meeting to ensure the hospital was making reasonable adjustments for their needs.

Dementia link nurses were available on every shift. Nursing and medical staff encouraged family members and carers to stay with the patient to provide familiarity. Patients living with dementia or learning disabilities were identified at admission and flagged electronically. Staff passed on the information at handover.

The service supported patients who had learning disabilities and their families in the hospital using the hospital passport to tailor care appropriately to ensure that reasonable adjustments were made.

The service used the ‘This is Me’ booklet which was completed with the patient and their relatives or carer to ensure patients received appropriate care. No This is Me booklets were available to be reviewed during the inspection.

The trust had a service level agreement (SLA) with a neighbouring NHS provider for a psychiatric liaison service, which was accessible seven days per week by telephone and the physical presence of a psychiatrist or psychologist during weekdays.

The service had information leaflets available in languages spoken by the patients and local community. Information leaflets, for example in the sleep studies department, were available in other languages.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. Staff knew how to access an interpretation service for those patients who did not speak English as a first language. This could be by telephone or face to face.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The trust wide menu had meals which were suitable for people who were vegan, vegetarian and those who required Halal food.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. During the period April 2018 to March 2019, four specialties out of six met the 18-week referral to treatment target (RTT); two specialties were slightly below the England average for RTT, this was cardiology and respiratory and sleep studies (RSSC). The trust had plans to address this issue for example by performing more day cases. At the time of our inspection, data provided in the Papworth Integrated performance (PIPR) report for July, showed cardiology was also now meeting the RTT and had been doing so since March 2019.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. The service reviewed RTT weekly at trust level and by clinical and operational staff. Medical staff reviewed individual patients to establish priority for treatment. The closure of a significant number of beds due to staffing shortage was impacting on RTT.

The service offered two transcatheter aortic valve implantation (TAVI) lists per week which met the requirement of the service. The service had recently appointed a new consultant in order to further improve and expand the TAVI service. TAVI is a minimally invasive cardiology procedure to repair the aortic valve without removing the old, damaged valve. Instead, replacement valve is inserted into the old aortic valve’s place. The procedure is especially beneficial to those patients who are too frail to undergo the traditional replacement surgery.

Managers monitored that patient moves between wards/services were kept to a minimum. The service did not move patients between rooms for non-clinical reasons. Staff did not move patients between wards at night.

Managers and staff worked to make sure that they started discharge planning as early as possible. Patients who were admitted to the hospital on a defined care pathway had a defined discharge date at the time of admission. Managers and staff worked to make sure patients did not stay longer than they needed to, but staff reported it was not always easy to repatriate patients to their local hospital.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff were able to use the discharge lounge between Monday and Friday from 8am until 4pm for those patients who were medically stable.

Managers monitored the number of delayed discharges, knew which wards had the highest number and acted to prevent them. Service leads were aware of delayed discharges back to the patients’ local hospital. Trust leads told us they used a ‘patient swap’ approach to repatriate patients who were struggling to be returned to their own hospital. This involved the chief operating officer liaising with the home trust to identify any patients who needed to be treated at Royal Papworth.

Staff supported patients when they were referred or transferred between services. As a tertiary referral centre the service kept patients up to date on their treatment and expected return to their referring hospital. Patients understood they were receiving specialist treatment and would be returned closer to home when it was safe to do so.

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. All patients were cared for within their own speciality area.

**Average length of stay**

From January to December 2018 the average length of stay for medical elective patients at the trust was 2.6 days, which is lower than the England average of 6.0 days.

For medical non-elective patients, the average length of stay was 4.7 days, which is lower than the England average of 6.2 days.

**Elective Average Length of Stay – Trust Level**

<table>
<thead>
<tr>
<th></th>
<th>This trust</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stay – Trust Level</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20191011 Evidence appendix Royal Papworth NHS Foundation Trust
The average length of stay for elective patients in respiratory medicine and cardiology is lower than the England average.

The average length of stay for elective patients in the adult cystic fibrosis service is higher than the England average.

Non-Elective Average Length of Stay – Trust Level

- The average length of stay for non-elective patients in cardiology is lower than the England average.
- The average length of stay for non-elective patients in respiratory medicine is higher than the England average.
- The average length of stay for non-elective patients in the adult cystic fibrosis service is similar to the England average.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From March 2018 to February 2019 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was worse than the England average for all of the 12 months reported.

The trust’s performance ranged from 69.4% to 83.9% compared to the England average of 86.9% to 90.0%
Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were 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>Thoracic medicine</td>
<td>88.0%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>74.2%</td>
<td>81.3%</td>
</tr>
</tbody>
</table>

Please note: as Royal Papworth is a cardiothoracic specialist trust not all specialty groupings for medicine are relevant and therefore not included in the table above.

Following the inspection, the trust provided additional data relating the RTT for admitted pathways in medicine. They noted that they have two key specialties within medical care which submit RTT data: cardiology and thoracic medicine.

Using figures published on NHS England website, the trust noted that the percentage of RTT admitted pathways closed within 18 weeks for cardiology and thoracic medicine only was below the national average from May 2018 to January 2019. However, the proportion within 18 weeks then rose above the national average in February 2019, as shown in the graph below:

The percentages of patients on admitted pathways who were seen within 18 weeks at specialty level were as follows:

- Cardiology RTT ranged from 58.7% to 83.1%. It was below the national average from May 2018 to January 2019 but rose above the national average in February 2019.
- Thoracic medicine RTT ranged from 83.7% to 92.1%. It was below national average from March 2018 to February 2019.

Patient moving wards per admission

The trust did not provide any data for this and have reported in their RPIR that as a specialist
tertiary hospital with low bed occupancy rates it is extremely rare to have to move patients for a non-clinical reason.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

**Patient moving wards at night**

From March 2018 to February 2019 there were 45 patients recorded as moving wards at night within medicine. Hemingford ward accounted for the vast majority of these with 43 patients moving ward throughout the period.

Please note: Hemingford ward was based at the previous Royal Papworth site and was a medical ward with four high dependency unit beds for acute cardiac patients.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

At the new site, ward, room moves for non-clinical reasons did not occur. Patient were cared for within their speciality.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. One family we spoke with knew how to raise a complaint, had done so and had been satisfied with the way in which it had been addressed and resolved.

The service clearly displayed information about how to raise a concern in patient areas. The trust informed patients of how to raise a concern or complaint via posters, patient information on the ward areas, patient advice and Liaison service (PALS) sign posting and the trust website.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff knew how to support patients and their families if they wished to complain. Staff referred to the complaints policy on the trust intranet.

Managers shared feedback from complaints with staff and learning was used to improve the service. The service could demonstrate where improvements had been made as a result of learning from reviews. For example, staff could describe a previous complaint which related to communication and the actions they had taken to prevent this reoccurring. This included ensuring patients received daily updates on plans for their care.

The assistant director for quality and risk in partnership with the clinical leadership team were developing a video about a patient experience which would be shown to staff in order to share learning from a patient complaint.

**Summary of complaints**

From March 2018 to February 2019 the trust received 21 complaints about medicine (37.5% of total complaints received by the trust).

All complaints for medicine had been closed at the time of reporting. The trust took an average of 24.2 working days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 25 working days.

Patient care was the subject that received the most complaints in medicine, accounting for 42.9% of all complaints.
A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient care</td>
<td>9</td>
<td>42.9%</td>
</tr>
<tr>
<td>Communications</td>
<td>8</td>
<td>38.1%</td>
</tr>
<tr>
<td>Facilities</td>
<td>1</td>
<td>4.8%</td>
</tr>
<tr>
<td>Admissions and discharges (excluding delayed discharge due to absence of care package)</td>
<td>1</td>
<td>4.8%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>4.8%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; well being</td>
<td>1</td>
<td>4.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>21</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From March 2018 to February 2019 the trust received 5,963 compliments in relation to all areas at Royal Papworth Hospital. The trust did not provide a ward or core service breakdown of the compliments. However, the trust has confirmed that they plan to record compliments by ward and department on the new site.

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

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Service leaders at directorate level were passionate, engaged and enthusiastic about their services. They were knowledgeable about the risks within their service and throughout the trust.

All staff we spoke with told us local managers and leaders were accessible and approachable. Directorate leaders told us the executive leaders were visible, approachable and were involved in a hands-on way throughout the hospital move.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Whilst the trust was currently working on a new strategy, service leaders had a clear vision for their services. The vision was challenging and involved the continued development of world class services at the trust. The new hospital had been designed in such a way as to facilitate the development of new services across medicine. For example, additional capacity had been built in to the cardiac catheter lab suite to allow the anticipated development of cross working with surgical colleagues. The extra capacity built into the trust allowed for future development of services both anticipated and unanticipated. The new hospital had been ‘future proofed’ with significant investment in the environment and equipment to ensure there was the capacity to develop new services in the future. For example, the design of the cardiac catheter labs and
theatre areas were designed to allow for comparatively easy extension in the future if additional capacity was required.

The service had invested in the most modern technology to support staff in developing the services. It was clear that the vision was focussed on improving care for patients now and in the future. The vision was aligned to wider work with the local strategic transformation plan (STP) as well as national commissioning objectives that Royal Papworth was involved with as a specialist centre. All staff we spoke with understood and shared the vision. Senior staff all spoke of the same vision and always spoke of them in relation to patient care and outcomes.

Staff we spoke with knew the trust wide vision and values. These were also displayed on the trust’s intranet and as a computer screen saver. Staff described the vision and strategy for the preceding years had been around moving to the new site.

Service leaders had a clear vision and strategy for cardiology. Cardiology had a clear vision for the development of their service, increasing research activity and developing services. All staff we spoke with were aware of this vision for the development of services, patient care now and in the future.

Thoracic medicine service leaders at directorate level described how each business unit was developing a vision and strategy which would then be aligned to the trust wide strategy.

The relocation to the biomedical campus had improved links with industry and research which was already improving professional relationships across the trust with other organisations.

All staff were highly motivated to provide the best possible care for patients and their relatives. There had been thorough staff engagement regarding the design of the new hospital and the move. It was clear that few compromises had been made in the design of the hospital and it was functioning well for the benefit of patients and staff. Staff said the move had been a very positive experience, they were supported fully by managers and had been able to keep patients safe during a busy period of change.

All leaders were aware of the risks and challenges they faced, with staffing being the major concern. They were however, focused on the significant opportunities that were now presented by the move to the new site.

**Culture**

*Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.*

All the staff we spoke with were positive about local leaders and colleagues. Staff told us they felt well supported.

Staff told us they were encouraged to identify training and learning opportunities and could attend courses offered by a local higher education facility nearby.

Staff at all levels described a no blame learning culture around incidents and near misses.

**Governance**

*Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.*

The trust had an established governance system and all staff we spoke with knew how the various quality assurance groups fed into the governance structure. Staff could describe clear routes of escalation of information from the ward to the board and back again. This was achieved through a series of weekly and monthly meetings with different groupings and grades of staff.

The management structure was such that each specialty, for example; cardiology; thoracic medicine and catheter labs, was led by a triumvirate of representation from operations, clinical and
nursing at directorate level. Each speciality was further subdivided into business units (BU), for example, cardiology was split into intervention business unit and pacing business unit among others. Each business unit was also managed by a triumvirate representing the service operation, clinical and nursing and this BU triumvirate reported to the directorate triumvirate.

The trust dedicated one morning per month of protected time for staff to attend governance meetings. For example, the quality and risk group meeting.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders within the medicine division understood and could describe to us the challenges that the department faced, including risks. All leaders were aware of the risks and challenges they faced, with staffing being the major concern and raised frequently in our conversations. The trust had taken robust action to mitigate risk. This had included the closure of a significant number of beds including the private patients ward to allow for deployment of safe staffing levels in other areas. Leaders were aware of the financial risk in closing beds in a new privately financed hospital but were clear that safety always took priority.

All leaders could describe risks on the risk register and were clear about how they were mitigated and managed. Ward managers were aware of the risks in their area and they and matrons could tell us how risk was escalated and put on the trust risk register if required.

All the leaders and managers we spoke with were passionate about delivering high quality care to patients, whilst supporting and leading operational staff to achieve this.

Thoracic services management group (TSMG) was a monthly meeting of thoracic leads. The agenda covered incidents, audits and research among other things and was multidisciplinary.

Each business unit held their own monthly mortality and morbidity review meetings which fed into the monthly quality management group (QMG) meeting.

The trust wide Papworth integrate performance (PIP) report was a monthly report compiled trust wide to present to the board covering all aspects of service performance.

Actions and learning from unexpected deaths were presented at morbidity and mortality (M&M) meetings, quality and risk management group (QRMG), business unit meetings among other meetings and with individuals involved.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust had effective arrangements to ensure data and notifications were submitted to external bodies, for example the CQC, and Clinical Commissioning Groups.

Staff used information technology systems effectively to monitor and improve the quality of care. The medical wards had enough computer work stations, which enabled staff to access key patient information across the department. Staff ensured that monitor screens were locked when not in use, and we noted staff usually used the screens facing away from patients, so no information could be seen by the patient themselves.

The trust considered people’s views on quality, operations and finances. The trust held annual general meetings throughout the year to encourage stakeholders and the public to feedback on its service and performance.

Staff from the information technology (IT) team visited wards to check equipment was working correctly. This also gave staff the opportunity to approach them and get support immediately.
Engagement
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

There had been thorough staff engagement regarding the design of the new hospital and the move to the new premises. Staff we spoke with told us that they had been involved with the design, that their opinions were respected and were directly used in the design of the new hospital. It was clear that few compromises had been made in the design of the hospital and it was functioning well for the benefit of patients and staff. Staff said the move had been a very positive experience, they were supported fully by managers and had been able to keep patients safe during a busy period of change.

The trust has developed a formal mechanism (Laudix) for capturing positive feedback in recognition of any member of staff who has gone the extra mile to support their colleague or improve patient safety and the patient experience. This has been received very positively by all staff across the trust.

Prior to opening at the new hospital site, trust leaders used a weekly ‘Our Big Move’ briefing to senior staff members to ensure they received regular updates on the move to the new hospital, as well as giving staff the opportunity to ask questions or raise concerns.

The briefings were well-attended, and managers monitored how well these updates were being shared to wider staff groups with monthly pulse surveys of staff. The trust held exhibition-style events to update all staff on the developments with regards to the move and produced weekly NewsBites and monthly NewsBeat communications to all staff.

Royal Papworth Hospital is famous for its duck pond, among other things, and because of patient and public feedback, a duck pond had been created at the new Royal Papworth site.

The trust had recently acted on feedback from staff and introduced reclining chairs for doctors and consultants to rest during break periods between cases.

The trust was developing a video using a patient’s family member to share their feedback around communication and the incident investigation process. The trust were planning to use the video as a learning tool for staff.

Learning, continuous improvement and innovation
All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us that the relocation of the trust to the Cambridge biomedical campus was already enhancing relationships with other organisations in industry, science, academia and healthcare. For example, clinicians at the trust were working with colleagues in other health and science organisations to develop a novel breath test for the early diagnosis of lung cancer. This kind of collaboration was enhanced by the siting of the new hospital. There were other examples of collaboration of this sort to develop services.

Through everyone we spoke with there was a constant focus on service improvement, innovation and striving for better care and services. All of our conversations with staff reflected the motivation of staff; to provide excellent care for patients.

Since the trust’s last inspection in 2014, they had developed and launched a quality strategy and refreshed this at the beginning of 2019. The ambitions within the strategy outlined the further improvements the trust wanted to make.

The service implanted its first revolutionary CardioMEMS device (December 2018), which will allow doctors to monitor heart failure patients from home. Doctors believe CardioMEMS devices will reduce the risk of long and expensive hospital admissions and patient feedback was it was
positive saying “it was reassuring to know that the device is constantly reviewing my heart every day and letting my doctor know straight away if there are any problems.”

The Service had received funding from the British Lung Foundation and was undertaking research and investigations into sarcoidosis.

The trust had secured funding, in partnership with a local university, to build a new dedicated heart and lung function research centre on the campus to develop better understanding of lifestyle and genetic factors in disease.

Surgery

Facts and data about this service

Royal Papworth Hospital NHS Foundation Trust’s surgical portfolio includes:

- Cardiac surgery – all adult cardiac surgery including coronary artery bypass grafting; valve replacement and repair surgery; thoracic aortic surgery; arrhythmia surgery.
- Thoracic surgery - surgical treatment of all benign and malignant thoracic disease including lung cancer; lung resections; pleural disease; chest wall surgery; advanced bronchoscopy and airway surgery; metastasectomy; thoracic sarcoma; lung volume reduction surgery; hyperhidrosis; treatment of thoracic endometriosis and thoracic trauma.
- Pulmonary endarterectomy surgery for pulmonary hypertension - currently the only UK hospital commissioned to provide this service.
- Transplantation and advanced heart and lung failure support - lung and heart including donation after circulatory death (DCD) transplantation, mechanical circulatory support and extra-corporeal membrane oxygenation (ECMO).
- Other surgical services such as endovascular stenting and minimal access (keyhole) procedures.
- The transplant service also provides a national organ retrieval services (NORS) for both adult and paediatric organ retrieval.

(Source: Routine Provider Information Request (RPIR) Acute – context tab)

The trust had 3,050 surgical admissions from January to December 2018. Emergency admissions accounted for 233 (7.6%), 411 (13.5%) were day case, and the remaining 2,406 (78.9%) were elective.

(Source: Hospital Episode Statistics)

Due to the number of core services inspected, our inspection of Royal Papworth Hospital was announced. Prior to our inspection we reviewed data we held about the service along with information we requested from the trust. The hospital moved to its new location in a purpose designed building in April 2019.

During our inspection of the surgery core service, we spoke with 50 members of staff including doctors, nurses, therapists, health care assistants and non-clinical staff. We spoke with seven patients and their relatives, reviewed 25 sets of patient records and considered other pieces of information and evidence to come to our judgement and ratings. We visited six clinical areas including wards, operating theatres, and the day procedure unit.

At our last inspection in December 2014, surgery was good overall with effective and caring rated outstanding, with safe, responsive and well-led rated as good.
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 had plans to ensure everyone completed it.

Mandatory training completion rates

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

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>151</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>148</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>148</td>
</tr>
<tr>
<td>Health and safety</td>
<td>148</td>
</tr>
<tr>
<td>Information governance</td>
<td>130</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>129</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>129</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>126</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>117</td>
</tr>
<tr>
<td>Immediate life support</td>
<td>0</td>
</tr>
</tbody>
</table>

In surgery the 90% target was met for four of the 10 mandatory training modules for which qualified nursing staff were eligible.

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

Post inspection the trust supplied evidence to show that five staff in surgery had completed ILS training and 52 had completed cardiac surgery advanced life support training (CALS) as at May 2019.

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>105</td>
</tr>
<tr>
<td>Health and safety</td>
<td>105</td>
</tr>
<tr>
<td>Information governance</td>
<td>87</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>82</td>
</tr>
</tbody>
</table>
In surgery the 90% target was met for two of the nine mandatory training modules for which medical staff were eligible.

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

The mandatory training was comprehensive and met the needs of patients and staff. Staff accessed training through the trust’s intranet, online, and face to face.

Following our inspection, we asked the trust for updates in relation to infection control training, which showed 89.3% compliance and moving and handling training which showed 80.7% compliance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff we spoke with told us training was comprehensive, encouraged professional development and was monitored during supervision and appraisal.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. 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 the completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for qualified nursing staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>150</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>150</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>150</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>150</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>2</td>
</tr>
</tbody>
</table>

In surgery the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff were eligible. The only courses not to meet the target were the two level 3 modules, which also had a low number of eligible staff.

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for medical staff in surgery is shown below:
<table>
<thead>
<tr>
<th></th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>104</td>
<td>109</td>
<td>95.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>104</td>
<td>109</td>
<td>95.4%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>98</td>
<td>108</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>98</td>
<td>108</td>
<td>90.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In surgery the 90% target was met for all four of the safeguarding training modules for which medical staff were eligible.

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

Nursing staff received training specific for their role on how to recognise and report abuse.

A trust wide policy was in place for safeguarding adults and a further policy for children. Staff we spoke with could easily access it. The policy was in date and included information about different types of abuse, female genital mutilation (FGM) as well as domestic violence and other key areas of safeguarding.

Medical staff received training specific for their role on how to recognise and report abuse.

Staff we spoke with could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

All staff we spoke with were clear about how to make a safeguarding referral or how to escalate concerns within the organisation which included contacting the trust safeguarding team for advice.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. The wards had designated rooms for patients who may have communicable diseases, however due to the design of the individual room’s patients could be isolated easily. We routinely observed staff using clear signage to warn staff and visitors of the risks of infection and using appropriate personal protective clothing.

Staff we spoke with could explain the protocol for isolating patients with a possible infectious disease. We observed appropriate signs for an infective patient being nursed in isolation, which reminded staff of the actions they must follow to minimise the risk of cross contamination.

All the disposable curtains we checked were clean and in date for renewal and disposal.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Staff used records to identify how well the service prevented infections. Green ‘I am clean’ stickers were affixed to equipment that had been decontaminated and was ready for use.

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 and the “Five Moments of Hand Hygiene” guidance was displayed at all hand washing stations. Five Moments for Hand Hygiene defines the key moments for hand hygiene, overcoming misleading language and complicated descriptions. Patients admitted were screened for colonisation with Methicillin Resistant Staphylococcus Aureus (MRSA). Screening was completed as part of pre-admission for elective patients and as soon as possible for emergency admissions.
There were clear guidelines for staff to follow in the event a patient was determined to be MRSA positive. Data supplied by the trust for May 2019 showed 97% for MRSA screening.

There were adequate hand washing facilities as well as hand hygiene gel positioned around wards and in theatres. Clinical waste was separated appropriately into clinical waste bins. We observed these being regularly collected and removed. General waste bins were available for non-clinical waste. Yellow sharps bins were used for all contaminated sharps such as needles, however we found these were not always dated or closed on the surgical wards.

All clinical areas we attended were visibly clean. Infection, prevention and control audits on all wards showed hand washing compliance at 100% and environmental audits at 100% during May 2019.

The trust had engaged with the getting it right first time (GIRFT) programme for surgical site surveillance. Staff worked effectively to prevent, identify and treat surgical site infections. The rate of infection in coronary artery bypass graft for April 2018 to March 2019 was 2.7% and the yearly rate of infection in valve only during the same period was 1.8%

Hand washing facilities, alcohol gel and hand conditioner were available throughout the department. We observed staff following hand hygiene, ‘bare below the elbow’ guidance, and wearing personal protective equipment (PPE) such as gloves and aprons whilst delivering care in line with the trust’s policy. The department had a plentiful supply of PPE and we observed staff restocking this as required.

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.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. Staff used technology in innovative ways to improve and promote patient outcomes.

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance. Clinical areas were found to be compliant with the Department of Health and Social Care Health Building Note 00-09: Infection control in the built environment in relation to floors, wall and easy clean furniture and furnishings.

We reviewed over 30 pieces of equipment including blood pressure machines, defibrillators, pumps and air mattresses and found all of them to have be up to date with electrical testing. Equipment that needed servicing was tracked and either returned to the manufacturer for servicing or serviced on site.

We checked a range of consumables in clean utility rooms including dressings, needles, syringes and sterilising solutions and found them all to be in date and stored correctly.

In theatres there was a clear process for segregation of used (contaminated) and sterile (clean) equipment sets. Used sets were collected several times a day and sent for decontamination. We saw that all unopened theatre sets that we checked were in date for sterility and were stored correctly.

Staff carried out daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients’ families.

Staff disposed of clinical waste safely. However, we found three sharps bins not dated or signed, and we found the bin lids not closed properly.

Staff did not always complete checks on resuscitation equipment.
Cleaning materials that were regulated by the control of substances hazardous to health COSHH regulations were stored securely in locked cupboards in line with legislation.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and acted to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Early Warning Scores (EWS) are used to identify and escalate deteriorating patients. EWS is a national tool which scores a patient’s vital signs to assess their physiological stability and their risk of deterioration.

Staff we spoke with understood the scoring system and what to do in the event of a raised score. Staff said they felt confident in escalating patients for review that they were concerned about and could refer patients for review based on clinical judgement and not just the patients EWS. Staff felt particularly well supported by the ALERT team who would review patients, offer advice and escalate to consultants.

The trust had an up to date and comprehensive procedure for the management of the deteriorating patient. All staff we spoke with knew how to escalate deteriorating patients in a timely fashion.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We reviewed 22 sets of patient records and found all were completed, legible and risks monitored routinely.

We observed a pre- procedure theatre checklist being completed fully. Allergies, previous procedures and medical history were all checked.

Staff told us they had received training in sepsis, its identification and treatment. The sepsis six bundle was in use at the trust. This instructs staff in actions to take in the case of suspected sepsis with a low threshold in activating the bundle so that patients are not missed. The trust used an electronic patient monitoring system which flagged any warnings regarding deteriorating patients to a central screen monitored by staff and sounded an alarm.

Theatres completed observational audits of the World Health Organisation (WHO) surgical safety checklist. We found preop sign in checks and time out led comprehensively by the surgeon. Sign out was also comprehensively completed and all records were made electronically.

Each month the trust audits 30 sets of notes to determine compliance with the WHO Surgical Safety Checklist. Five elements are audited, pre-procedure checks completed, team brief completed, post procedure checks completed, number of checklists that had all 3 criteria completed (Overall Compliance) and checklist present in the notes. In May 2019, overall compliance was 90% and 100% of checklists were present in the patients notes.

Local safety standards for invasive procedures (LocSSIPs) were in place in all areas we visited.

Staff knew about and dealt with any specific risk issues.

Staff shared key information to keep patients safe when handling over their care to others.

Surgical pre- assessment used standard criteria to determine the relative risk of patients undergoing surgery. There was a clear process for identifying patients who may be at greater risk due to health complexities who would be escalated for review by an anaesthetist.

Shift changes and handovers included all necessary key information to keep patients safe.

The trust had introduced a daily trust wide safety briefing, highlighting vulnerable patients and other issues.

Staff did not always complete intentional rounding records. Intentional rounding records are used by staff every half hour to record details such as patient comfort and pain. Of the 15 records we reviewed seven had a minimum of one check missing. Staff explained this was usually due to staff
going for breaks, or busy with other patients. Senior staff told us the tool was under continual review and staff feedback on the rounding tool was being used to develop the intentional rounding process.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for surgery.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>131.0</td>
<td>166.9</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the nursing staffing rate within surgery was 92.2%

The staffing rate has increased from the previous period, March 2017 to February 2018, where the staffing rate was 78.5%. This is due to a combination of a reduction in the number of planned staff, and an increase in the number of actual staff in post between the two time periods.

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

The service had enough nursing staff of all grades to keep patients safe.

The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers.

Wards displayed staffing numbers on each ward which matched the acuity of patients and rotas showed staffing levels were appropriate during the inspection.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance.

The ward manager could adjust staffing levels daily according to the needs of patients by delegating staff and utilising bank and agency staff to cover any shortfalls.

**Vacancy rates**

From March 2018 to February 2019 the trust reported a vacancy rate of 14.1% for nursing staff in surgery, this was higher than the trust target of 6.0%.

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

The service had vacancy rates above the trust target. The trust was actively recruiting new staff and encouraging existing staff to complete appropriate training or conversion activities to increase staffing levels. The trust was restricting patient capacity due to nurse staffing levels, which was impacting on patient flow.

**Turnover rates**

From March 2018 to February 2019 the trust reported a turnover rate of 16.1% for nursing staff in surgery, this was higher than the trust target of 15.0%.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)
The service turnover rates were above the trust target. The trust told us that some staff had chosen not to move to the new site due to its relocation. The trust was engaged in ongoing recruitment activity and staff engagement to maintain staffing levels and staff satisfaction.

**Sickness rates**

From March 2018 to February 2019 the trust reported a sickness rate of 4.1% for nursing staff in surgery, this was in line with the trust target of 4.0%.

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

**Bank and agency staff usage**

The table below shows the numbers and percentages of nursing hours in surgery at the trust from March 2018 to April 2019 that were covered by bank and agency staff or left unfilled.

Of the 282,387 total working hours available, 1.5% were filled by bank staff and 3.6% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 2.1% of the available hours were unable to be filled by either bank or agency staff.

Of the 87,946 total working hours available, 6.5% were filled by bank staff and 19.7% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, 7.5% of the available hours were unable to be filled by either bank or agency staff.

(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

Managers used bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for surgery (including junior doctors in training posts).

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>101.0</td>
<td>105.5</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the medical staffing rate within surgery 96.9%.

The staffing rate has increased from the previous period, March 2017 to February 2018, where the staffing rate was 95.7%. There has been an increase in both the number of planned posts.
and staff in post between the two time periods.

Excluding junior doctors in training posts the trust reported the following WTE medical staffing numbers.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>28.0</td>
<td>24.0</td>
</tr>
</tbody>
</table>

The fill rate remained similar between the two time periods as the number of planned posts and the number of staff in post both fell by 1.0 WTE.

The trust have confirmed that they have more junior doctors in post than planned as they do not often receive their full allocation of rotational trainees due to shortages across the region. This is mitigated by employing a mixture of locum appointments for service (LAS) and Clinical Fellows to cover these gaps and this inflates the employed junior doctor numbers. Secondly as a specialist trust they often attract experienced, senior clinical fellows who are close to or post certificate of completion of training (CCT). To avoid having lengthy vacancies the schedule takes into account that these clinical fellows may move on quickly which can lead to short periods of overlap between staff members.

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

The service had enough medical staff to keep patients safe
The medical staff matched the planned number on all shifts in each department.

Vacancy rates

From March 2018 to February 2019 the trust reported a vacancy rate of 4.9% for medical staff in surgery (including junior doctors in training posts), this was lower than the trust target of 6.0%.

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

The service had had vacancy rates for medical staff at or below the trust target.

Turnover rates

From March 2018 to February 2019 the trust reported a turnover rate of 49.5% for medical staff in surgery (including junior doctors in training posts), this was higher than the trust target of 15.0%.

Turnover among surgical consultants was 16.6%, this was higher than the trust target of 15.0%.

The trust noted that there are a number of areas with high turnover, especially in anaesthetics. Turnover amongst all surgical medical staff ( juniors doctors and consultants, excluding junior doctors on rotation) was 12.7%, which was lower than the trust target of 15%.

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

The service had turnover rates for medical staff above the trust target.

Sickness rates

From March 2018 to February 2019 the trust reported a sickness rate of 0.4% for medical staff in surgery (including junior doctors in training posts), this was lower than the trust target of 4.0%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)
Sickness rates for medical staff were below the trust target.

**Bank and locum staff usage**

The table below shows the numbers and percentages of medical hours in surgery at the trust from March 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Of the 213,710 total working hours available, 0.7% were filled by bank staff and none were covered by locum staff to cover sickness, absence or vacancy for medical staff. In the same period, all of the available hours were able to be filled by bank staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Total hours available</th>
<th>March 2018 to February 2019</th>
<th>Bank usage</th>
<th>Locum usage</th>
<th>Not filled by bank or locum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Anaesthetics (junior)</td>
<td>58,889</td>
<td>627</td>
<td>1.1%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Anaesthetics (senior)</td>
<td>48,345</td>
<td>155</td>
<td>0.3%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Surgery (junior)</td>
<td>39,837</td>
<td>449</td>
<td>1.1%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Transplantation (junior)</td>
<td>34,936</td>
<td>276</td>
<td>0.8%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Transplantation (senior)</td>
<td>14,426</td>
<td>48</td>
<td>0.3%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Surgery (senior)</td>
<td>17,277</td>
<td>16</td>
<td>0.1%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>All medical staff</strong></td>
<td><strong>213,710</strong></td>
<td><strong>1,571</strong></td>
<td><strong>0.7%</strong></td>
<td><strong>0</strong></td>
<td><strong>0.0%</strong></td>
</tr>
</tbody>
</table>

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

The service had low rates of bank and locum staff used on the wards.

**Staffing skill mix**

In January 2019 the proportion of consultant staff and junior staff (foundation year 1-2) reported to be working at the trust was higher than the England average.

**Staffing skill mix for the whole time equivalent staff working at Royal Papworth Hospital NHS Foundation Trust**

- Consultant: 60% (This Trust) vs. 49% (England average)
- Middle Career: 3% (This Trust) vs. 11% (England average)
- Registrar Group: 24% (This Trust) vs. 29% (England average)
- Junior: 13% (This Trust) vs. 11% (England average)

^ 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
The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

**Records**

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

Records were stored securely.

Staff we spoke with explained that there were issues with the way that theatre lists were generated. Sometimes the list was generated offsite. Any changes to the list from the staff team briefing were annotated by hand and communicated via the theatre coordinators or leads. We observed that an additional elective case had been omitted from the list and was then added by hand to the emergency list to ensure its inclusion. This practice allowed opportunities for transcription errors or lack of communication, best practice would be to reprint all lists.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed 25 records in relation to the management of medicines and pain relief and found these completed in line with the trusts policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

**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 April 2018 to March 2019 the trust reported no incidents which were classified as never
Evidence

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from April 2018 to March 2019.

A breakdown of incidents by type is below:

- One surgical/invasive procedure incident meeting SI criteria.
- One pending review (this relates to a system and process failure to send clinical information / letters)
- One HCAI/Infection control incident meeting SI criteria**

** This incident relates to both a medical and surgical ward and has been counted under both core services

*Source: Strategic Executive Information System (STEIS)*

All staff knew what incidents to report and how to report them, this was an improvement from our inspection in December 2014.

Staff reported all incidents that they should report. We reviewed three serious incident reviews and fund the trust had used route cause analysis, implemented action plans to improve performance and minimise future incidents.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made because of feedback. We observed that staff on wards had made specific changes to the way medications were stored due to previous medication errors.

Managers shared learning about never events with their staff and across the trust.

Managers shared learning with their staff about never events that happened elsewhere.

**Safety thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance and we observed the matrons score card displayed on all wards showing the number and occurrence rates for falls, pressures sores and other key safety data.

Staff used the matrons score card to further improve services.

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 no new pressure ulcers, one fall with harm and no new catheter urinary tract infections from March 2018 to March 2019 for surgery.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at Royal Papworth Hospital NHS Foundation Trust**

1. Total Pressure ulcers (0)
2. Total Falls (1)
3. Total CUTIs (0)

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)

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

There were processes in place to ensure that national guidance supported local trust policies. New National Institute for health and care Excellence (NICE) guidance was reviewed by relevant clinical staff to determine any actions required to ensure the trust was working to the guidance.
At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patients care was risk assessed and their care planned based on national and local guidance. This included assessment using nationally recognised tools for falls, pressure ulcer risk, venous thrombosis and anaesthetic risk amongst others.

**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. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patient menus provided compressive advice on allergies, cultural choices and health related guidance.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We reviewed 25 patient records and found malnutrition screening tools completed where necessary.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it.

Patients waiting to have surgery were not left nil by mouth for long periods.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We routinely observed staff checking patients for any symptoms of pain and offering analgesia in line with the trust medication policy.

Patients received pain relief soon after requesting it. We reviewed 25 patient records and found staff prescribed, administered and recorded all pain relief accurately and administered this in a timely manner.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and outstanding outcomes for patients.**

The trust used safe, innovative and pioneering approaches towards achieving positive patient outcomes and was a leader in cardiothoracic and transplant surgery.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further.

New evidence-based techniques and technologies are used to support the delivery of high-quality care.

The trust actively participated in benchmarking, peer review and research to improve patient outcomes.

Staff had a holistic approach to planning patient discharge, and this was monitored and done at the most appropriate stage.

**Relative risk of readmission**

From December 2017 to November 2018 all patients at the trust had a higher expected risk of readmission for elective admissions and a lower expected risk of readmission for non-elective admissions when compared to the England average.
Elective Admissions – Trust Level

Of the top three specialties, based on count of activity for elective admissions;

- Cardiac surgery and thoracic surgery patients at the trust had a similar to expected risk of readmission for elective admissions when compared to the England average.
- Cardiothoracic transplantation patients at the trust had a higher expected risk of readmission for elective admissions when compared to the England average.

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 represents the opposite. Top three specialties for specific trust based on count of activity.

Non-Elective Admissions – Trust Level

Of the top specialties, based on count of activity for non-elective admissions;

- Cardiothoracic transplantation and cardiac surgery patients at the trust had a similar to expected risk of readmission for non-elective admissions when compared to the England average.

(Source: Hospital Episode Statistics - HES - Readmissions (01/12/2017 - 30/11/2018))

National Emergency Laparotomy Audit

Royal Papworth Hospital

The trust did submit data to the National Emergency Laparotomy audit, however as they are not eligible to participate in the audit (due to being a specialist trust with low case numbers) we have not included any performance data.

(Source: National Emergency Laparotomy Audit)

The service regularly reviewed the effectiveness of care and treatment through local audit and national audit.
Managers carried out a comprehensive audit programme and participated in national audits. For example, the National Adult Cardiac Surgery Audit 2018, National Audit of Cardiac Rehabilitation, the National Adult Cardiac Surgery Audit and The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Study: Peri-operative management of surgical patients with diabetes.

Managers used information from the audits to improve care and treatment. Information about the outcomes of patient’s care and treatment was routinely collected and monitored.

Managers carried out a comprehensive local audit programme and used information from the audits to improve care and treatment. For example, staff from the surgery team supported the trust’s falls quality initiative. As a result, the average number of falls on wards reduced, additional staff training on falls was offered and the trust implemented a new approach to multidisciplinary intentional rounding.

Managers shared and made sure staff understood information from the audits. Audit outcomes were shared in team meetings, through the trust’s newsletter and we noted performance dashboard data available to staff within the wards we visited.

**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 development.

**Appraisal rates**

From April 2018 to February 2019, 91.7% of all staff within surgery received an appraisal compared to the trust target of 90%. This was higher than the trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff received appraisal</th>
<th>Number of required staff</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>16</td>
<td>16</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>13</td>
<td>14</td>
<td>92.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional professional, scientific and</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>technical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>133</td>
<td>145</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>44</td>
<td>48</td>
<td>91.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>58</td>
<td>65</td>
<td>89.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>287</strong></td>
<td><strong>313</strong></td>
<td><strong>91.7%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

In surgery only one staff group did not meet the 90% target for appraisals.

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The trust recognised that the development of staff skills, competence and knowledge is as being integral to ensuring high quality care.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers supported staff to develop through yearly, constructive appraisals of their work.
Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff we spoke with explained that appraisals were an opportunity to access training and feedback on their performance and seek any additional qualifications relevant to their respective role.

Managers gave all new staff a full induction tailored to their role before they started work. Staff moved to the new hospital site in April 2019 and had received full induction into the new environment and facilities as well as any additional training, for example around infection prevention and control due to the single occupancy rooms and isolation procedures.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Medical staff we spoke with said the trust was supportive of additional training and teaching sessions, including secondment and the opportunity to engage with professionals from overseas when identifying and imbedding innovative surgery and care procedures.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Staff we spoke with said that due to the move to the new hospital location, meetings had been slightly interrupted, but a new schedule was in place and staff handovers and meetings were now happening as planned.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

The trust had a truly holistic approach to assessing, planning and delivering care. Therapists and clinical speciality teams contributed to joint multidisciplinary team meetings with other specialities within the trust, for example, physiotherapists, occupational therapists and speech and language therapists, cardiologists and nurses to improve the patient experience.

Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver joined up care for people who used the service. Throughout our inspection, we observed good interactions between medical, nursing and support staff in the surgery teams. Staff we spoke with confirmed there was good multidisciplinary team working within the service and with external organisations.

Staff worked across health care disciplines and with other agencies when required to care for patients.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Consultants led daily ward rounds on all wards. Patients are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support on every ward/unit.
Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The trust had an active program for smoking cessation and alcohol advice with brief intervention and level one advice. This was led by specialist nurse teams and advanced nurse practitioners.

As part of the flu campaign the trust offered the flu vaccine to groups of patients that regularly use the service and advised patients waiting for procedures to access the general practitioner or pharmacy service to have the flu jab to reduce the likelihood of the need to cancel due to illness.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions. They used agreed personalised measures that limit patients' liberty.

Mental Capacity Act and Deprivation of Liberty training completion

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for the MCA training module from April 2018 to February 2019 at trust level for qualified nursing staff and medical staff in surgery is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>150</td>
<td>152</td>
</tr>
<tr>
<td>Medical staff</td>
<td>104</td>
<td>109</td>
</tr>
</tbody>
</table>

In surgery qualified nursing staff and medical staff met the 90% target for MCA training.

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

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Evidence of this was present within the 25 sets of patient care records we reviewed, and we noted care plans and consent forms were completed and reflected the patients’ needs.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had completed training in the MCA and understood how to assess a patient’s capacity and support day to day decision making.

When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented DoLS in line with approved documentation.
Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Feedback from people who use the service, those close to them and stakeholders was consistently positive.

The trust promoted a strong and visible person-centred culture. Staff we spoke with were highly motivated and inspired to offer care that was kind and promoted patients’ dignity.

We observed that relationships between staff, the people who use the service and those close to them were strong caring and supportive. These relationships were highly valued by staff and promoted by leaders within the service.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff introducing themselves and explaining why they were providing care and engaged the patients in making choices and decisions about their care.

Staff followed policy to keep patient care and treatment confidential. Records were secure and during patient handovers and ward rounds, patients’ doors were closed and staff were conscious of not sharing information which was not relevant to the individual patient being discussed.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for discussing patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Ward staff displayed cards from patients. One card said, “To all the wonderful staff on ward 5, thank you so much for your wonderful care.” Another card read, “Special thank you to the staff who made my night as pain free as possible.”

Patients said staff treated them well and with kindness.

Patients we spoke with said that staff showed very caring attitudes, and nothing was ever too much trouble. Staff routinely offered additional support, shopping for items, taking patients down to the pond outdoors and making phone calls to relatives.

We observed a doctor assessing a patient who said, “This patient’s biggest concern is the welfare of their pet at home, let’s get onto social services and sort this for them, so we can focus on getting them better”.

Friends and Family test performance

From March 2018 to February 2019 the trust’s Friends and Family Test performance for surgery (% recommended) was generally better than the England average.

In the latest month, February 2019 the trust had 100% recommended compared to the England average of 96.1% recommended.
Please note: as Royal Papworth is a cardiothoracic specialist trust not all specialty groupings for surgery are relevant and therefore not included in the above chart.

(Source: NHS England Friends and Family Test)

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff respected and promoted the totality of people’s needs, always taking into account the personal, social, cultural and religious needs.

The trust had a service level agreement with the local NHS provider of mental health services to provide a psychiatric liaison service to any patient who may have additional mental health or emotional support needs.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

**Understanding and involvement of patients and those close to them**

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke to patients and their families who told us they were engaged in their care and discharge planning.

We observed staff talk with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. One patient said, “Staff have explained why my operation is cancelled, I am not happy about this, but understand that changes have to happen and staff have told me what will happen next”.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.
A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey.

The feedback from the Friends and Family Test was positive for all wards.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local and national population including transplantation pulmonary endarterectomy (PTE) and extra-corporeal membrane oxygenation (ECMO). The facilities and premises were new and carefully designed to best meet the services delivered. The surgical wards and theatres were clearly signposted as patients entered the hospital and had restricted access to promote patient and staff safety.

All surgical wards and theatres had appropriate facilities to meet the needs of patients awaiting treatment. This included single rooms, access to en-suite bathrooms and free TV and WIFI.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered. The trust moved to a new specialist designed hospital in April 2019 and the local population and staff team were engaged in its design.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and acted to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted. Patients we spoke with told us they received notification of any appointment changes and cancellations.

The service relieved pressure on other departments when they could treat patients in a day.

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Wards were designed to meet the needs of patients living with dementia. Each of the surgical ward areas had designated rooms next to the staff station to enable staff to have direct observation of patients who may need additional support.

Managers made sure staff, and patients, relatives and carers could get help from interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Equipment for bariatric, patients’ that are morbidly obese, was readily available.

The trust had a service level agreement with the local NHS provider of mental health services to provide a psychiatric liaison service. The education team have arranged mental health first aid training during 2019 for designated staff.

**Access and flow**

Most people could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and
Discharge patients were in line with national standards. However, vacancies within the nursing staff team affected capacity.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, at the time of our inspection the wards and theatres were not working at capacity due to a lack of nursing staff which affected the number of surgical procedures and led to cancelled appointments. This issue was on the risk register and the trust were actively recruiting new staff and taking mitigating actions to reduce the number of cancelled operations.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to.

Managers worked to keep the number of cancelled operations to a minimum.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We spoke with two patients who had their surgery cancelled on the same day due to a lack of emergency care beds at the time of our inspection.

The service moved patients only when there was a clear medical reason or in their best interest.

Staff did not move patients between wards at night.

Managers and staff worked to make sure that they started discharge planning as early as possible.

Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of delayed discharges, knew which wards had the highest number and acted to prevent them.

Staff supported patients when they were referred or transferred between services.

Managers monitored patient transfers and followed national standards.

**Average length of stay**

From January to December 2018 the average length of stay for surgical elective patients at the trust was 8.0 days, which is higher than the England average of 3.9 days.

For surgical non-elective patients, the average length of stay was 11.5 days, which is higher than the England average of 4.7 days.

**Elective Average Length of Stay – Trust Level**

![Graph](image)

*Note: Top three specialties for specific trust based on count of activity.*

- The average length of stay for patients having elective cardiac surgery is similar to the England average.
- The average length of stay for patients having elective thoracic surgery is higher than the England average.
- The average length of stay for patients having elective cardiothoracic transplantation surgery is
lower than the England average.

(Source: Hospital Episode Statistics)

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to.

**Non-Elective Average Length of Stay – Trust Level**

![Graph showing average length of stay](image)

Note: Top three specialties for specific trust based on count of activity.

- The average length of stay for patients having non-elective cardiothoracic transplantation surgery and cardiac surgery is lower than the England average.
- The average length of stay for patients having non-elective thoracic surgery is higher than the England average.

(Source: Hospital Episode Statistics)

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From March 2018 to February 2019 the trust’s referral to treatment time (RTT) for admitted pathways for surgery was worse than the England average for all of the 12 months reported.

The trust’s performance ranged from 43.3% to 64.9% compared to the England average of 64.3% to 68.3%.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

One specialty was 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>Cardiothoracic Surgery</td>
<td>54.8%</td>
<td>78.6%</td>
</tr>
</tbody>
</table>

Please note: as Royal Papworth is a cardiothoracic specialist trust not all specialty groupings for surgery are relevant and therefore not included in the table above.

(Source: NHS England)

The trust had an RTT recovery plan in place with detailed actions and timescales to respond to any shortfalls in the service.

**Cancelled operations**

Managers worked to keep the number of cancelled operations to a minimum.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

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 patients with cancelled operations and not treated within 28 days at the trust has been consistently better than the England average.

Trust performance throughout the period was relatively stable, with the percentage of cancellations not treated within 28 days ranging from 0% (quarter 1 2017/18) to 3% (quarter 2 2017/18).

In the latest quarter, Q3 2018/19 the trust cancelled 92 surgeries, and of those cancellations 2% weren't treated within 28 days.

**Percentage of patients whose operation was cancelled and were not treated within 28 days - Royal Papworth Hospital NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Q4 2015/16</th>
<th>Q1 2017/18</th>
<th>Q2 2017/18</th>
<th>Q3 2017/18</th>
<th>Q4 2017/18</th>
<th>Q1 2018/19</th>
<th>Q2 2018/19</th>
<th>Q3 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Cancelled Operations as a percentage of elective admissions - Royal Papworth Hospital NHS Foundation Trust**
Over the two year time period, the percentage of cancelled operations for elective admissions at the trust has been higher than the England average, with Q4 2017/18 having the lowest percentage of cancellations during the period.

Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Patient moving wards per admission

The trust did not provide any data for this and have reported in their RPIR that as a specialist tertiary hospital with low bed occupancy rates it is extremely rare to have to move patients for a non-clinical reason.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Patient moving wards at night

From March 2018 to February 2019 there were no patients recorded as moving wards at night within surgery.

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient communal areas. However, as the rooms were all single occupancy, we found no information informing patients and their families how to make a complaint or raise a concern.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. We reviewed three complaints and noted the trust had followed its complaints policy and met the appropriate time scales for response.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Summary of complaints

From March 2018 to February 2019 the trust received nine complaints about surgery (16.1% of
All complaints for surgery had been closed at the time of reporting. The trust took an average of 19.1 working days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 25 working days.

Access to treatment or drugs was the subject that received the most complaints in surgery, accounting for 77.8% of all complaints.

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Type of complaint</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to treatment or drugs</td>
<td>7</td>
<td>77.8%</td>
</tr>
<tr>
<td>Communications</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td>Consent</td>
<td>1</td>
<td>11.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

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

**Number of compliments made to the trust**

From March 2018 to February 2019 the trust received 5,963 compliments in relation to all areas at Royal Papworth Hospital. The trust did not provide a ward or core service breakdown of the compliments. However, the trust has confirmed that they plan to record compliments by ward and department on the new site.

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

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The surgery division had a clear leadership structure, with defined roles and responsibilities. The deputy director of operations led the surgery and transplant teams, supported by an operations manager, head of nursing, matron and lead nurse for transplant.

Leaders had an inspired and shared purpose. Staff were highly motivated to provide care and individualised support that meet the needs of the people served by the trust.

Local leaders were highly valued and respected by the staff team.

The trust had comprehensive strategies to develop leadership skills and encourage talent across the organisation.

Leadership within the trust drove continuous improvement and sought ways to embed new and sustainable models of care.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders and staff understood and knew how to apply them and monitor progress.

The trust strategy and vision were stretching and innovative.
All staff we spoke with were focused on achieving the trust vision and embedding the trust values in the everyday practice.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with were universally proud to work for the trust and there was a strong focus on collaboration to improve outcomes for patients.

Staff told us they felt very supported and valued in their roles, by staff of all grades and we noted consistent mutually respectful interactions between staff. Staff described an open culture where they felt able to raise concerns and suggestions to managers who staff described as approachable, interested and willing to provide them with advice and support at any time.

Staff were very proud of the care they provided, and of the resources they had. The improvements in the physical environment had created a strong sense of ownership within the team, who felt the changes had lifted staff morale and created a pleasant working environment for patients and staff.

Staff described leaders as always prepared to go the extra mile, willing to be involved in day to day work and not afraid to do any tasks however menial, to ensure patients and staff were supported.

There was a high level of enthusiasm and motivation for working in the department. Staff knew they had shortages in the work force, but they knew the recruitment plans were in place and were confident that the management team listened to their concerns and supporting them to recruit new staff.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The trust had an established governance system and all staff we spoke with knew how the various quality and assurance groups fed into the governance structure.

Directorate meetings had an agreed governance agenda, minutes and action log. We reviewed minutes from directorate meetings for March, April and May 2019. These were comprehensive and contained a range of quality issues and actions taken by respective staff and teams to improve and monitor quality and performance.

We reviewed three sets of mortality and morbidity meeting records from March, May and June 2019. Meeting records reflected learning from mortality and set actions with timescales for staff to make improvements in the service.

Since the trusts last inspection in 2014, the trust developed and launched a quality strategy and refreshed this at the beginning of 2019. The ambitions within the strategy outline the further improvements the trust want to make.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was no separate risk register for the service. Risks were entered onto the trust wide risk register. We reviewed the trust wide risk register and found this to be up to date, with named staff
allocated to each risk and clear timescales for improvement, as well as mitigation to manage any risk. Risks included the amount of qualified nursing staff,

Leaders within the surgery teams understood and could tell us the challenges that the department faced, including risks. All the leaders and managers we spoke with were passionate about delivering high quality care to patients, whilst supporting and leading operational staff to achieve this.

We reviewed performance data from the surgery and transplant business report month two, 2019. Risk and performance were covered extensively throughout the report and detailed action logs were in place to improve performance.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems and these were in line with data security standards.

The trust had arrangements to ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. Information was shared via team meetings, on the internal trust dashboard, and at governance and mortality and morbidity meetings. Senior staff we spoke with during our inspection understood key performance data and how this was used to drive improvement. Staff within the surgery teams were aware of internal performance standards and worked with other teams meet performance standards.

The trust had effective arrangements to ensure data and notifications were submitted to external bodies, for example the CQC, and Clinical Commissioning Groups.

Staff used information technology systems effectively to monitor and improve the quality of care. The surgery wards had an abundance of computer work stations on wheels, which enabled staff to access key patient information across the department. Staff ensured that monitor screens were locked when not in use, and we noted staff usually used the screens facing away from patients, so no information could be seen by the patient themselves.

The trust considered people’s views on quality, operations and finances. The trust held annual general meetings throughout the year to encourage stakeholders and the public to feedback on its service and performance.

Nurses and medical staff had access to information technology systems to track patients through journey within the surgery wards.

Staff had access to policies, procedures and clinical guidance through the trust’s intranet and staff could access these in a timely manner.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

During 2018, the trust developed a formal mechanism (Laudix) for capturing positive feedback in recognition of any member of staff who had gone the extra mile to support their colleague or improve patient safety and or the patient experience. This had been received very positively by all staff across the trust.

The trust carried out staff surveys annually, however as the trust had recently moved sites results from 2018/19 related to the previous hospital environments and culture.

The trust used a weekly ‘Our Big Move’ briefing to senior staff members to ensure they received regular updates on the move to the new hospital, as well as giving staff the opportunity to ask questions or raise concerns.
The briefings were well-attended, and managers monitored how well these updates were being shared to wider staff groups with monthly pulse surveys of staff. The trust held exhibition-style events to update all staff on the developments with regards to the move and produced weekly NewsBites and monthly NewsBeat communications to all staff.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in audits.

The service undertook opportunities to share learning. For example, thematic reviews were undertaken in relation to incidents. Presentations were shared at conferences and the national cardiac benchmarking collaborative.

Safe innovation was strongly encouraged and celebrated by the trust.

The trust had significantly invested in improving digital maturity and introduced new functionality such as ‘On the Wall’ screens in clinical areas to capture and display patient vital signs and monitoring.

The trust had achieved interoperability between their electronic patient record and the local NHS trust IT system through a two-way interface to record laboratory result to share patient details and speed up diagnosis and treatment.

The trust had introduced a system called Open Health Connect which enabled the trusts IT systems to communicate with those used in the community.

The trust adopted E-Prescribing, which saw a reduction in medication errors and reduced the organisations carbon footprint by removing paper charts and reducing paper use.

Royal Papworth won the Tech Project of the Year category at the Health Tech Newspaper Awards 2018.

Royal Papworth Hospital became the first in Europe to remove a chest tumour using a minimally invasive technique that reduces patient recovery time and minimises pain and side effects. A consultant surgeon worked with consultant anaesthetists at the hospital to perform the pioneering procedure (called subxiphoid non-intubated thymectomy) on a patient who presented an anterior mediastinal tumour called thymoma with associated myasthenia gravis, a condition which weakens body muscles.

Royal Papworth Hospital recently had one of its cardiothoracic surgeons appointed as the Associate National Clinical Lead for Organ Retrieval for NHS Blood and Transplant. They are the first Royal Papworth surgeon and the first ever cardiothoracic surgeon to hold the position and will be in post for the next three years.

Royal Papworth Hospital performed its 2,000 pulmonary endarterectomy (PTE) procedure, 23 years after the hospital’s first in 1996. This is the second biggest PTE series in the world and is one of the most active currently, with nearly 200 operations carried out each year. Royal Papworth remains the only centre in the UK offering the service with some of the best long-term outcomes internationally.

Royal Papworth Hospital’s pioneering DCD heart transplant programme reached a significant milestone when clinicians used the new life-saving technique on the 50th patient. That transplant took place in October 2018, and at the time of our inspection, surgeons and physicians had taken the total number of non-beating heart transplants to 68 and lung transplants to 58. In addition, the trust surgeons and physicians had also undertaken the world’s first heart and lung transplant.

Staff are supported to celebrate innovation and the Trust runs staff awards on an annual basis which had a category to celebrate innovation in practice. The 2019 Awards were held recently at the new Royal Papworth Hospital site, prior to being fully occupied.
Two surgeons from Royal Papworth Hospital won the ‘Pioneering Hero’ award at the ITV NHS Heroes Awards in 2018, a special event to celebrate the 70th anniversary of the NHS. Staff received the award in recognition of their work to establish a new type of heart transplantation at Royal Papworth Hospital.

The trust transplant team picked up the accolade for ‘Excellence in Organ Retrieval’ at the ‘Inaugural UK Awards for Excellence in Organ Donation and Retrieval’. The judges praised the entire hospital staff for several reasons, including completing five transplants in 36 hours last year. Other achievements during the year included a world record in the number of adult donation after circulatory death (DCD) heart retrievals, resulting in a 40% increase in the number of patients who have benefitted from transplantation, leading to a significant reduction in the hospital’s heart transplant waiting list.

### Critical care

### Facts and data about this service

Royal Papworth Hospital NHS Foundation Trust’s critical care service is led by dedicated consultant intensivists and care is delivered by a multidisciplinary team (MDT) which works closely with all other specialists within the hospital. The MDT includes medical, nursing (including nurse consultant), physiotherapy, pharmacy, dietetics, occupational therapy, speech and language therapy and health care scientists.

The critical care unit also cares for patients following primary percutaneous coronary intervention (PPCI) for acute coronary syndrome (ACS) who may have had an out of hospital cardiac arrest (OHCA).

As a national tertiary referral centre, the service accepts patients with cardiac and/or respiratory failure for mechanical support with extra-corporeal membrane oxygenation (ECMO) or ventricular assist device (VAD) as well as specialist surgery including transplantation and pulmonary endarterectomy (PEA).

(Source: Trust Routine Provider Information Request (RPIR) Acute – Context tab)

The service works closely with the trust’s ‘Alert team’. The Alert team support acutely ill patients in all areas of the hospital, including those discharged from the critical care area as required.

The trust has capacity for 46 adult critical care beds. At the time of our inspection, the service had 33 critical care beds open. The trust does not provide any paediatric critical care.

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

This was the first time we had inspected the service since their move to a new site in Cambridgeshire in April 2019.

### 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

Nursing staff received and kept up to date with their mandatory training. The trust set a target of 90% for the completion of mandatory training. In critical care the 90% target was met in eight of the nine modules for which qualified nursing staff were eligible. The trust target was narrowly missed for one subject which was conflict resolution.

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>229</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>228</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>228</td>
</tr>
<tr>
<td>Health and safety</td>
<td>228</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>220</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>220</td>
</tr>
<tr>
<td>Information governance</td>
<td>220</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>209</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>196</td>
</tr>
</tbody>
</table>

Medical Staff: Please note, the trust does not have medical staff that fall directly under the critical care core service. Critical care medical staff are listed under anaesthetics (surgery) or their other specialties.

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

The mandatory training was comprehensive and met the needs of patients and staff. It covered core areas such as infection control, adult basic life support and medicines management amongst others. Training was provided as online learning and face to face sessions.

Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, autism or dementia. Staff could access training on delirium through using links on the electronic patient record system’s delirium assessment page. The service was looking to introduce training on mental health and had been in touch with a registered mental health nurse to help facilitate this.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was monitored as part of the services’ appraisal process. The service linked mandatory training completion to nurses incremental pay. This motivated staff to complete their training.

The service monitored medical staff’s mandatory training through their annual appraisals. Clinicians were unable to complete their appraisal if they had not completed their mandatory training.

Safeguarding
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. 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 the completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>April 2018 to February 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 2)</td>
<td>220</td>
<td>231</td>
<td>95.2%</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>220</td>
<td>231</td>
<td>95.2%</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>217</td>
<td>231</td>
<td>93.9%</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>217</td>
<td>231</td>
<td>93.9%</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>5</td>
<td>15</td>
<td>33.3%</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>5</td>
<td>15</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

In critical care the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff were eligible.

For the two modules in which nursing staff did not meet the target (level 3 adults and children) there were lower numbers of staff eligible for the training.

**Medical Staff:** Please note, the trust does not have medical staff that fall directly under the critical care core service. Critical care medical staff are listed under anaesthetics (surgery) or their other specialties.

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

Nursing staff received training specific for their role on how to recognise and report abuse. However, the service did not meet their training target for Level 3 safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A safeguarding policy was available, and staff knew how to access it.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff within the service were aware of who the safeguarding lead was for the trust.

Staff followed safe procedures for children visiting the ward. The service had an intercom system which prevented children or their relatives from accessing the unit without speaking with a member of staff first.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, we observed two instances where staff did not wash their hands following patient contact.

All areas within the unit were clean and had suitable furnishings, which were clean and well-maintained.
Cleaning records were not available to demonstrate that all areas were cleaned regularly. An external organisation was contracted to clean the critical care environment, and healthcare assistants cleaned equipment and bed spaces. Two cleaners who worked for the external organisation told us that they did not have a cleaning schedule to work to. However, cleaning undertaken by the external organisation was audited on a weekly basis and staff were provided with feedback on any areas for improvement. Audit results were displayed on visitors’ boards, we saw that the service achieved a 99.28% cleanliness score for May 2019.

Cleaning products that came under Control of Substances Hazardous to Health Regulations (COSHH, 2002) were not always being stored securely. The dirty utility rooms on the critical care unit were not locked and chorine solutions were stored in the rooms without being locked away. We raised this with the matron who informed us that they would ensure solutions would be kept locked away in future and that they would share the need to do this with staff by adding it to the daily safety brief. When we returned to the dirty utility rooms during the inspection we saw the solutions had been locked away.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service employed patient environment assistants to damp dust and clean equipment. All pieces of equipment that we checked had green “I am clean stickers”, indicating regular cleaning.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE) and bare below the elbows standards. However, we saw two occasions where staff did not wash their hands after removing their PPE following patient contact. We raised this with the matron who informed us that a reminder about infection control principles would be added to the service’s daily safety brief.

The service monitored infection rates and presented them to the services monthly business unit meeting. We requested the services infection rate data, this was provided for the service’s old site due to only being at the new site for six weeks when we inspected. From April 2018 to March 2019, the service had seven cases of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA). MRSA is a type of bacteria that's resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections. The service had nine cases of hospital acquired Clostridium difficile (C.difficile). C.difficile is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics. It can spread easily to others. The service had nine cases of methicillin-susceptible Staphylococcus aureus (MSSA). MSSA is also known as Staph infections, which are caused by bacteria called staphylococcus. They most often affect the skin. They can go away on their own, but sometimes they need to be treated with antibiotics. The service had six cases of hospital acquired Escherichia coli (E. coli), which is a type of bacteria common in human and animal intestines, and forms part of the normal gut flora (the bacteria that exist in the bowel). There are a number of different types of E. coli and while the majority are harmless some can cause serious food poisoning and serious infection.

The service had developed link roles for infection prevention and control at both nursing and healthcare support worker level. The link role involved meeting monthly at an infection prevention and control group to discuss best practice and to educate members of the team when on the care floor.

**Environment and equipment**

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The design of the environment followed national guidance. The bed spaces had been designed to comply with the Department of Health’s *Health Building Note 04-02 Critical care units*. This included having a clinical hand-wash basin in each bed space, a ceiling-mounted, twin-armed pendant to accommodate a range of equipment and a ceiling-mounted hoist for lifting patients.
The service had suitable facilities to meet the needs of patients’ families. The service was in a purpose-built unit with sliding doors between each bay to allow each patient and their relatives the option to have their own room to protect their privacy or to create a bay by sliding the doors back.

Staff carried out daily safety checks of specialist equipment. This included the resuscitation trolley. There was a pre-planned maintenance programme in place to ensure that equipment was serviced in line with manufacturer’s recommendations. We saw that daily checks were undertaken of the service’s resuscitation equipment.

The service had enough suitable equipment to help them to safely care for patients. All consumable items checked during our inspection were within their expiry date and all equipment checked was found to be in date for servicing.

Staff disposed of clinical waste safely. There were clinical waste bins in every room and we saw staff using these appropriately.

**Assessing and responding to patient risk**

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. However, the service was not auditing the Alert teams response to deteriorating patient times or sepsis management on the critical care unit. This meant that they could not evidence whether the alert teams were meeting their targets or that patients with suspected sepsis were treated in line with national guidance.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The alert team used NEWS2 to identify deteriorating patients on the hospital’s wards, a score of five or more meant that a notification was automatically sent to the alert team to respond to the patient. The service had targets to respond to patients with a score of less than seven within 30 minutes and to respond immediately to anyone who scored seven or more.

Staff knew about and dealt with any specific risk issues. The trusts alert team were available within the hospital 24 hours a day, seven days a week. The alert team responded to deteriorating patients throughout the hospital and facilitated admissions to critical care where necessary.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We reviewed five sets of patient care records and found that all these patients had received an assessment for venous thromboembolism (VTE) and had been reviewed by an intensive care consultant within 12 hours of admission to the critical care unit. In addition, other pertinent risk assessments such as those used to assess a patient’s risk of developing pressure ulcers and malnutrition had also been assessed and reviewed regularly.

The service used the sepsis six bundle and followed the trust’s sepsis protocol.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health).

Staff shared key information to keep patients safe when handling over their care to others. The service’s electronic system had a discharge summary that was completed and added to the medical records system for the wards that the patient was discharged to.

Shift changes and handovers included all necessary key information to keep patients safe. We attended the morning handover and saw that it included the nursing leads allocating staff to patients matching staff with knowledge and skills for the patient’s condition, providing a brief handover of all patients to staff, the service’s safety briefing and then comprehensive individual handovers for each patient. The service had a handover form with a checklist to ensure all aspects of a patient’s care were handed over each shift.

**Nurse staffing**

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patient’s safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.
The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for critical care.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>183.3</td>
<td>201.5</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the nursing staffing rate within critical care was 101.1%. This is due to an over-establishment of 2.1 WTE nurses.

The staffing rate has increased from the previous period, March 2017 to February 2018, where it was 91.0%.

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

The service had enough nursing staff of all grades to keep patients safe. We saw that staffing levels were displayed at the entry of the ward. On the day of our inspection there was 38 nurses for 30 patients, which was in line with planned staffing levels. Nursing staff that we spoke with told us they felt staffing levels on the unit were safe. The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers.

Nurse staffing numbers exceeded those recommended by the faculty of intensive care medicine. The guidelines for the provision of intensive care services, 2015, recommend that Level 2 patients have a registered nurse to patient ratio of 1:2 and that Level 3 patients have a nurse ratio of 1:1. We saw that the service always maintained a ratio of at least 1 registered nurse to every patient on the unit.

The service had three band seven nurses on at all times in a supernumerary role to coordinate the unit and to provide support for more junior staff.

Staff within the service told us that due to the new layout with individual rooms that they had felt they needed additional staffing when the unit opened. In response the service had increased their template staffing numbers to provide each set of four bays with a senior nurse to assist.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. In accordance with national guidance. The trust held three bed meetings a day to review staffing levels. These were attended by operational managers and the service’s duty sister who would present any concerns they had with staffing.

The unit manager could adjust staffing levels daily according to the needs of patients. The duty sister calculated the services staffing levels using an electronic acuity tool.

The service had standardised shift handover procedure. This commenced with a unit-wide handover led by the nurse in charge of the shift. The skill mix of the registered nurses was reviewed and patients were matched with nurses with appropriate skill sets. Following the unit-wide handover, registered nurses handed over their patients in their individual bays.

The service had an induction tailored for bank and agency staff that included a competency sign off sheet and induction book.

There were two critical care pharmacists allocated to the unit, this exceeded the recommendations in national guidance.

Vacancy rates

From March 2018 to February 2019 the trust reported a vacancy rate of 1.2% for nursing staff in critical care, this was lower than the trust target of 6.0%.
The service had low vacancy rates for nurse staffing. However, the service had a high vacancy rate for healthcare support workers. The service was actively recruiting to these roles and using innovations such as offering nursing apprenticeships to try and increase numbers. At the time of our inspection the service had 16 healthcare support worker vacancies.

**Turnover rates**

From March 2018 to February 2019 the trust reported a turnover rate of 17.1% for nursing staff in critical care, this was higher than the trust target of 15.0%.

**Sickness rates**

From March 2018 to February 2019 the trust reported a sickness rate of 4.3% for nursing staff in critical care, this was in line with the trust target of 4.0%.

**Bank and agency staff usage**

The table below shows the numbers and percentages of nursing hours in critical care at the trust from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 395,787 total working hours available, 1.9% were filled by bank staff and 2.6% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, 0.8% of the available hours were unable to be filled by either bank or agency staff.

Of the 92,409 total working hours available, 5.7% were filled by bank staff and 3.4% were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, 1.9% of the available hours were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total hours available</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>395,787</td>
<td>7,690</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>92,409</td>
<td>5,273</td>
</tr>
<tr>
<td>All nursing staff</td>
<td>488,195</td>
<td>12,963</td>
</tr>
</tbody>
</table>

Managers limited their use of bank and agency staff and when they were used, staff familiar with the service were requested.

Managers made sure all bank and agency staff had a full induction and understood the service.
Medical staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

No medical staffing data was available as the trust did not have medical staff that fell directly under the critical care core service. Critical care medical staff were listed under anaesthetics (surgery) or other specialties.

The service had a consultant critical care intensivist as clinical lead for the unit. They were supported by another consultant intensivist, five registrars and two junior doctors. Medical staffing was in line with the guidelines for the Provision of Intensive Care Services 2015. Medical leads told us they were actively recruiting for a new consultant intensivist to support the opening of the additional ten beds in September 2019.

The service had onsite consultant cover from 8am until 10pm. After this time there was on call cover from a consultant. The service held consultant-led multidisciplinary ward rounds at each patient’s bedside at 9am and 8pm, seven days a week. In addition, there was a consultant-led office based multidisciplinary ward round at 2pm seven days a week. There was also a 5pm informal goals catch-up before the consultants’ hand-over.

Records

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

Patient notes were comprehensive, and all staff could access them easily. We viewed five sets of patient records and could see that patients received coordinated care with clear and accurate information exchanged between relevant health professions.

Documentation in the patient records of the time and decision to admit to intensive care was in line with national guidance. We reviewed five sets of patient records, three patients were elective surgery patients, so this was not applicable; in the two sets of records where patients were emergency admissions we saw that the decision to admit was documented and that patients had been admitted within an hour of the decision.

When patients transferred to a new team, there were no delays in staff accessing their records. The trust had electronic record systems throughout the services meaning that staff had access to patients records electronically instantly.

Records were stored securely. The service used an electronic records system which staff had access to using an electronic card. The system interacted with other systems within the hospital. We saw that the electronic system included handover summaries from theatres which included a surgeon handover summary, the therapeutic plan for the patient, patient history, anaesthetic information handed over by the anaesthetist, patient allergies and the theatre nurse handover.

The record system enabled staff to see trends in a patient’s observations and pain scores by including an option to display this data as charts and graphs.

Patient handovers were undertaken using an electronic form on the system which included checks for both the nurse handing over and the nurse receiving the patient to ensure all aspects of the patient’s care were handed over.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely, and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs (CD) were stored securely and managed appropriately. Regular balance checks were performed in line with trust policy. Allergies
Evidence were recorded on patient’s charts in line with National Institute for Health and Care Excellence (NICE) guidance. There was a clinical pharmacy service every weekday on critical care. Principles of antimicrobial stewardship were implemented.

Staff reviewed patient’s medicines regularly and provided specific advice to patients and carers about their medicines. We saw that, where appropriate, nursing staff introduced themselves to patients before offering them medicines and they explained what they were giving. A pharmacist visited daily on weekdays to review prescriptions and advise medical staff when doses needed to be revised.

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy. Patient’s medicines were stored in a locked medicines drawer on the equipment pendant in each bay. Records showed that daily checks of medicines stock on the resuscitation trolleys had been performed to ensure that they were fit for use in accordance with trust policy. Medicines fridge records showed that medicines were stored within the recommended range.

Staff followed current national practice to check patients had the correct medicines. Policies and procedures were available and accessible to staff via the trust intranet. Policies we viewed as part of our inspection were in date and in line with best practice and national guidelines. Clinical guidance was also available on the trust intranet.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The provider had a medication safety officer who had an active role in national medication safety networks and a CD accountable officer who participated in the local CD intelligence network.

A pharmacist completed full medicine reconciliation for all patients within 24 hours of admission.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

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 April 2018 to March 2019, the trust reported one incident which was classified as a never event for critical care.

The never event occurred in March 2019 and relates to a misplaced naso-gastric tube.

(Source: Strategic Executive Information System (STEIS))

Not all staff we spoke with in the service were aware of the recent never event, one nurse and one healthcare support worker we spoke with were unaware. However, three members of staff were aware of the event and told us that it had been reported in the services daily safety briefs and discussed at the services multidisciplinary team (MDT) meeting. When we raised this with the service’s leaders we were told that the final incident report had recently been completed and the learning from the incident was due to be shared at the service’s mortality and morbidity meeting on the second day of our inspection. Leaders told us that information about the never event had also been shared at the service’s safety huddle, so they were surprised that there were some members of staff who were unaware.

We viewed the investigation report into the never event and saw that learning was identified
alongside arrangements for sharing the learning at various critical care meetings and the services
daily safety briefs. The service was also in the process of setting up further training on naso-
gastric tubes to ensure staff were fully supported.

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported three serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from April 2018 to March 2019.

A breakdown of incidents by incident type are below:

- One medical equipment/devices/disposables incident meeting SI criteria
- One pressure ulcer meeting SI criteria
- One incident pending review (this is the above never event)

(Source: Strategic Executive Information System (STEIS))

All staff knew what incidents to report and how to report them and reported all incidents that they should report. Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff could give examples of incidents where the duty of candour had been exercised including when the wrong piece of equipment had been used on a patient.

Managers debriefed and supported staff after any serious incident. Managers told us that those involved in a serious incident were involved in the investigation process and that all learning shared was anonymised.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The trust had a serious incident executive review panel to ensure all serious incidents were investigated appropriately and lessons shared.

We requested the last three root cause analysis (RCA) investigations undertaken by the service. We saw that the incidents were appropriately investigated with contributing factors and learning from the incident identified. We saw that the serious incident action plans assigned actions resulting from the serious incident report recommendations to individuals and provided a deadline for completion.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. The service’s incident reporting system included an option to receive feedback, staff told us that if they asked for feedback it was provided by email or in person. Incidents and learning from them were discussed as part of the service’s weekly multidisciplinary meeting and the services daily safety huddles. The trust also had an intranet page called “lessons learned” which gave feedback on incidents that happened across the trust.

There was evidence that changes had been made as a result of feedback. Staff told us about changes that had occurred as the result of incidents including storing some pieces of speciality equipment in the matron’s office, so it could only be used when retrieved by the nurse in charge of the shift with the keys to the office. Another example was minimum alarm noise levels were set on all the patient machines following an incident where a patient’s vital signs had dropped but the alarm volume had been lowered which caused a delay in identifying this.
Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information.

The service continually monitored safety performance. Staff used the safety thermometer data to further improve services.

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 12 new pressure ulcers, one fall with harm and two new catheter urinary tract infections from March 2018 to March 2019.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at Royal Papworth Hospital NHS Foundation Trust

1. Total Pressure ulcers (12)
2. Total Falls (1)
3. Total CUTIs (2)

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)

The service had put plans in place to address the increase in pressure ulcers on the unit. The services tissue viability link nurse was working alongside the trust’s tissue viability team to support investigations into pressure ulcers and to provide training to staff.
Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance, which managers checked to make sure staff followed. The physiotherapy service had introduced a tracheostomy ward round to discuss patients weaning plans with doctors and nurses. Staff told us they found it easier to involve doctors and provide more consistent weaning this way. The service was in the process of auditing the difference in patient outcomes before the introduction of the ward round, and after and hoped to present their findings at the European Conference on Weaning and Rehabilitation in Critically Ill Patients.

The service followed national guidance including the guidelines for the provision of intensive care services (GPICS) and the National Institute for Health and Care Excellence (NICE). Practice was in line with the Intensive Care Society (ICS) and the Faculty of Intensive Care Medicine (FICM).

Staff used a holistic approach to assessing patient needs on admission to the critical care unit, and this included their emotional and social needs as well as their physical needs.

National institute for Health and Care Excellence (NICE) guidelines were followed for patients receiving Intravenous (IV) fluid therapy and patients were assessed to assess their level of risk VTE in accordance with NICE guidance.

Staff followed best practice as patient needs were continuously assessed in line with national guidance. For example, staff assessed patients using the nationally recognised Malnutrition Universal Screening Tool (MUST). Records also documented use of nationally recognised tools such as the assessment of skin integrity using the Braden score and SSKIN care bundle.

The service contributed and uploaded data regularly to the Intensive Care National Audit Research Centre (ICNARC), which provides information and feedback about the quality of care to those who worked in critical care to allow service benchmarking against similar critical care units nationally.

New evidence-based techniques and technologies were used to support the delivery of high-quality care. The physiotherapy team undertook innovative projects to improve patient care. For example, the service had recently introduced the use of the Passy-Muir valves which allowed patients to speak whilst ventilated alongside other clinical benefits including improved swallowing and secretion management. The service had also recently trained three physiotherapists to perform lung ultrasound scans which can help diagnose lung conditions and help inform treatment options. The ultrasound scans could be performed at the patient’s bedside without exposing them to ionising radiation like more traditional diagnostic options. The service was also working on introducing high-flow oxygen for patients with a tracheostomy. This had been shown to improve oxygenation and decrease the work of breathing in critically ill patients.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice.

At handover meetings and during ward rounds staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed the lead clinician on the ward round enquiring about relative’s support systems and ensuring that staff made time to contact relatives and offer support as part of care planning alongside patient’s clinical needs.

The service held critical care conferences throughout the year with external speakers to ensure that staff were aware of emerging evidence based-care. Recent conferences included topics such as Novichok, management of acute peri-operative stroke, pre-hospital management of cardiothoracic emergencies and dermatological emergencies in intensive care.
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.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We saw evidence of this when reviewing patient’s records.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All the records we reviewed evidenced staff had competed the malnutrition universal screening tool risk assessment tool.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. The service had two dietitians assigned to the critical care unit who were available five days a week from 7am to 3pm. The service did not have out of hours dietician support.

Staff made sure patients had support with nutrition and hydration to meet their needs. Dietitians within the service were available to support with the prescribing and advice for patients receiving total parenteral nutrition (TPN). TPN is a way of supplying all the nutritional needs of the body by bypassing the digestive system and dripping nutrient solution directly into a vein.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. We routinely observed staff checking patients for any symptoms of pain and offering analgesia in line with the trust medication policy.

Patients received pain relief soon after it was identified they needed it or they requested it. The service had access to a specialist pain team who could be contacted to assist with patients with complex pain. Staff we spoke with knew how to refer to the team and could provide examples of when they had accessed them.

Staff prescribed, administered and recorded all pain relief accurately. We saw that pain was regularly assessed and pain relief given where appropriate in all of the patient records we looked at. Patient’s we spoke with told us that their pain had been well managed by staff.

The service used a critical care pain observation tool to assess patients’ pain who were sedated. We saw evidence that this was used regularly in the patient records we reviewed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Intensive Care National Audit Research Centre (ICNARC) Participation

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.

We used data from the 2017/18 Annual Report.

(Source: Intensive Care National Audit Research Centre (ICNARC))

ICNARC results

Papworth Hospital
The table below summarises performance at Papworth Hospital, Critical Care Unit in the 2017/18 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>0.0%</td>
<td>Within expected range</td>
<td>✓</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>1.6%</td>
<td>Within expected range</td>
<td>×</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td>1.1%</td>
<td>Not in the worst 5% of units</td>
<td>×</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio (all patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.0</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>0.8</td>
<td>Within expected limits</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: Intensive Care National Audit Research Centre (ICNARC))

The ICNARC results for the critical care unit at this trust demonstrated they were within the expected range when compared to other comparable units. The service was one of the first cardiothoracic intensive care units in the country to join ICNARC and supported the development of a subset of ICNARC data for those units, known as Assessment of Risk in Cardiothoracic Intensive Care (Arctic).

The service provided us with their latest quarterly ICNARC report to the clinical commissioning group (CCG). In this report we saw that the latest figures for the service showed they were performing better than comparative units for five out of the eleven metrics and in all but one metric the service performed ‘better than expected’.

The service performed poorly in one metric, the unplanned readmission within 48 hours. Service leads told us that actions had been put in place to reduce this rate including a GIRFT (Getting it Right First Time) review into readmissions, weekly meetings between the alert team and the intensivists and looking at readmissions as part of the services MDT meeting.
The guidelines for the Provision of Intensive Care Services, 2015, states that unplanned readmission rates within 48 hours of discharge to a ward should be minimal. From June 2018 to May 2019 the trust had an average of 3.8 readmissions to the critical care unit within 48 hours of discharge per month. The service had put actions in place to reduce these rates and from December 2018 to May 2019 the rate had reduced to an average of two readmissions within 48 hours of discharge per month.

The service participated in all relevant national clinical audits. Managers carried out a comprehensive audit programme. We saw that this included participation in nine national audits, eight regional audits and twelve local audits. We were provided with the results for some of the services audits including Audit of the Appropriate Administration of rFVIIa (NovoSeven) as an Emergency Haemostatic Agent for Intractable Bleeding in Cardiac Surgery and the Audit of antimicrobial prescriptions on CCA. We saw that the audits clearly outlined their methods, findings and ‘next steps’. However, actions in the next steps section were not assigned to members of staff and there was not a timescale for completion.

However, we saw that the services antibiotic use in the critical care unit audit had a clear action plan in place with actions assigned to a member of staff with a completion date. The service achieved above 90% for: the appropriate microbiology samples/cultures are taken before antibiotics are stated in patients with clinical evidence of bacterial infection, indication for antibiotics started is documented in the patient’s clinical notes and antibiotics are reviewed at 48 hours and the antibiotic plan is updated in the patient’s clinical notes. The service achieved 24% against a target of 100% for the metric of duration of antibiotic treatment is documented in the patient’s clinical notes. However, the audit provided possible explanations for clinicians not documenting this and included an action to research barriers to prescribing antibiotic stop dates in critical care.

Managers used information from the audits to improve care and treatment. The outcomes of local audits were monitored and shared in the services business unit meeting and mortality and morbidity multidisciplinary meeting. Managers shared and made sure staff understood information from the audits.

The service audited sepsis outcomes for patients through their ICNARC return data. ICNARC data showed that high-risk sepsis admissions from the ward outcomes were as expected.

The service’s Alert team had targets to respond to patients with a NEWS2 score of less than seven within 30 minutes and to respond immediately to anyone who scored seven or more. At the time of our inspection the service did not audit the alert team’s response times and therefore could not provide us with data to demonstrate that they were meeting these targets. The service leads told us that they intended to audit the response times going forward and provided us with an October 2019 audit that showed that 69 patients seen by the alert team triggered the key threshold for review within 30 minutes. 97% of the patients who triggered this key threshold were reviewed within 30 minutes as per the trust’s escalation algorithm. The audit included a section for recommendations and action plans which stated that the recommendation was to conduct another audit in 6 months’ time to ensure 100% compliance, however no actions were put in place to achieve 100% compliance and the action was not assigned to any member of staff.

**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 development.

The continuous development of staff's skills, competence and knowledge was recognised as being integral to ensuring high quality care within the service. Staff were proactively supported and encouraged to develop new skills, use their transferrable skills and share best practice.
Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The service had an educational programme for each band of nursing staff working in the critical care unit from healthcare support workers to nursing management roles.

The service had a structured training and support programme for newly qualified nurses which was accredited by a local university. The training programme included eleven study days, 200 hours of work-based learning and aimed to ensure that staff working in the unit were academically and practically trained to care for cardiothoracic patients.

The service ran development training for each band of nursing role working in the service, which was tailored to providing the skills necessary for each band. For example, the service’s band seven management and leadership study programme focused on compassionate leadership and feedback from the trust’s freedom to speak up guardian.

The service however did not meet the national standard of 50% of registered nurses with a post-registration award in critical care, as set out in the Faculty of Intensive Care Medicine’s (FICM) Guidelines for the Provision of Intensive Care Services. The service had a training rate of 17% of staff at the time of our inspection. The services educational leads were aware that this was an issue and had a plan in place and approved by the trust board to release 10% of their nursing staff each year to undertake the course to ensure the service was in line with the national guidance in three years’ time. The service set the goal of three years as the unit had over 200 members of nursing staff and they needed to ensure that unit staffing levels remained safe whilst providing nurses with study days to attend university. The service educational leads told us that their mitigation for the low training levels was that all staff attend the in-house accredited Intensive care unit course in cardiothoracic nursing.

There were enough clinical educators to support staff learning and development. The service’s education department was led by an experienced nurse who had been in post for three years at the time of our inspection. They were supported by a team of clinical educators including four registered nurses, two healthcare support workers and one administrator. The clinical educators divided their time to work two thirds of the time in their clinical educator role and one third undertaking clinical shifts to ensure they maintained their competencies and to provide one to one teaching support with staff who were working at the bed side. Clinical educators and mentors assessed staff’s competencies and kept up to date records of them. Feedback from staff was continually positive about the clinical educators and the development opportunities offered to staff.

Managers gave all new staff a full induction tailored to their role before they started work. The induction programme within the trust was structured and included four weeks supernumerary working for registered nurses and six weeks for newly qualified registered nurses. The induction also included two months of supervised practice, induction checklists and competency sign offs. The standard induction period was three months and included a check in with the clinical education team at one and three months before handing over to the nurse’s line manager.

Managers made sure staff received any specialist training for their role. This included providing specialist in-house training courses on extracorporeal membrane oxygenation (ECMO) which is used when a patient has a critical condition that prevents the heart and lungs from working normally. Royal Papworth was one of only five sites in the UK offering ECMO to patients. The service held weekly simulation training sessions on deteriorating patients and resuscitation. These were facilitated by the clinical educators and doctors on the unit. The alert team were provided with a consultant mentor, had to have achieved advanced assessment skills and were supported to undertake a masters in advanced clinical practice.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. All newly qualified members of staff were aligned to a manager to conduct their one to ones and appraisal and a nursing mentor who offered them additional pastoral and clinical support.

The service ran a study day programme to share best practice among staff, the study days ran bi-annually for different bands of staff and included training on specialist equipment on the unit.
There was a multidisciplinary approach to training on the unit with allied health professionals attending training set up by the clinical educators and facilitating training for other healthcare professionals. For example, the service’s physiotherapy team had run sessions on chest oscillation and rehabilitation of patients for the wider multi-disciplinary team. The physiotherapy team had access to weekly training held by physiotherapy staff at the trust.

The service had two working time equivalent pharmacists working on the unit who were trained to a senior level and had advanced clinical skills such as non-medical prescribing. The pharmacy team could access advice from a consultant pharmacist if they required advice.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

The service was using innovative new ways to address their shortage of healthcare support workers (HCSW) by offering direct entry nursing apprenticeship roles. The apprenticeship programme was run by the service’s clinical educators and involved a four-year training programme that saw recruits join as HCSW’s, complete the care certificate qualification whilst working 80% of the time as a HCSW and 20% of the time as a supernumerary student. The service had piloted the scheme with eight members of staff and had a successful recruitment round which saw a significant increase of applications for the HCSW role. The pilot was so successful that the trust had identified funding for 25 more nursing apprenticeships trust-wide.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. The service held different educational forums including the apprenticeship steering group and student nurse’s forum to ensure that feedback about training programmes was used to improve them.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The service had recently introduced a monthly journal club where an article relevant to the service would be discussed and staff were encouraged to participate in discussions. Staff told us that the latest topic had been rehab after critical care and how staff could involve patients and individualise care.

Staff within the service had access to coaching to help support them reach their professional goals. Some staff we spoke with in the service told us that they accessed a coaching qualification through the trust and were now utilising this to coach other members of staff.

Managers supported staff to develop through yearly, constructive appraisals of their work. The appraisal process ensured nurses received a one to one meeting every three months with their line manager and an annual formal appraisal. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers identified poor staff performance promptly and supported staff to improve through this process.

**Appraisal rates**

From April 2018 to February 2019, 88.0% of all staff within critical care at the trust received an appraisal. This was lower than the trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff received appraisal</th>
<th>Number of required staff</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estates and ancillary</td>
<td>3</td>
<td>3</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional professional, scientific and technical staff</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>192</td>
<td>216</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>
In critical care two staff groups did not meet the 90% target for appraisals, however nursing staff were close to the target with 88.9%.

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

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

There was a holistic approach to delivering care and treatment to all people who used the service. This included assessing their nutrition, hydration and pain relief needs. The service’s dietetic team attended and inputted into the service’s ward round to discuss their input for patients’ nutritional needs. We saw that the consultant leading the ward round actively sought the input of allied health professionals and registered nurses and that they worked together as a team to come up with a plan of care for patients.

The service held a high-level handover meeting at 8am which was attended by the service’s doctors, ward sisters and the service’s physiotherapy lead. Staff told us this meeting helped target patients who may require greater input across the multidisciplinary team in advance of the ward round to ensure those patients needs were met quicker. Where relevant, the service’s pharmacists also joined the services ward round to ensure that they appropriately managed new and existing patients.

The service’s physiotherapy team attended ECMO meetings with physiotherapists from other centres to discuss best practice, outcomes and data collection.

There was a holistic approach to planning people’s discharge, transfer or transition to other services which was done at the earliest possible stage. The service performed bi-weekly rehabilitation rounds with the services consultants, the physiotherapy and occupational team, nurses and the speech and language therapy teams. The ward round focused on ensuring that patients would be fit for an effective discharge.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We reviewed the minutes from the services morbidity and mortality multidisciplinary team (MDT) meeting, we saw that the service lead’s encouraged staff to comment and challenge. The meeting outlined learning points from case reviews, readmissions, out of hours transfers and site move concerns. The service had an electronic issue log which all staff members could raise issues from on their pendant computers to be discussed at the meeting.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service leaders had sought the input of the trusts microbiology team in trying to alleviate staff’s feeling of isolation with new units’ single rooms and the need to keep side room doors shut to prevent infection. Using the team’s advice leaders had come up with a criterion for when the doors should be open and shut. Staff could provide examples of seeking input from other specialities including the trust’s stoma nurse visiting patients and seeking input from the neurological team at the neighbouring trust.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic services, 24 hours a day, seven days a week.

Consultants led twice daily ward rounds, including at weekends. The ward round had input from nursing staff, microbiology staff, pharmacy staff and physiotherapy. The microbiology team conducted a microbiology ward round weekly.
The services critical care pharmacists ran a five-day service with a hospital wide pharmacy provision at the weekends. Staff on wards could call for support from the critical care alert team seven days a week. The service had two members of nursing staff working onsite 24 hours a day, seven days a week. The service’s physiotherapy team were onsite from 8am to 4:30pm on weekdays and 8:30am to 5pm on weekends. The service operated a telephone on call service outside of these times.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.** Patients were admitted under specialist pathways and staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Nursing staff completed the health assessment as part of the patient admission process. This was a holistic assessment and covered things such as family, family history, home environment and lifestyle factors for example, smoking and drinking status.

The service had a follow up service in place for extra-corporeal membrane oxygenation (ECMO) patients which involved a consultant review and a World Health Organisation quality of life survey. The follow up included advice on exercise and psychology.

Patient pathways had their own follow up pathways, and patients were reviewed post-surgery at cardiac surgical clinics.

The trust had an active program for smoking cessation and alcohol advice with brief intervention and level one advice. This was led by specialist nurse teams and advanced nurse practitioners.

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

**Staff supported patients to make informed decisions about their care and treatment.** They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions. They used agreed personalised measures that limit patients' liberty.

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

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for the MCA training module from April 2018 to February 2019 at trust level for qualified nursing staff in critical care is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>217</td>
</tr>
</tbody>
</table>

In critical care qualified nursing staff met the 90% target for MCA training. **Medical Staff**: Please note, the trust does not have medical staff that fall directly under the critical care core service. Critical care medical staff are listed under anaesthetics (surgery) or their other specialties.

*(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)*

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff clearly recorded consent in the patients’ records.
Evidence appendix Royal Papworth NHS Foundation Trust

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed daily mental capacity assessments for their patients as part of their observations. We saw that this was embedded practice and that the clinical staff reminded nursing staff of the importance of completing this.

When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff gave us examples of when they had made best interest decisions for patients who did not have capacity.

Staff made sure patients consented to treatment based on all the information available.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff we spoke with could explain under what circumstances they would apply for a DoLS and provided examples of patients they had done this for.

Staff could describe and knew how to access the services Mental Capacity policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The service’s electronic mental capacity form had a link to up to date guidance, policy and training on mental capacity assessments.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff on the ward round taking their time to speak with each patient or their family and ensuring that the patient was treated with dignity and respect.

Staff ensured the dignity of patients who were unconscious was protected. We saw staff introducing themselves to these patients, explaining their role and what they were going to do and why the patient was in the critical care unit.

Patients said staff treated them well and with kindness. Staff gave us examples of where they had demonstrated kindness to their patients including getting patients newspapers from the onsite shop when televisions were not working.

The service had a standard operating procedure to enable patients receiving mechanical ventilatory support to go outside. Multiple staff told us about a patient who had been with the service for a long time and how a group of staff had worked together to enable this patient, who was receiving mechanical ventilatory support to go outside to visit the duck pond.

Another member of staff told us about providing support to a relative who lived in another country by arranging accommodation for them and providing them with hospital meals, so they could eat with their relative after their long flight.

Staff followed policy to keep patient care and treatment confidential. We saw staff using designated rooms to speak with patient’s relatives about their care and ensuring that all doors were shut in the bays before commencing discussions and examinations with patients.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.
Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff demonstrated empathy when having difficult conversations and understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff gave us examples of where they had assisted distressed patients and ensured that the curtains were drawn and doors closed to protect their dignity. One member of staff gave the example of a staff member hugging an extremely agitated patient and how this helped them to feel less anxious.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. The service created patient diaries for patients on Extracorporeal membrane oxygenation (ECMO) so that patients could better understand the care and treatment that had been provided to them whilst they had been critically ill. The idea of the diary was that nurses would regularly fill them in explaining what had happened to a patient whilst they had been staying on the critical care unit. However, these were not provided to all patients even though staff told us they felt other patients could have benefitted from them.

The service’s ECMO nurse consultant ran an ECMO follow up clinic to assist the patient and their relatives with adjusting to the time spent unconscious during their stay. The clinic involved a quality of life survey, presenting of the ECMO diary to the patient and an opportunity to discuss how they are feeling. Patients were offered the opportunity to have a tour of the critical care unit if they wished to see where they were cared for when they were unwell.

We observed a doctor on the medical round asking the nursing team to find out what support a patient’s relative had in place and offering to speak to the relative by telephone to better understand their reasoning for not wishing to visit.

During our inspection, the trust was planning the critical care’s remembrance service to help support relatives of those patients that had died in critical care. This was due to take place in September 2019.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with four relatives, who told us that staff had made them feel at ease.

We observed the service’s medical round and saw medical staff asking patients whether they understood the plan for them and whether they had any questions. One member of staff asked the patient if they wanted them to get hold of anyone for them to explain what is happening.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients relatives told us they felt they had been included in the plan of care for their relative and that staff had made sure they understood what was happening to their relative.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.
Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service’s design included a room that could be designated for bariatric patients and could accommodate specialist bariatric equipment. Bariatric describes the medical treatment of seriously overweight patients.

The service had eight designated side rooms for patients requiring isolation or respiratory Extracorporeal membrane oxygenation (ECMO).

The service leaders had designed the new unit having sought feedback from previous patients, staff and having visited other trusts who had recently built critical care units.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service’s design with sliding doors between each bay meant that each bay could become a separate room therefore preventing mixed sex breaches occurring.

Facilities and premises were appropriate for the services being delivered. The service had designed the unit with the needs of the local population in mind. The service had access to three different rooms that were designated for speaking with patient’s relatives which gave relatives privacy and dignity when being updated on their loved one’s condition. Staff told us that this was an improvement on the previous unit where they often struggled to find space to have private conversations.

The service’s relative room was not functioning well. There were not enough chairs for the number of relatives on the day of our inspection and the telephone that was meant to link directly to patient’s bed spaces was not working. We raised this with senior staff who told us they were aware of the concerns and were reviewing the room and its use.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health conditions, learning disabilities and dementia. The service had access to a team with mental health trained nurses and a trust dementia lead.

The service had systems to help care for patients in need of additional support or specialist intervention. The service had a service-level agreement for a local trust to provide neurological support for patients with a neighbouring hospital trust. The premises had been designed with tunnel access to a neighbouring trust which had been used in the run up to our inspection to transfer a patient requiring neurological support in a timely way.

The service had an arrangement with a nearby hotel that offered accommodation exclusively for relatives of patients at Royal Papworth and a neighbouring trust. However, two different relatives we spoke with also told us that they didn’t have access to information on accommodation and parking and that they would have found this helpful.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health conditions, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff we spoke with were aware of the documents and could tell us about specific patients who had used them.

Wards were designed to meet the needs of patients living with dementia. The service’s layout ensured that all patient bays were visible from the corridor and the next bay to ensure that patients could always be directly observed.
Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff we spoke with told us they could access communication aids available for patients who may have difficulties communicating.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed, either by telephone or face to face. Staff were aware of how to access interpreters when required. Staff had access to communication aids to help patients become partners in their care and treatment. However, the service did not have information leaflets available in languages other than English.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

**Bed occupancy**

From March 2018 to February 2019, Royal Papworth Hospital NHS Foundation Trust has seen adult bed occupancy remain relatively stable, with occupancy levels increasing from September 2018 onwards.

Bed occupancy levels were similar to the England average for the first half of the period, but were worse than the England average from September 2018 onwards.

**Adult critical care Bed occupancy rates, Royal Papworth Hospital NHS Foundation Trust.**

![Graph showing bed occupancy rates](image)

**Note:** data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The trust had three daily bed meetings with representatives from critical care in attendance to discuss availability of beds, patient safety, staffing levels and the acuity of patients.

Performance data indicated that patients could access critical care in a timely manner. The Faculty of Intensive Care Medicine’s (FICM) *Guidelines for the Provision of Intensive Care Services* state that “admission to Intensive Care must occur within 4 hours of making the decision to admit”. From June 2018 to May 2019 only one patient had been admitted outside this window.

Service leaders had been working to identify trends and staff forecasting to try and optimise the use of the unit better and reduce surgical cancellations in lieu of emergency admissions. We saw that the service had a target of between 0-10 cancellations per month and classes more than 20 cancellations as ‘high risk’. From June 2018 and May 2019 the service had an average of 51 cancelled operations each month. Every month was classed as high risk.
Managers worked to keep the number of cancelled operations to a minimum. The service monitored how many surgical cancellations were due to a lack of critical care beds and how many were down to a lack of critical care staff. The service had a target of 0-5 cancellations due to lack of critical care beds, however between June 2018 and May 2019 there was an average of 11 cancellations per month attributable to a lack of critical care beds. The service was due to open a further 10 beds and were recruiting additional staff to improve the number of cancellations due to critical care bed availability.

Managers and staff worked to make sure patients did not stay longer than they needed to. Work was ongoing to ensure patients were repatriated to their local trusts sooner. The service leaders were using links with the critical care network and other trusts to facilitate repatriations sooner to ease flow and enable patients to be closer to their relatives whilst recovering.

Managers monitored that patient moves between wards/services were kept to a minimum. All night time transfers were reviewed at the services multidisciplinary meeting. The service moved patients only when there was a clear medical reason or in their best interest.

Managers and staff worked to ensure they started discharge planning as early as possible.

Managers monitored the number of delayed discharges and acted to prevent them. The service monitored the number of beds that were occupied by ward patients on an average of nights per month. From June 2018 to May 2019 the service lost an average of 17 nights per month.

Staff supported patients when they were referred or transferred between services.

**Learning from complaints and concerns**

*It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.*

Patients, relatives and carers knew how to complain or raise concerns. Staff told us that in the event of a patient or relative wishing to complain they would ask the nurse in charge to speak to them to resolve the issue in the first instance and provide them with the details of the Patient Advice and Liaison Service (PALS).

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes and shared these in the meetings. We reviewed the service’s business unit meeting and saw that these were discussed.

Staff knew how to acknowledge complaints and patients received feedback from managers following the investigation into their complaint. We reviewed the service’s latest three complaint responses and saw that managers apologised when care did not meet expected standards and how the learning has been shared among staff to prevent reoccurrence. We saw that staff were compassionate, open and honest in their responses.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff we spoke with could give examples of recent complaint outcomes including reminders of how to communicate professionally with family members after a complaint was made about terminology used.

**Summary of complaints**

From March 2018 to February 2019 the trust received two complaints about critical care (3.6% of total complaints received by the trust).

All complaints had been closed at the time of reporting. The trust took an average of 30.0 working days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 25 working days.

The two complaints related to patient care and communications.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)
Number of compliments made to the trust

From March 2018 to February 2019 the trust received 5,963 compliments in relation to all areas at Royal Papworth Hospital. The trust did not provide a ward or core service breakdown of the compliments. However, the trust has confirmed that they plan to record compliments by ward and department on the new site.

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

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had the skills, knowledge, experience and integrity necessary for their roles. In line with the guidelines for the Provision of Intensive Care Services, 2015, the nursing team was led by a matron recognised as having overall responsibility for the nursing elements of the service and a designated Clinical Director for Intensive Care. Both the matron and clinical director had extensive experience within critical care.

Leaders we spoke with understood the challenges to quality and sustainability and could identify actions needed to address them. Service leaders were working towards increasing capacity within the unit by an additional 10 Beds by September 2019. Service leaders told us the service had received an increased number of emergency admissions over the last year and needed to expand the service to ensure sustainability. Plans for increasing capacity included growing the service’s workforce and ensuring safe staffing levels were maintained. Nursing leaders told us that other challenges included ensuring that 50% of their nursing staff completed a post graduate course in critical care.

The matron received support from the service’s head of nursing. The trust leads had identified that the nursing staff base and workload was too large for one matron and therefore had recruited a second matron who was due to start in September 2019.

Staff told us that leaders at all levels were visible and approachable. Staff felt supported by their managers and had regular one to ones and annual appraisals. Staff told us the trust’s chief nurse and chief executive officer were approachable and they felt they listened to any concerns they had.

Leadership development programmes were in place to ensure sustainable, compassionate, inclusive and effective leadership. Senior leaders also had access to clinical supervision and coaching arranged by the trust’s chief nurse.

Vision and strategy

The service did not have a formal strategy in place.

The service did not yet have a formal strategy in place. Service leaders told us this was because the trust was currently in the process of refreshing their strategy and the service leads wanted to ensure their new strategy aligned with the trust’s refreshed strategy.

There was however a mission statement and the service leaders had a clear vision for the service which included streamlining pathways and promoting research and education.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where
patients, their families and staff could raise concerns without fear. However, some members of staff told us that they felt that at times they felt bullied by staff.

Staff we spoke with were mostly positive about the culture of the service and told us they were proud to work for the service. However, three members of staff told us they felt there were issues with bullying among the nursing staff. Two of these staff members told us they had not experienced this directly but were aware of concerns. One member of staff told us they had directly experienced bullying.

Service leaders were aware that staff felt that there were issues with bullying and had taken positive steps to try and address the behaviours. In response the service had held freedom to speak up guardian drop in sessions and investigated alongside human resources. The service was working on delivering positive behaviour workshops to promote kinder interactions among staff in an attempt to change the culture within the service.

There was a strong emphasis on safety and well-being of staff from leaders we spoke with. The service’s leaders were taking actions to address the concerns raised during the staff survey including setting up staff forums based on nurse banding and creating an additional, more detailed survey to try and understand some of the issues identified in further detail.

The service had a ‘Bravo’ page on the intranet on which positive feedback about staff could be posted. This feedback then also fed into the service’s multidisciplinary team meeting. One member of staff provided us with an example where they had posted on the page because they had witnessed a healthcare support worker calming a distressed patient and giving them a cuddle to help alleviate their anxiety.

The service was in the process of introducing a psychological well-being service accessible to staff. They had secured funding for a psychologist to attend the unit once a week to speak with patients and staff who wished to raise concerns about their wellbeing or mental health.

The service had recently moved sites into a new location. Staff we spoke with told us that the move and new ways of working had resulted in staff feeling more isolated than previously. Managers were aware of the impact this had upon staff and that there was a period of adjustment for staff ongoing. The service’s leaders had set up a celebration event to thank staff for their efforts during the move. This was due to take place three weeks after our inspection. The service had set up drop in sessions for staff to attend during the move period to provide feedback on the move and raise any concerns. In addition to this all staff were offered a one to one with managers to talk through any concerns about the move they may have.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective structures, processes and systems of accountability to support the delivery of good quality, sustainable services. The service sat within the Clinical and Diagnostic Services (CADS) directorate. The critical care unit was regarded as a business unit under the division and held monthly business unit meetings. We reviewed the minutes of these meetings and saw that discussions included incidents, complaints, activity in the service including cancellations, bed occupancy, finance, research, audits, workforce, sickness and education. The business unit meetings then fed into the monthly CADS meetings and monthly performance meetings, which were attended by executives.

The services weekly multidisciplinary team meeting fed into the service’s business unit meeting and clinical concerns discussed in the meeting featured as part of the service’s monthly quality, safety and risk report, which was presented at the business unit meeting.

Staff had regular opportunities to meet, discuss and learn from the performance of the service. The service’s clinical lead, matron and physiotherapy lead met weekly to discuss planned admissions for the week and to address any concerns they may have about the service. The
The service had a daily safety briefing as part of their handover process to ensure staff were informed about any risks and to provide them with the opportunity to raise concerns.

The service had more formal nursing team meetings which staff were invited to attend monthly. We requested the minutes of these meetings, but they were not provided by the trust.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were robust arrangements in place for identifying, recording and managing risks. The service had an electronic risk register which dated risks, rated the level of risk, assigned a review date and detailed controls that were in place. Risks on the register reflected risks that staff and leaders spoke about on our inspection including staffing levels, feelings of isolation in the new bay layout and accommodation for relatives.

The service’s risk register was reviewed at the monthly business unit meetings. The service invited a representative from the trust’s risk department to ensure that decisions being made about risks were aligned to the rest of the trust and to escalate any risks that needed to be raised at trust level. Risks were escalated to the trust wide quality and risk management group.

The service managed risk, issues and performance through the critical care business unit meeting. A monthly quality, safety and risk report was prepared for each meeting which featured a comprehensive overview of incidents including identifying any themes and trends and serious incident review progress, ‘excellent incidents’ reported (where staff could report positive events), complaints, morbidity report, clinical issues discussed at the multidisciplinary meeting, infection controls report, hand hygiene and infection related audits, staffing, the staff survey and risks.

Performance information was fed to the business unit meeting through the services business unit report. We saw performance was tracked over a period of a year, so the service could recognise trends. The service tracked cancellations, theatre utilisation, critical care bed occupancy, readmissions, out of hours discharges, delayed admissions and beds occupied by ward-ready patients.

Mortality and morbidity meetings on a weekly basis. All members of the multi-disciplinary team were invited. Minutes for the meetings clearly recorded background information to the cases discussed, details of the discussions held and any learning that was identified as part of the meeting. This meant that the minutes could be shared with those not in attendance, to ensure that learning was shared with all relevant staff. Actions were identified in response to learning that had been identified as part of the discussions held in the meeting. In addition, monthly ECMO mortality and morbidity meetings took place and key staff from the critical care unit attended the dedicated surgical, transplant and pulmonary vascular disease unit mortality and morbidity meetings.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

There was a holistic understanding of performance, which sufficiently covered and integrated people’s views with information on quality, operations and finances. Quality and sustainability both received sufficient coverage in relevant meetings at all levels and staff had sufficient access to information.
There were clear and robust service performance measures which were reported on and monitored through the services business unit meetings. These included cancellations, bed occupancy rates and discharge delays.

Information technology systems were used effectively to monitor and improve care. The services patient record system allowed staff to view patients’ observations in graphs and charts to enable staff to see if trends or deterioration could be more easily identified.

There were mostly robust arrangements to ensure the confidentiality of identifiable data, records and data management systems, in line with data security standards. Staff received training on information governance and patient records were stored securely electronically. We observed staff locking their computer screens when walking away from them.

**Engagement**

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service gathered the views and experiences of staff to improve services. The service had recently conducted a consultation with staff to change shift patterns on the unit. Staff that we spoke to were positive about the changes made and the input they had.

The service displayed both staff and patient feedback on the visitors boards alongside actions that had been taken. Staff feedback included that extra nurses were needed because of the service’s new layout, in response the service had reviewed daily staffing numbers and increased the number of staff on each shift. Patient feedback had included that it was noisy and too light at night time, in response the service had fed back to staff about reducing noise levels at night, lowering monitor alarm volumes and turning off non-essential lights.

Leaders within the service told us that they had open days for previous patients to provide feedback on the new unit.

During the recent move to a new site the service held regular drop in sessions where all staff were invited to provide feedback or raise any concerns they had. Staff could provide examples of changes made as a result of this feedback including creating an override standard operating procedure for staff escorting patients when the lifts were taking too long. Staff we spoke with told us they felt listened to by the management team and that they had been responsive to the concerns raised about staffing levels. Staff told us that the service leaders were quick to implement additional staffing to alleviate their concerns.

The service had a page on their records system where staff could raise topics, feedback or concerns that they would like to be discussed with the wider team. This information was then discussed at the services multi-disciplinary team (MDT) meeting every Wednesday. Staff within the service were emailed the meeting minutes of the services MDT meeting so that those who were unable to attend could still view the feedback.

The service had a monthly newsletter that was sent to staff. We reviewed the last three newsletters and saw they updated staff on information relating to the education team, the services journal club, staff wellbeing support, international and national conference reports and the service’s performance figures.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system. The service offered rotational secondments to the neighbouring acute trust to give staff the opportunity to work in other units and experience different specialties. The service currently had one registered nurse and one doctor on this rotation with a further four registered nurses due to commence the rotation in September 2019.

The service had worked alongside system partners including the critical care network and other trusts to plan the new unit and had visited other trusts that had implemented single room units or had recently moved sites. The service worked closely with the neighbouring trust and had service level agreements for neurological support on the unit as well as a connecting tunnel between the
sites to be able to quickly transfer patients if they required a speciality service at the neighbouring trust.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The unit participated in and learnt from internal and external reviews. The unit had participated in a Getting It Right First Time (GIRFT) review. Actions had been implemented in response to areas of concern identified. Actions included improving pathways as a trust to reduce surgical cancellation rates and to address potential inaccurate coding for safety thermometer data by conducting a review into the data.

The service was actively involved in the regional critical care operational delivery network (ODN) and as part of this, a range of projects had been undertaken to continuously improve services. For example, the practice educators had worked to develop their own in-house post registration critical care course, which had been accredited by a local university.

There was an active research programme at Royal Papworth Hospital with involvement from staff, patients and the public. Staff were encouraged to develop ideas to improve patient services and outcomes and the annual staff awards had a category to celebrate innovation in practice. The trust had an active quality improvement programme and research and development team who supported research into practice.

The professional practice team supported the development of training and work to ensure staff were up to date with current practice. The professional practice team introduced new ideas across the service including the development of the services nursing apprenticeship roles.

Mortality and morbidity meetings were held within the sub-specialty business units, they were attended by a multidisciplinary team and learning was shared with staff of all grades.

E-Prescribing had been adopted by the trust, which had seen a reduction in medication errors and reduced the organisations carbon footprint by removing paper charts and reducing paper use.

The trust had developed the Donation After Circulatory Death (DCD) heart programme, the largest in the world. This programme had enabled more than 50 patients to receive hearts from donors which would otherwise not have been used, resulting in an increase in the number of heart transplants per year by a third.

The trust’s transplant team picked up the accolade for ‘Excellence in Organ Retrieval’ at the ‘Inaugural UK Awards for Excellence in Organ Donation and Retrieval’. The judges praised the entire hospital staff for several reasons, including completing five transplants in 36 hours in 2018. Other achievements during 2018 included a world record in the number of adult DCD heart retrievals, resulting in a 40% increase in the number of patients who have benefitted from transplantation, leading to a significant reduction in the hospital’s heart transplant waiting list.

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**Outpatients**

**Facts and data about this service**

Outpatient care at the Royal Papworth Hospital NHS Foundation trust is delivered via three key settings:

- Face to face contact either at Royal Papworth Hospital or via outreach clinics at district general hospitals
- Non face to face contact - telephone clinics
- Virtual clinics which includes care plan reviews.
A team of nurses, healthcare support assistants and administrative staff are responsible for coordinating the delivery of outpatient clinics. Clinics are led by surgeons, doctors, nurses, allied health professionals (AHP) and clinical scientists.

Services include cardiology, surgery, thoracic, transplant, diagnosis and pre-operative assessment.

There is close collaboration with the diagnosis units as patients are offered ‘same day’ diagnosis tests following their clinic appointment.

(Source: Routine Provider Information Request Acute – Context)

**Total number of first and follow up appointments compared to England**

The trust had 96,647 first and follow up outpatient appointments from January 2018 to December 2018. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

**Number of appointments by site**

The following table shows the total number of outpatient appointments by site, a total for the trust and the total for England, from January 2018 to December 2018.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papworth Hospital</td>
<td>106,388</td>
</tr>
<tr>
<td>Ely Cathedral Medical Centre</td>
<td>137</td>
</tr>
</tbody>
</table>
The Brampton Surgery | 121  
The Spinney Surgery | 107  
Dumbelton Medical Centre | 101  
Other locations | 553  
**This Trust** | **107,407**  
**England** | **108,908,946**

(Source: Hospital Episode Statistics)

Type of appointments

The chart below shows the percentage breakdown of the type of outpatient appointments from January to December 2018.

**Number of appointments at Royal Papworth Hospital NHS Foundation Trust from January 2018 to December 2018 by site and type of appointment.**

(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**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.
Nursing staff received and kept up to date with their mandatory training.

**Mandatory training completion rates**

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

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>6</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>6</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>6</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>6</td>
</tr>
<tr>
<td>Information governance</td>
<td>6</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>6</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>6</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>6</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>6</td>
</tr>
</tbody>
</table>

In outpatients all eligible qualified nursing staff had completed the nine mandatory training modules.

**Medical Staff:** Please note, a breakdown of training compliance for medical staff is not available as the trust do not have medical staff that fall directly under the outpatients core service. Medical staff run outpatient clinics but sit under their respective core service (specialty).

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

The mandatory training was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Nursing staff received training specific for their role on how to recognise and report abuse.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff provided an example of a recent safeguarding case they had dealt with and described the communication they had engaged in with other teams in the hospital including the inpatient wards and the lead social worker.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The chief nurse was the executive lead for safeguarding, supported by the deputy chief nurse as the strategic lead. The lead social worker was the operational lead and had job planned time for safeguarding. Staff we spoke with knew how to contact the lead social worker and posters with contact details for safeguarding were displayed in the coordinating rooms in the clinics.
When a prison officer had recently attended with a patient who was a high security prisoner, staff had walked around the department with the officer to agree a process and familiarise them with the layout before the patient was brought in. This enabled the prison officer to take the patient straight into a clinic room, without having to wait at reception or in the waiting room. This had worked well, and managers were going to discuss this at the next safeguarding meeting with a view to writing a formal protocol.

Staff followed safe procedures for children visiting the department.

A very small number of children attended the department following pulmonary endarterectomy and were under the care of the sub-specialty clinical team. Chaperones were available in the department to attend appointments with children.

There was a transitioning period for young adults with cystic fibrosis who were seen at a neighbouring NHS trust for paediatric care to move to adult services at Royal Papworth Hospital. This usually took place from the age of 16 to 19 years. These patients received extra support from the sub-specialty service and a chaperone attended their clinic appointments with them.

Chaperone guidelines and details of how to request one were on all clinic doors.

### Safeguarding training completion rates

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

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children (level 1)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In outpatients all eligible qualified nursing staff had completed the six safeguarding training modules.

**Medical Staff:** Please note, a breakdown of safeguarding training compliance for medical staff is not available as the trust do not have medical staff that fall directly under the outpatients core service. Medical staff run outpatient clinics but sit under their respective core service (specialty).

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

### Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All outpatient areas were clean and had suitable furnishings which were clean and well-maintained. The outpatient facilities included 10 clinic rooms each in clinics A, B and C, as well as a clean utility room and a treatment room. Privacy curtains were in place in clinic B and C.
treatment rooms but in clinic A privacy screens were used so they could be cleaned between patients. Clinic A was dedicated to the Cambridge Centre for Lung Infection (CCLI) and had different cleaning processes in place than B and C. Four of the 10 rooms in clinic A were en-suite and reserved for patients who were immunocompromised. In clinic A the rooms and adjacent corridors had an enhanced ventilation system that changed the air every four minutes which meant that airborne bacteria and viruses were extracted very quickly.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Clinical equipment cleaning protocols were in place and individual infection prevention and control checklists were completed in the clinic rooms to show that non-clinical equipment such as keyboards and desks had been wiped. All rooms were checked at the end of each day to ensure they had been cleaned.

Ambulatory care areas were audited at least twice monthly for cleaning standards. If the score fell below 95% an action plan was put in place. The matron for ambulatory care conducted regular walk-rounds with the manager for the cleaning team. We saw the report for the most recent walk-round in June 2019 which reported an overall cleaning score in the department of 98.8%. The report identified that the main waiting room floor was difficult to maintain and was being deep cleaned that weekend.

Staff followed infection control principles including the use of personal protective equipment (PPE). Stringent procedures were in place to minimise the risk of cross-infection for patients attending the cystic fibrosis clinics. People with cystic fibrosis are vulnerable to different bacteria which grow in their lungs and can be easily transmitted from one person with cystic fibrosis to another.

Patients were seen in specialist cystic fibrosis clinics according to their sputum microbiology and whether or not any bacteria were transmissible, for example: no regular infection, non-epidemic Pseudomonas aeruginosa, epidemic Pseudomonas aeruginosa, Burkholderia cepacia complex, Mycobacterium abscessus and methicillin-resistant Staphylococcus aureus (MRSA) clinics.

When a patient attended the hospital, they were advised to arrive wearing a disposable cotton surgical mask (once inside the building) provided by the outpatient department, until they were shown through to one of the dedicated clinic rooms. Clinicians and staff who needed to see the patient entered the room wearing personal protective equipment including a single use long-sleeved gown and gloves to minimise the spread of infection. If the patient needed blood taking this would also take place in the same clinic room to negate the need for the patient to access other clinical areas.

Cuffs used to record blood pressure were single patient and disposed of after each use.

Wall-mounted glove, apron and mask dispensers were in every clinic room, and in clinic area A they were outside each room for infection prevention and control purposes.

Regular hand hygiene audits, comprising 20 observations per month, were undertaken in each clinical area to monitor compliance with effective hand hygiene at the point of care and the policy of being bare below the elbows. Results were collated and displayed in the department. Compliance of between 76% and 94% required an action plan within five days. Compliance of less than 75% required an action plan within three days.

Recent hand hygiene compliance was displayed on a noticeboard in the reception area of the department. For May 2019 it was 100%. Following our inspection, the service sent us reports showing 100% compliance with hand hygiene for the outpatient department in April, May and June 2019.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. In between each patient with cystic fibrosis, all room surfaces, and equipment were cleaned with a high-level antibacterial solution before being treated with ultra violet disinfection between patients; this meant that all bacteria living on surfaces (door handles, tables, chairs, and taps) were killed.

There were two ultra violet cleaning machines. These were used routinely in clinic A, and as and when required in the other clinic areas, for example if a transplant patient with carbapenemase
producing enterobacteriaceae (CPE) had attended. Transplant patients are highly susceptible to infections by multidrug-resistant organisms including CPE which can be passed from person to person so robust infection prevention and control processes are essential.

**Environment and equipment**

**The design, maintenance and use of facilities, premises and equipment kept people safe.**

**Staff managed clinical waste well.**

The new outpatient department had been purpose-built and was designed specifically to accommodate the needs of the service. The department comprised three clinic areas; clinic A was where lung defence clinics were held and patients with cystic fibrosis were seen; clinics B and clinic C were where transplant and cardiology patients were seen.

There was a welcome notice board in the reception area of the department. This included information about the department, including safety results, infection prevention and control compliance and a uniform chart defining the roles for different coloured uniforms.

Staff carried out daily safety checks of specialist equipment. There was a resuscitation trolley in each clinic area with up to date completed checklists showing they had been checked daily as fully stocked and tagged, with working oxygen. Tags were removed weekly so that the medicines inside the trolley could be checked before re-tagging.

There was a medication fridge in each clinic area with completed checklists where fridge temperatures were recorded. If a medicines fridge temperature went out of range there was a section on the checklist to record what action had been taken, for example that pharmacy was alerted or the manager had been informed.

The glucose monitoring machine was tested every morning and results were logged and stored in the machine, so no paper documentation was required.

Following our inspection, the trust provided evidence to show that regular environmental walk rounds were conducted by the executive team and the matrons. Actions were put in place where issues were identified.

The service had suitable facilities to meet the needs of patients’ families. There was a spacious, light and airy reception area with access to free WiFi, a shop selling snacks, magazines and newspapers, a café and a coffee shop. Banks of plug sockets were available in the outpatient waiting area for use with clinical equipment, or to charge mobile phones or laptop computers.

The service had enough suitable equipment to help them to safely care for patients. There was an annual rolling equipment replacement programme, which was under review following the move to the new hospital. The outpatient department had received and installed much new equipment and orders were underway for the remainder which included further bariatric seating.

The medical engineering team were responsible for the repair and maintenance service programmes for both electronic and non-electronic medical equipment.

Staff disposed of clinical waste safely. There were arrangements in place to dispose of clinical waste separately to general waste. There was a dirty utility area where chemical disinfectants and urine collection containers containing acid were stored in locked cupboards.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.**
Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Clinic rooms were equipped with touch screen electronic monitoring devices which were used to carry out patient observations, including some machines with the ability to perform electrocardiograms (ECG). National early warning scores (NEWS) were calculated electronically and results were recorded by staff in the electronic patient records. The devices had the capability to link to the patient electronic records and automatically update them, but this system was not yet in place.

Staff we spoke with provided examples of actions they had taken when patients deteriorated or became unwell. Some of the clinic rooms had en-suite bathrooms which meant staff had been able to accommodate a patient who had become unwell, without them having to use a public area. Specialist nurses from the clinics assisted the outpatient nurses when necessary if a patient became unwell. On two occasions at the previous site patients had been transferred out of the department by ambulance but this had not happened recently.

Staff completed risk assessments for each patient on admission / arrival and updated them when necessary and used recognised tools. We reviewed six patient records and saw completed risk assessments where appropriate. These included the malnutrition universal screening tool (MUST), and assessments for falls, dementia, pressure ulcers, venous thromboembolism (VTE) and alcohol use.

Staff knew about and dealt with any specific risk issues. Many of the patients attending outpatients were very well known to the service as they had attended the department frequently for many years. There was a sepsis policy and pathway in place and staff we spoke with knew where to find it. Alerts could be added to the electronic patient record by anyone with the relevant access permissions.

The service had access to mental health liaison and specialist mental health support. The service accessed regular support from a clinical psychologist who helped patients with long term conditions to manage their emotional and psychological well-being. The clinical psychologist attended clinic to see some patients, and others were seen separately, outside of the clinic. There were also links with psychiatric services which could be accessed if required, and an on call mental health team at a local NHS mental health trust.

Staff shared key information to keep patients safe when handling over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. There was a staff huddle in the department every morning attended by everyone on shift. The coordinator passed any relevant information to the administration team and any nursing staff coming on shift later in the day.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of all grades to keep patients safe. The outpatient nursing team comprised one band 7 sister, two band 6 qualified nurses and one band 5 staff nurse. There had been a band 5 staff nurse vacancy since the service had moved site, and another band 5 staff nurse had recently left. Nursing staff were supported by two clinic coordinators, five healthcare assistants and an administration team.

The clinic coordinators could be contacted by mobile telephone and duties included resolving environmental issues, responding to a request for cleaning, moving patients to ambulatory care and facilitating a smooth flow through the department. They also liaised with other teams in the hospital when necessary, for example the bed managers when a patient need an inpatient admission arranging.
There was no formal acuity tool in place to calculate staffing needs and managers told us that at the time of our inspection they were reviewing staffing levels as they monitored the workload in the new outpatient department. There had been significant changes to the way the department operated so the existing staffing model had not yet been fully tested in the new premises.

The establishment number was for four qualified nurses per day, supported by four or five healthcare assistants. This was not being achieved, however one of the vacant band 5 posts was in the process of being filled and another band 5 post was being advertised. The vacant healthcare assistant posts were not being advertised until a workforce review had been completed to determine what skill mix was required.

Managers told us that in the meantime the outpatient nursing staff were working closely with the specialist teams to ensure the clinical areas were adequately staffed. The cardiology team and ambulatory care in particular provided support to the department.

When the department was exceptionally busy steps were taken to minimise the impact on patients. On one recent occasion the role of clinic coordinator was passed to the administration team which enabled the clinic coordinator to deal with patients and support the clinics.

The trust reported the following whole time equivalent (WTE) nurse staffing numbers for the periods below for outpatients.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>6.3</td>
<td>10.5</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the nursing staffing rate within outpatients was 75.4%.

The staffing rate has increased from the previous period, March 2017 to February 2018, where it was 59.8%. There was a reduction in the number of staff in post but a larger reduction in the number of planned staff.

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

Vacancy rates

From March 2018 to February 2019 the trust reported a vacancy rate of 26.3% for nursing staff in outpatients, this was higher than the trust target of 6.0%.

This performance should be viewed in the context of the low numbers of nursing staff in outpatients.

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

Turnover rates

From March 2018 to February 2019 the trust reported a turnover rate of 19.5% for nursing staff in outpatients, this was higher than the trust target of 15.0%.

This performance should be viewed in the context of the low numbers of nursing staff in outpatients.

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

From March 2018 to February 2019 the trust reported a sickness rate of 2.4% for nursing staff in outpatients, this was lower than the trust target of 4.0%.

This performance should be viewed in the context of the low numbers of nursing staff in outpatients.

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

Bank and agency staff usage

The service had low rates of bank and agency nurses used in the outpatient department. Bank staff were occasionally used in the outpatient department, usually for administrative duties. Agency nursing staff were not used by the service.

The table below shows the numbers and percentages of nursing hours in outpatients at the trust from March 2018 to February 2019 that were covered by bank and agency staff or left unfilled.

Of the 13,753 total working hours available, 0.3% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for qualified nurses. In the same period, all of the available hours were able to be filled by bank staff.

Of the 19,495 total working hours available, 1.1% were filled by bank staff and none were covered by agency staff to cover sickness, absence or vacancy for non-qualified nurses. In the same period, 0.8% of the available hours were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>March 2018 to February 2019</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total hours available</td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
</tr>
<tr>
<td>Qualified staff</td>
<td>13,753</td>
<td>44</td>
<td>0.3%</td>
<td>0</td>
</tr>
<tr>
<td>Non-qualified staff</td>
<td>19,495</td>
<td>224</td>
<td>1.1%</td>
<td>0</td>
</tr>
<tr>
<td>All nursing staff</td>
<td>33,248</td>
<td>268</td>
<td>0.8%</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing – Bank and Agency tab)

Medical staffing

No medical staffing data is available as the trust do not have medical staff that fall directly under the outpatients core service. Medical staff run outpatients clinics but sit under their respective core service (specialty)

Records

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

Patient notes were comprehensive, and all staff could access them easily. Patient records were electronic so were easily accessible to all necessary staff. They contained hyperlinks to other care providers which meant test results and information recorded by another hospital could be accessed by the specialist teams.

We reviewed six electronic patient records and found them to be complete with risk assessments, care plans and doctors’ letters all easy to find. Test results and prescribed medicines were referenced and accessible.

When patients transferred to a new team, there were no delays in staff accessing their records. Letters to GPs were completed electronically and were filed in the patient records.
Records were stored securely.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Most medication in the outpatient department was managed within the sub-specialty clinical teams. Outpatient nursing staff said they gave intravenous antibiotics prescribed by the doctors but rarely administered oral medication other than an occasional paracetamol. Prescribing was completed on the electronic patient record where letters could also be generated for the patient’s GP.

Electronic prescriptions were sent directly to pharmacy which reduced the time it took for the medicine to be ready for collection. Paper prescription forms (FP10) were only used when the pharmacy was closed. At the time of our inspection, seven had been used so far in 2019.

Medicines were stored and managed appropriately.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

**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 April 2018 to March 2019, the trust reported no incidents which were classified as never events for outpatients.

*(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 outpatients which met the reporting criteria set by NHS England from April 2018 to March 2019.

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

Staff we spoke with knew what incidents to report and how to report them. The number of reported incidents for the last month was displayed on a notice board in the reception area of the department. There had been 16 incidents reported in May 2019. From 1 January 2018 to 31 December 2018 there had been 54 incidents reported. Following inspection the service provided information showing the types of incidents reported, and the level of harm.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with said there was a culture of openness in the service. They kept patients informed when clinics were running late and apologised for any delays or errors. The manager told us they made a point of being “pro-active and visible”.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Information provided by the service following inspection showed the most common
reason for reporting an incident was administration related to booking appointments (admission/ discharge/ transfer). In 2018 39% (21 of 54 reported incidents) fell into this category.

This continued to be an issue that managers were aware of. Managers were holding regular meetings with the booking team to improve processes and were working to resolve the problems.

Staff received feedback from investigation of incidents, both internal and external to the service. Outcomes from incidents and associated trends and themes were communicated through the quality and risk management group reports which were disseminated through the organisation and available on the trust intranet and website. A quarterly lessons learned bulletin was also disseminated across the trust and available on the intranet. All action plans from serious incidents and moderate harm patient safety incidents were monitored through the relevant business unit meetings and reported to the quality and risk management group.

Staff met to discuss the feedback and look at improvements to patient care.

**Safety thermometer**

*The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.*

In the entrance to the outpatient department there was a noticeboard which displayed the scorecard for May 2019 showing safety information and patient feedback. There had been no falls and no moderate or severe incidents reported. The scorecard was adapted from a ward tool and there was an ongoing review to adapt it appropriately for the outpatient department and ensure it provided useful information.

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**Is the service effective?**

**Evidence-based care and treatment**

*The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.*

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access current policies and guidelines on the trust intranet pages. Staff we spoke with said they did this regularly and showed us how it worked. The information was easily accessible.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Where staff needed advice or support in relation to a patient’s mental health they had access to a clinical psychologist who helped patients with long term conditions to manage their emotional and psychological well-being.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. There was a clinical psychology service based at the hospital which supported the outpatient department clinics and the adult cystic fibrosis service provided specialist cystic fibrosis psychological medicine clinics.

**Nutrition and hydration**

*Staff gave patients enough food and drink to meet their needs and improve their health.*

There were facilities next to the outpatient department where patients could buy refreshments. When patients using patient transport were delayed in the department they were provided with snacks such as a drink and a sandwich.
Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed six patient records and saw completed malnutrition universal screening tool (MUST) assessments where appropriate.

Specialist support from staff such as dietitians was available for patients who needed it.

**Pain relief**

*Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.*

Staff assessed patients’ pain and gave pain relief in line with individual needs and best practice. This was managed within the clinical specialties so was tailored to the relevant patient group. There was not a generic outpatients’ pain assessment.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded all pain relief accurately.

**Patient outcomes**

*Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.*

The outpatient service did not monitor follow-up to new rates as these were managed within the individual sub-specialties. However, many of the people attending the outpatient department required lifelong follow-up appointments, for example all cystic fibrosis attendances were follow-up appointments.

The service participated in all relevant national clinical audits. The service performed well in national clinical outcome audits and managers use the results to improve services further. The service participated in the NHS Benchmarking Network (NHSBN) project and provided a copy of the 2018 outpatients project draft report. The outpatients project aimed to provide benchmarked analytics across all outpatient departments; it included profiling of service models, access and availability, activity, workforce and quality. These indicators were monitored by the service and managers we spoke with were well-sighted on their status.

Following our inspection, the service sent a status log setting out the position of the department in relation to the recommendations made in the report Outpatients: the future - adding value through sustainability (Royal College of Physicians, 2018). These included summaries of how the service was providing outpatient care pathways designed to minimise disruption to patients’ and carers’ lives, appointments timed flexibly depending on case complexity and the needs of the patient and alternatives to face-to-face appointments.

Managers carried out a comprehensive audit programme. Outpatient staff completed environmental and infection prevention and control audits, and clinical audits were completed within the sub-specialty teams.

Managers used information from the audits to improve care and treatment. We saw action logs in place to improve care and treatment and the provision of services where issues had been identified. For example, there was an ambulatory booking office action log in place to implement and monitor the processes for completing patients’ outcome, ‘cashing up of clinic' and updating patient access plans following a clinic appointment.

Actions related to clinical care and treatment were managed within the sub-specialty teams.

Improvement was checked and monitored, for example by the outpatient project described above.

**Follow-up to new rate**

From January to December 2018 the follow-up to new rate at Papworth Hospital was higher than the England average.

The follow-up to new rate for all other locations was lower than the England average.
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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Outpatient nursing staff supported the clinics with tasks such as inserting cannulas and setting up and starting intravenous therapy for patients, for example home intravenous antibiotics for patients with an abscess related to cystic fibrosis or iron infusions for transplant patients. They completed a two-week training course to become competent in this and were reviewed at day seven and day 14. The vascular access service involved the insertion of mid-line catheters and accessing portacaths and we saw evidence that appropriate competency training was in place.

Managers gave all new staff a full induction tailored to their role before they started work. Managers made sure all staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. The structure of the team had been organised so that the band 6 nurses supervised the registered band 5 nurses and the band 4 nursing staff. The band 4 nursing staff supported the band 3 and band 2 healthcare assistants. Role-appropriate online leadership training was available to nursing staff who were band 4 and above, and they were encouraged to complete this.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. There was a matrix of nursing competencies required for the different staff levels on display in the office in the department and individual certificates of competency were filed on the computer with paper copies in the staff files.

Managers recruited, trained and supported volunteers to support patients in the service. At the former hospital site there had been volunteers in the department who had helped to distribute the questionnaires but at the time of our inspection these had reduced due to the site move. The trust were advertising for new volunteers on their website.
Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection we saw evidence that the appraisal rate for outpatient staff met or exceeded the trust target for all staff disciplines.

From April 2018 to February 2019, 90.3% of all staff within outpatients at the trust received an appraisal. This was in line with the trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff received appraisal</th>
<th>Number of required staff</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare scientists</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
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</tr>
<tr>
<td>Nursing and midwifery registered</td>
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<td>6</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>10</td>
<td>12</td>
<td>83.3%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td><strong>31</strong></td>
<td><strong>90.3%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

In outpatients all of the eligible nursing staff members had received an appraisal.

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

Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary team meetings were held regularly between staff at the hospital, and also between staff from different hospitals. For example, there were two oncology multidisciplinary team meetings held each week between all the local hospitals where test results were discussed. Planning meetings were held three times each week, with all the different disciplines. This enabled the patients to progress more quickly through the clinical pathway.

Clinic areas A and B had space allocated as ‘coordinating rooms’ where multidisciplinary discussions took place and staff could access computers.

There was a daily safety huddle in the coordinating room where staff looked at the plan for the day and discussed any relevant information, for example incidents, patients due in, infection prevention and control and security. Any staff concerns could be raised in this meeting, for example there had been a concern around portering and specimen collection times that had been raised and resolved through this meeting.

At the time of our inspection formal team meetings had not yet been re-established since the site move.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw good evidence of multidisciplinary working. Patients attending clinics were seen by different clinicians as appropriate, including medical and specialist nursing staff, allied health professionals such as a dietician or physiotherapist and other staff as required, for example a social worker, phlebotomist or healthcare assistant. Pre-admission clinics were also supported by anaesthetists and pharmacists.
There was a clinical psychology service based at the hospital which supported the outpatient department clinics. Clinical specialists from neighbouring NHS trusts also delivered clinics in the department, including hepatologists, oncologists and diabetes specialists.

**Outpatients:** Patients could see all the health professionals involved in their care in one-stop clinics.

**Seven-day services**

The outpatient department was open from Monday to Friday. On Wednesday it was open from 7.30am to 8.30pm for pre-admission patients and on the other four days it was open from 7.30am to 6.30pm. This schedule had only been in operation for four weeks and was still being trialled at the time of our inspection.

Facilities were available within the individual specialities to support patients who were acutely unwell, for example there was 24 hours a day, seven days a week emergency service for people with cystic fibrosis who required urgent support. This was provided from the adult cystic fibrosis centre which was part of the Cambridge Centre for Lung Infection (CCLI) based at the hospital.

The pharmacy was open from 9am to 5pm Monday to Friday with a pharmacist available from 8am to 6pm on site. Outside those hours there was an on call pharmacist available via switchboard.

**Health promotion**

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient’s health and provided support for any individual needs to live a healthier lifestyle. The specialist nurses in the oncology clinic used Macmillan literature and this was included in an information pack provided to new patients.

The service had a number of ‘admission avoidance’ clinics which were delivered either face to face or by telephone to support patients who required additional support or had concerns around their health or condition.

Telephone support and nurse-led telephone clinics were open to cardiology patients immediately post procedure or for symptom return. The clinic outcome was often the discussion of medication versus procedure options, with the decision being reached collaboratively between the patient and clinician.

Surgical and transplant services offered a direct line to all their patients. Dedicated access was provided by the specialist nurses who supported ongoing management and self-care by patients.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice (AMSAT).

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The formal consent process was managed by the sub-specialty clinicians in the individual clinics, not by the core outpatient team.

All nursing staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target.
Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

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

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for the MCA training module from April 2018 to February 2019 at trust level for qualified nursing staff in outpatients is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>6</td>
</tr>
</tbody>
</table>

In outpatients all eligible qualified nursing staff had completed the MCA training module. Performance should be taken in context when dealing with low numbers of eligible staff.

**Medical Staff:** Please note, a breakdown of training compliance for medical staff is not available as the trust do not have medical staff that fall directly under the outpatients core service. Medical staff run outpatient clinics but sit under their respective core service (specialty).

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

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff treating patients with compassion and respect. We spoke with three reception staff who had sight of the waiting areas and said they kept an eye on people waiting to make sure everyone was alright. When people arrived at the reception desk they would either be booked in by the reception staff, or where appropriate, staff would direct them to the electronic book-in.

Patients said staff treated them well and with kindness. We spoke with six patients and 11 relatives or carers, all of whom were positive about the treatment they received from staff in the department.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and carers we spoke with felt well supported by the service. One person told us they
had a patient coordinator, who had spent over an hour discussing the procedure they were waiting for and the implications. The coordinator had made them and their family them “feel safe”. Another patient described the care as “fantastic”.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Information leaflets and other paper sources such as magazines were not kept in the department as an infection prevention and control measure. Patients were signposted to electronic information or given information brought in by the specialist staff in clinics. The patients and carers we spoke with all understood their care and treatment and had been given the information they needed.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We attended an appointment with a patient in the cystic fibrosis clinic. We observed good communication from the clinic staff, and the patient and their partner were fully involved in the discussion throughout the appointment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a noticeboard in the reception area of the department displaying information about changes made following patient feedback, for example some patients had raised concerns about their names showing on the screens when they were called through to their appointments. In response to this, patients were given the opportunity to pick a different name to display on the screen, or to not have a name shown at all.

There were other examples of actions taken following concerns raised by patients, for example the relevance of declaring gender when booking in had been raised as a concern and referred to the IT team managing the process to review. When patient groups had expressed disquiet about the site move the chief executive and the head of nursing for clinical and diagnostic services went to meet with them to answer questions and provide reassurance.

There was a trust-wide patient and carer experience panel where outpatient department related issues were raised, for example concerns about patients no longer being able to have their next appointment booked when they attended if it was more than four weeks away. These concerns were fed back to managers and discussed with the panel to provide information.

There were local support groups for some patients, for example a transplant support group. The trust website also had links to support groups for some services, so that patients could easily access the relevant information and support.

Friends and family patient questionnaires were available on the reception desk for patients to pick up, however patients who booked in on the electronic system and the patients with cystic fibrosis who went straight through to the clinic rooms did not visit the reception desk. There was also a high proportion of patients who attended very regularly and were unlikely to complete a questionnaire at each attendance.

Staff acknowledged there was work to be done on increasing patient engagement which was 2.7% for completion of friends and family questionnaires in May 2019. However, managers told us this was misleading as the denominator used to calculate this included all the telephone clinics and all the outreach clinics where patients were not always given the opportunity to complete a questionnaire.
At the former hospital site there had been volunteers in the department who had helped to distribute the questionnaires but at the time of our inspection these had reduced due to the site move. The trust were advertising for new volunteers on their website.

Friends and family test results were discussed in a weekly matrons meeting and were reported in the monthly Papworth integrated performance report and the ambulatory care business unit report. The business unit report for January 2019 stated friends and family scores remained high, but with very low compliance. A plan was agreed to investigate an electronic option, potentially via text message.

Staff supported patients to make informed decisions about their care. Patient and carers we spoke with said they had been fully informed about their conditions and the treatment options. One patient said staff had been “very frank” with them and had explained all the risks about the surgery they were waiting for. Patients were encouraged to be part of the care planning process.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. In May 2019 88% of patients recommended the service. This was displayed on a noticeboard in the department.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The outpatient facilities included 10 clinic rooms, a clean utility room and a treatment room in each of the clinics A, B and C. Patients with cystic fibrosis were always seen in clinic A which was specifically designed with specialist infection prevention and control measures in place. Transplant patients who were immunocompromised were always seen in clinic C, to minimise the opportunity for them to come into contact with any respiratory bugs carried by respiratory patients attending clinic A.

The Cambridge Centre for Lung Infection (CCLI) based at Royal Papworth NHS Foundation Trust specialised in the diagnosis and treatment of difficult lung infections and comprised three specialist groups: the regional adult cystic fibrosis centre, the lung defence clinic and the respiratory immunology clinic. Patients attending all of these services were seen in the outpatient department.

The department also accommodated complex patients attending the hospital for pulmonary endarterectomy (a surgical operation in which the blood vessels of the lungs were cleared of clot and scar material). This was not offered by any other service in the United Kingdom, so patients attended from all over the country and from abroad.

Annual cystic fibrosis transition clinics were delivered jointly with the paediatric teams from other services to meet children and families prior to moving their care to the adult service. These took place across the country. In the local area transition clinics were held across the region and staff went out to them to meet the patients. Patients were invited to attend the outpatient department for a walk round and when they attended their first appointments with the adult service they were accompanied by an outpatients’ chaperone, as well as any family members who attended with them.

The adult cystic fibrosis service provided specialist cystic fibrosis psychological medicine clinics and cystic fibrosis diabetes and liver disease clinics with the specialist clinicians from a neighbouring NHS trust.
Outpatients: Additional Statement-

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. As the department was a tertiary centre some patients were travelling a long distance to attend and required multiple tests. The clinics were planned to facilitate this, and patients were offered access to all the necessary staff and tests in one attendance. Patients were advised that this may mean arriving early and appointments may last up to three hours.

Some of the sub-specialties provided community-based outreach clinics, for example the respiratory support and sleep centre which aimed to provide care as close as possible to the patient’s home. This was in line with the report ‘Outpatients: the future - adding value through sustainability’ which recommended outpatient care pathways aim to minimise disruption to patients’ and carers’ lives. The pulmonary vascular disease unit provided satellite clinics as well as telephone clinics run by specialist nurses to monitor complex patients’ progress and to prevent re-admission to local hospitals.

Cambridge Centre for Lung Infection (CCLI) provided a nurse-led telephone helpline for existing patients on home intravenous therapy and cystic fibrosis patients could access a remote telephone follow up clinic. The interstitial lung disease service provided a virtual multidisciplinary team meeting for new patient discussions in line with alternatives to face-to-face appointments as recommended in the above report.

Outreach clinics were also available for frequently returning patients, for example pacemaker checks by the cardiology team. Specialist nurses replied to telephone requests for advice to prevent unnecessary attendances for all cardiology specialties. Transplant patients were classed as a high risk group and the service did not want them travelling a long distance to attend the department more frequently than necessary.

Facilities and premises were appropriate for the services being delivered. There was a large screen in the reception area, displaying the names of the clinic doctors, their team members, waiting times and location. This meant that patients arriving could see at a glance the status of the clinic they were attending.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Cystic fibrosis, immunology and congenital heart disease patients aged 16 to 18 years were supported by specialist nurses within the medical sub-specialties.

Managers monitored and took action to minimise missed appointments. Text message appointment reminders were sent to patients prior to their appointments. Patients could telephone the contact centre to re-arrange their appointments if the date was not convenient. Did not attend rates were monitored and discussed within the business unit meetings.

Managers ensured that patients who did not attend appointments were contacted. There was a new standing operating procedure in place setting out a process to follow to standardise practice across all sub-specialties when a patient did not attend. The emphasis was on it being a clinical decision whether to offer a patient a further appointment.

Specialist nurses contacted patients well known to the service who did not attend, to check on their welfare.

Did not attend rate

Managers told us their ‘did not attend’ (DNA) rate was approximately 8-10% overall with quite a lot of variation between the sub-specialties. The department had identified various different reasons why patients did not attend, including booking errors, transport issues and patients being too unwell to attend. When a patient known to the department did not attend for their appointment the specialist nurse contacted the patient directly.

The highest rate was for respiratory support and sleep clinics which had a high volume of patients who tended to be in better health when compared with patients attending other specialist clinics.
The DNA rates for these clinics had reduced from 25% but were still approximately 16% despite
the introduction of telephone and text reminders. Other specialties had DNA rates of less than 7%
and surgery rates were around 3%. Following our inspection, the service sent us information which
confirmed this.

The respiratory support and sleep centre (RSSC) held a regular business unit meeting where DNA
rates were discussed. Minutes from this meeting were taken to the thoracic directorate meeting
where options to improve the DNA rates were considered. These included remote management of
continuous positive airway pressure (CPAP) for people with sleep apnoea associated breathing
problems so that people did not have to attend the clinic.

Home monitoring for some chronic disease patients was also being investigated as an option for
cystic fibrosis patients and a telemetry at home project was underway, led by a specialist nurse.

From January to December 2018 the ‘did not attend’ rate at Papworth Hospital and all other
locations was generally higher than the England average with the following exceptions. The
Brampton surgery ‘did not attend’ rate was below the England average in October 2018 and the
Spinney surgery ‘did not attend’ rate was below the England average in both January and April
2018.

The chart below shows the ‘did not attend’ rate over time.

**Proportion of patients who did not attend appointment, Royal Papworth Hospital NHS
Foundation Trust.**

![Proportion of patients who did not attend appointment, Royal Papworth Hospital NHS
Foundation Trust.](chart.png)

*(Source: Hospital Episode Statistics)*

**Meeting people’s individual needs**

The service was inclusive and took account of patients’ individual needs and preferences.
Staff made reasonable adjustments to help patients access services. They coordinated
care with other services and providers.

Staff we spoke with were mindful that some patients travelled a long way to attend their
appointments, sometimes using a patient transport service. There was a patient transport office on
the hospital site so staff were able to liaise with them when there were delays, either with transport
or in clinic.

Many of the clinic rooms had couches and the day ward was nearby which was equipped with a
portable hoist, sliding sheets and hover mattresses should these be required by a patient waiting a
long time for transport. Staff provided refreshments such as a cup of tea and a sandwich for
patients who were delayed, and stayed with them until they had left.
If patient transport was unable to pick a patient up as planned, staff could ring the on call duty matron to request authorisation to book a private ambulance or a taxi where this was appropriate.

The seating in the reception area was suitable for bariatric patients (up to 250 kilograms) and there were five bariatric couches in clinic C. Further bariatric chairs that met the necessary infection and prevention criteria were being ordered as the respiratory support and sleep centre (RSSC) needed equipment for patients up to 300 kilograms. Bariatric scales with hand rails for larger or less mobile patients were available in some clinic rooms.

Piped oxygen was available in all clinic rooms and in the waiting room. There was a system in place to allow patients to swap from their own oxygen, to oxygen supplied by the hospital while in the outpatient department and registered nurses facilitated this.

Telephone helplines were available within some of the specialty services including lung defence, cardiology and transplant services, where patients could ring to speak with a specialist nurse or leave a message for someone to return their call.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The outpatient department specialist services accessed regular support from a clinical psychologist who helped patients with long term conditions to manage their emotional and psychological well-being. Staff we spoke with said it was mainly the patients with cystic fibrosis who had input from clinical psychology, but patients receiving palliative care were also sometimes referred.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Touch screens were in place for patients to book in at the reception area if they wished. We reviewed the booking in process and saw on screen options to choose different languages and options for patients who were hard of hearing or suffered with visual impairment. When the visual impairment option was selected patients saw text using a black and yellow screen which increases contrast and is considered easier to read for some people.

The service had taken a decision to keep patient information leaflets to a minimum to help prevent the risk of spreading infection, however information was available electronically and staff directed patients to where they could find this, or printed it off for them when necessary.

Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. Interpreters could be booked for patients who required them. When patients arrived unexpectedly without an interpreter the service had access to a language line facility.

Staff had access to communication aids to help patients become partners in their care and treatment.

**Access and flow**

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Oncology patients referred to the outpatient department were those with lung cancer being treated with surgery. National cancer waiting time standards require that patients be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. However, they would not be referred by a GP directly to Royal Papworth NHS Foundation Trust so this standard did not apply.

The standards provide a maximum one month (31 day) wait from the date a decision to treat is made to the first definitive treatment for all cancers which may be radiotherapy or chemotherapy,
not provided at this hospital. There is a further maximum 31 day wait for subsequent treatment where the treatment is surgery, hence 62 days in total. Managers explained that a patient may already be at day 50 in the process by the time they were referred for surgery so were at the end of the clinical diagnostic trajectory. There was a detailed plan around this which was owned by the thoracic directorate although outpatient managers said they were well sited on it.

The service did not offer ‘hot clinics’, however they were able to accommodate patients with cystic fibrosis if they needed an urgent appointment. Ambulatory care supported the outpatient department with starting routine intravenous therapies so that clinics did not get behind with their lists. Certain intravenous therapies were always started in outpatients for infection prevention and control purposes, for example patients with non-tuberculous mycobacteria (NTM).

Cardiology activity in the outpatient department had been significantly above plan, assisted in February by three cardiologist all day clinics on a Saturday. There was a weekly clinical access meeting led by the operations team and attended by all the sub-specialty operational managers and booking office staff. Waiting times and capacity were on the agenda, and clinic information such as requests for additional clinics were discussed at this meeting. Referral to treatment metrics were reviewed in detail within the sub-specialty business units.

When patients were booked in when arriving in the department this showed on the electronic system so that the clinic staff could call them through when they were ready. To be called through, the patient’s name scrolled across large screens which were available throughout the outpatient area. When a new name appeared, the screens ‘beeped’ to alert waiting patients. When a patient arrived in the clinic room the nursing staff logged them in on the electronic system. This meant that the service should be able to easily collect data showing the length of time between patients arriving, being seen, and leaving the department. However, the system was new and at the time of our inspection the staff were still being trained and resolving minor issues with it.

The different sub-specialties had their own standards for new and follow-up appointments. In cardiology a 30 minute appointment was booked for a new patient with 15 minutes for a follow-up patient attendance, however there were 40 minutes unbooked in every clinic to allow for further discussion if required. In surgery a 20 minute appointment was booked for a new patient with 10 minutes for a follow-up patient attendance, however the clinician requested a double appointment if a complex patient was scheduled. This was in line with the recommendations made in the report Outpatients: the future - adding value through sustainability that clinic templates should allow for timing flexibility depending on case complexity and the needs of the patient.

Patients attending the department could book appointments convenient to them with reception if it was within four weeks but appointments outside of that time frame were managed by the booking team. If a patient received an initial or follow-up appointment through the post that was inconvenient they could telephone the contact centre.

Managers worked to keep the number of cancelled appointments to a minimum.

When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff supported patients when they were referred or transferred between services.

There was a transitioning period for young adults with cystic fibrosis who were seen at a neighbouring NHS trust for paediatric care to move to adult services at Royal Papworth Hospital. This usually took place from the age of 16 to 19 years. These patients received extra support from the sub-specialty service and a chaperone attended their clinic appointments with them.

Chaperone guidelines and details of how to request one were on all clinic doors.

**Referral to treatment (percentage within 18 weeks) – non-admitted pathways**

From February 2018 to January 2019 the trust’s referral to treatment time (RTT) for non-admitted pathways has been similar to the England overall performance, ranging from 83.2% to 88.8% compared to the England performance of 86.7% to 89.1%.
The latest figures for January 2019, showed 86.3% of this group of patients were treated within 18 weeks versus the England average of 86.7%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, Royal Papworth Hospital NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

One specialty was above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic medicine</td>
<td>92.3%</td>
<td>86.0%</td>
</tr>
</tbody>
</table>

Two specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic surgery</td>
<td>84.1%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>74.5%</td>
<td>85.5%</td>
</tr>
</tbody>
</table>

Please note: as Royal Papworth is a cardiothoracic specialist trust not all specialty groupings are relevant and therefore not included in the tables above.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From February 2018 to January 2019 the trust’s referral to treatment time (RTT) for incomplete pathways was worse than the England overall performance for the first half of the period. The trust’s performance improved from September 2018 onwards and has been better than the England overall performance for the rest of the period.

Trust performance ranged from 83.2% to 90.9% compared to the England performance of 86.2%
to 87.7%.

The latest figures for January 2019, showed 90.9% of this group of patients were treated within 18 weeks versus the England average of 86.3%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, Royal Papworth Hospital NHS Foundation Trust.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

One specialty was above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracic medicine</td>
<td>96.5%</td>
<td>88.4%</td>
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Two specialties were below the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>83.6%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>70.1%</td>
<td>84.1%</td>
</tr>
</tbody>
</table>

Please note: as Royal Papworth is a cardiothoracic specialist trust not all specialty groupings are relevant and therefore not included in the tables above.

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

The trust is only on one cancer pathway – lung cancer. Referrals come from secondary care and not directly from GPs, therefore there is no data for this as it is not relevant to the trust.
Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

From Q4 2017/18 to Q3 2018/19 the trust met the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) in all four quarters.

The performance over time is shown in the graph below.

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

From Q4 2017/18 to Q3 2018/19 the trust met the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral in the first two quarters. However, trust performance has declined throughout the period with the trust failing to meet the 85% in the last two quarters.

The performance over time is shown in the graph below.
Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Information about how to feed back to the service was readily available in the outpatient department. Leaflets about how to contact the patient advice and liaison service were on the desk in reception and patient feedback information was displayed on the notice board near the entrance to the department.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Managers provided a recent example of a complaint involving a patient journey to the hospital. They described the steps taken to resolve the issue, and the discussion with the other staff and teams involved. They said there had been a lot of learning from the complaint.

Summary of complaints

From March 2018 to February 2019 the trust received 17 complaints about outpatients (30.4% of total complaints received by the trust).

At the time of reporting there was one complaint still open, which had been open for 21 days. The trust took an average of 21.4 working days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 25 working days.

Communications was the subject that received the most complaints in outpatients, accounting for 64.7% of all complaints.

A breakdown of complaints by subject is shown below:

<table>
<thead>
<tr>
<th>Subject of complaint</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>11</td>
</tr>
<tr>
<td>Patient care</td>
<td>4</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

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

Number of compliments made to the trust

From March 2018 to February 2019 the trust received 5,963 compliments in relation to all areas at Royal Papworth Hospital. The trust did not provide a ward or core service breakdown of the compliments. However, the trust has confirmed that they plan to record compliments by ward and department on the new site.

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

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The outpatient service was led by the head of nursing for clinical and diagnostic services, the operations manager and the matron. The band 7 manager played an active and visible role in running the department. There was no medical lead and the non-medical lead had retired.

We observed members of the senior management team in the department and directorate and divisional managers were very visible. Staff told us they felt well supported by the matron, manager, band 6 sisters and lead nurse who were “always around”.

We met with the leads for the department and found they had a commitment to the service, a clear view of what they had achieved in the site move, and a shared enthusiasm to develop it further.

Vision and strategy

The service was working on a new vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust vision, values and objectives were displayed on a welcome noticeboard in the reception area of the department. Outpatient managers said this was being revisited and there was a consultation for a new vision and strategy because in recent months and years the focus had been on achieving a successful site move.

In outpatients the team were having operational and clinical discussions around pathways between their service and other local NHS trusts with a view to streaming them and offering more alternatives to face-to-face appointment for some specialties. They were also looking at refining the electronic patient flow and clinic management system and realising the potential of the electronic patient record.

They said these concepts were “the bones of the strategy” and this was their opportunity to do things in a different way. Plans were being taken to the next stakeholder meeting for further discussion.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had previously operated as five separate outpatient departments with individual teams for surgery, cardiology, transplants, respiratory and pre-admission patients. These teams had come together to be based in one cohesive outpatient department team and staff we spoke with were proud of the work they had undertaken to achieve this.

All the outpatient qualified nursing staff had originally been part of the thoracic outpatient team and the other teams had been separate and staffed by their own specialist nurses. In order to plan for the change there was a weekly department organisational readiness and commissioning (DORAC) working group with core attendance comprising representation from the teams for transplant, cardiology, continuous positive airway pressure (CPAP) and administration. These meetings started two years ago with the aim of finding ways for all the different teams to come together and work as one department and were ongoing.
There were also bi-monthly steering groups and stakeholder groups where people’s roles were matched with their job plans outside of outpatients, for example clinicians who needed their outpatient clinics to be scheduled around their other commitments such as the inpatient wards.

Staff told us there were opportunities for professional development and career progression. Online leadership training was widely available, and staff were encouraged to reflect on their roles, for example what was going well, what was not going well, what did they expect from their line managers. There was a poster on the door near the staff lockers to remind staff of this as they arrived and left work.

Staff were encouraged to apply for promotion and to challenge themselves. We spoke with one member of staff who had successfully applied to move from one clinical area to another and they said they had been well-supported to do so. Another member of staff was completing a qualification to enable them to move into a vacancy at a higher band.

There were trust achievement awards for different categories such as care and compassion, learning and development and team of the year. There was also an award of the week within the outpatient team where the winner had use of a designated cup for the week and received a certificate.

There had been no outpatient incidents that required duty of candour but staff we spoke with said there was a culture of openness and transparency within the department. The trust did not have one person with overall responsibility for duty of candour as it was overseen by the serious incident executive review panel. The process was monitored by the quality and risk management group chaired by the associate medical director and clinical governance lead.

The principles of duty of candour were included in incident training available to all staff at induction and when training on the electronic incident reporting system. Staff expected to be involved in duty of candour discussions were provided with further training in annual investigations skills workshops. There was a Being Open and Duty of Candour policy on the intranet available for all staff.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance processes in place for the department and staff we spoke with knew where to raise matters related to the performance of the service. At an operational level this process started with the daily huddle, where anything noteworthy or of concern could be raised by the staff on duty. The clinic coordinators and manager could escalate matters where appropriate, or where possible, liaise with the relevant staff or teams to resolve them.

Some outpatient team meetings had been missed in the process of the site move, but there were regular meetings to discuss the service. Following our inspection, the service sent us evidence of discussions within the team and with wider teams regarding working together to facilitate the smooth running of the department on the new site. This included recent minutes from an outpatient administrators team meeting, a heart and lung function team meeting, an outpatient action log detailing current issues and actions and a department organisational readiness and commissioning (DORAC) newsletter.

The outpatient department, along with the day unit, was part of the ambulatory directorate at the hospital. There was a monthly ambulatory care report which was discussed at a monthly ambulatory business unit meeting. Key performance indicators, the monthly scorecard and areas of concern were all discussed at this meeting.

Anything that needed escalating from the monthly ambulatory care report were taken to either the monthly clinical and diagnostics service (CADS) or the quality and risk management group, dependent on the issue was. The quality and risk management group was a trust level meeting.
with attendance from every directorate. There were also monthly trust wide performance review committee meetings which included risk and quality, and monthly trust wide health and safety meetings.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was a monthly ambulatory care report which was discussed at a monthly ambulatory business unit meeting. This included a summary of actual versus planned outpatient department activity (thoracic outpatients, transplant, respiratory support and sleep centre, Varrier Jones outpatients) and performance against a range of key indicators.

The key performance indicators were red, amber, green (RAG) rated with comments and areas of concern recorded. Comments and key updates were included where actions had been put in place. Areas reported as key performance indicators included DNAs and appointments without an outcome, incidents, friends and family questionnaire response rates and results, waiting times and staffing.

Managers told us the biggest risk for the outpatient department was glitches within the booking system. The booking team were based off-site and were mostly new members of staff following the site move so were unfamiliar with some of the processes. The administrators in the department booked appointments for patients who attended and needed to be seen again within four weeks, but appointments outside of that timeframe were managed by the booking team. There had been some recent incidents with patients not booked in with the right person at the right time, however most had been resolved by staff at the time of the patients’ attendance.

Meetings were being held between managers and the booking team to try and resolve the issues which staff were recording via the incident reporting system for monitoring purposes.

We reviewed the monthly ambulatory care reports between June 2018 and May 2019. Recent reports showed that the areas of concern discussed with us by managers corresponded with those recorded at the monthly business unit meetings, for example problems with the booking system, staff vacancies and glitches with the new IT systems. All were being actively managed.

There was a monthly scorecard which recorded performance scores for criteria including hand hygiene, infections and staff sickness. This had been adapted from a ward performance tool, so was being monitored and reviewed regularly to make it more appropriate for the outpatient environment. The most recent report was displayed on the wall in outpatients.

There was an outpatient risk register in place, detailing current risks, controls and the risk level. A monthly ambulatory quality, safety and risk report was produced which detailed the number and level of incidents reported, risk management including any new risks added to the risk register, staffing, infection control and patient environment updates. Patient experience was reported, including complaints, claims and friends and family results.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Key performance indicators for the outpatient department included DNAs and appointments without an outcome, incidents, friends and family questionnaire response rates and results, waiting times and staffing. The new electronic clinic management system had the potential to provide a large amount of high-quality information related to how appointments in clinic were performing in relation to monitoring multiple tests and procedures in one appointment and clinic waiting times.
However, the system was new and learning was ongoing. The team were working hard to iron out glitches and understand the strengths and limitations of the recording processes. Maximising the potential of the new systems formed part of the plans for a new outpatient strategy.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

Patients’ and staff views and experiences were gathered and acted on to shape and improve the services and culture. There was a noticeboard in the reception area of the department displaying information about changes made following patient and staff feedback, for example one of the teams had not had enough room to work in so some re-allocation of space had taken place to rectify this.

The noticeboard also had a ‘meet our team’ section showing photographs of the staff with their names.

Examples of changes made following patient feedback included the option to choose what name was displayed for the patient when calling them through to their appointments and the provision of banks of plug sockets in the outpatient waiting area for patients to use with clinical equipment, or to charge mobile phones or laptop computers.

The ambulatory directorate had participated in the most recent available staff survey and the results published in 2018 showed they had scored the same or higher than the overall trust score in every domain.

The weekly department organisational readiness and commissioning (DORAC) meetings had been established for two years to provide a forum for input to the outpatient service planning from all the different sub-specialties and teams comprising the outpatient department. These meetings fed into the bi-monthly steering groups and stakeholder groups which informed the planning of the department.

The service participated in the NHS Benchmarking Network (NHSBN) project which aimed to provide benchmarked analytics across all outpatient departments; it included profiling of service models, access and availability, activity, workforce and quality. These indicators were monitored by the service and managers we spoke with were well-sighted on their status.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

There was an active research programme at Royal Papworth Hospital with involvement from staff, patients and the public. Staff were encouraged to develop ideas to improve patient services and outcomes and the annual staff awards had a category to celebrate innovation in practice. The trust had an active quality improvement programme and research and development team who supported research into practice.

The professional practice team supported the development of training and courses and an active continuing professional practice team that worked to ensure staff were up to date with current practice and introduced new ideas across the trust.

Staff we spoke with knew about the outcome of various research projects, including published studies, and how they impacted their patients. They were enthusiastic about the innovative practice in the department, for example their infection prevention and control processes for patients with cystic fibrosis. We saw evidence that research undertaken by a professor and research director at the Cambridge Centre for Lung Infection (CCLI) had recently been published in the official journal of the European Cystic Fibrosis Society.
The trust offered annual research skills courses which were free for their staff and were designed to introduce research methodologies to staff involved with research or advance the skills of experienced patient facing research staff.

There was a patient research ambassador who promoted health research from a patient point of view, including reviewing research project proposals from a patient’s perspective and engaging with other patients and members of the public about their role and the importance of research.

Mortality and morbidity meetings were held within the sub-specialty business units.

## Diagnostic imaging

### Facts and data about this service

Royal Papworth Hospital NHS Foundation Trust moved to a newly built hospital in April 2019. The diagnostic imaging department provides a number of non-invasive and invasive diagnostic services.

Diagnostic services include:

- Cardiac and thoracic computerised tomography (CT)
- Cardiac magnetic resonance imaging (MRI)
- Ultrasound
- Plain films (departmental and mobile)
- Nuclear medicine including myocardial perfusion scans (MIBI) and ventilation–perfusion (VQ) scans
- Transthoracic and transoesophageal echocardiography
- Catheter angiography
- Electrocardiogram (ECG) and other electrophysiology procedures
- Pulmonary function tests

These services are provided by a team of radiologists, radiographers, physiologists and other support staff.

*(Source: Routine Provider Information Request Acute – Context)*

Royal Papworth Hospital is a purpose-built hospital on the Cambridgeshire University Hospital Campus, Addenbrookes. It is the UK’s largest specialist cardiothoracic hospital and the country’s main heart and lung transplant centre. The hospital offers a range of services for outpatients and inpatients, including cardiac, thoracic, transplant, radiology and pathology services.

The Radiology department is part of the Clinical and Diagnostic Services Directorate. The department runs five days a week for booked cases, offering a clinical service to the local and visiting cardiologists, chest physicians, oncologists, transplant and surgical teams, and provides 24-hour cover for emergencies. Direct access to a range of imaging tests is available to GPs and hospital clinicians from other Trusts. Emergency cover is provided by an on-site radiographer outside of normal working hours (Monday to Friday 8am to 6pm).

The radiology department imaged approximately 49,000 patients between May 2018 and April 2019, of which 32,833 was in plain film.

### 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; however, there was low compliance with some modules.

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

Nursing staff received and kept up to date with their mandatory training.

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for qualified nursing staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Health and safety</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>Information governance</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>22</td>
<td>25</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 90% target was met for six of the nine mandatory training modules for which qualified nursing staff were eligible. It required one additional member of nursing staff to complete their training to achieve the 90% target in the three modules below 90%.

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

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Health and safety</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td>Information governance</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

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

The trust submitted data following inspection which reflected medical staff mandatory training compliance at May 2019.
<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention and control (level 1)</td>
<td>13</td>
</tr>
<tr>
<td>Fire safety</td>
<td>12</td>
</tr>
<tr>
<td>Infection prevention and control (level 2)</td>
<td>12</td>
</tr>
<tr>
<td>Moving and handling (level 2)</td>
<td>12</td>
</tr>
<tr>
<td>Resuscitation (level 1)</td>
<td>12</td>
</tr>
<tr>
<td>Resuscitation (level 2) - adult basic life support</td>
<td>11</td>
</tr>
<tr>
<td>Information governance and data security</td>
<td>9</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>8</td>
</tr>
<tr>
<td>Equality, diversity and human rights</td>
<td>8</td>
</tr>
<tr>
<td>Health, safety and welfare</td>
<td>5</td>
</tr>
<tr>
<td>Moving and handling (level 1)</td>
<td>5</td>
</tr>
</tbody>
</table>

Medical staff received and but did not keep up to date with their mandatory training.

(Source: Data quest)

A breakdown of compliance for mandatory training courses from April 2018 to February 2019 at trust level for allied health professionals in diagnostic imaging is shown below. The 90% target was met for four of the nine mandatory training modules for which allied health professionals were eligible.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>34</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>33</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>33</td>
</tr>
<tr>
<td>Health and safety</td>
<td>33</td>
</tr>
<tr>
<td>Adult basic life support</td>
<td>29</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>27</td>
</tr>
<tr>
<td>Information governance</td>
<td>28</td>
</tr>
<tr>
<td>Fire safety - 1 year</td>
<td>28</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>26</td>
</tr>
</tbody>
</table>

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

The trust submitted data following inspection which reflected allied health professionals mandatory training compliance at May 2019.
Clinical staff completed training on recognising and responding to patients with mental health needs, learning, disabilities, autism and dementia.

The mandatory training was comprehensive and met the needs of patients and staff. The Trust recently updated mandatory training requirements in line with the Core Skills Training Framework. Managers monitored mandatory training and alerted staff when they needed to update their training. However, we were told that not all staff were confident with the self-service system and how to record their training, which may, in part be a contributing factor to low training compliance rates for medical and allied health professional staff. An electronic staff record self-service system was launched in September 2018 where staff accessed their learning record and complete mandatory training via eLearning programmes. Most training was delivered as eLearning from February 2019, with face-to-face training provided for fire, resuscitation and moving and handling level 2.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**

Medical staff, allied health professionals and nursing staff received training specific for their role on how to recognise and report abuse. Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. They said there was robust support from the trust social work team, as well as the safeguarding lead.

Royal Papworth hospital treated patients from age 16. Members of the senior leadership team told us patients aged 14 and 15 were treated on very rare occasions (fewer than one per year). When treatment of a minor was undertaken, appropriate safeguarding measures were initiated. Child safeguarding protocols from a leading children’s hospital were adapted; the patient in question was discussed at a multidisciplinary meeting, which included the trust safeguarding lead. During inspection, we were told that Safeguarding Children level 3 training for all radiologists was recently agreed and would take place in the month following this inspection.
The trust set a target of 90% for the completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for qualified nursing staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>25</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>25</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>1</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 90% target was met for four of the six safeguarding training modules for which qualified nursing staff were eligible.

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

A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for medical staff in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>15</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>15</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>14</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 90% target was met for two of the four safeguarding training modules for which medical staff were eligible.

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

The trust submitted data following inspection which reflected medical staff safeguarding training compliance at May 2019.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>13</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>13</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (PREVENT awareness)</td>
<td>14</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>0</td>
</tr>
</tbody>
</table>
A breakdown of compliance for safeguarding training courses from April 2018 to February 2019 at trust level for allied health professionals in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>April 2018 to February 2019</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 children (level 2)</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 2)</td>
<td>33</td>
<td>35</td>
<td>94.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In diagnostic imaging the 90% target was met for all four of the safeguarding training modules for which allied health professionals were eligible.

The trust submitted data following inspection which reflected allied health professionals safeguarding training compliance at May 2019.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>As at May 2019</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 2)</td>
<td>33</td>
<td>34</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children (level 2)</td>
<td>33</td>
<td>34</td>
<td>97.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>23</td>
<td>34</td>
<td>67.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 1)</td>
<td>23</td>
<td>34</td>
<td>67.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing radicalisation - levels 3, 4 &amp; 5 (PREVENT awareness)</td>
<td>9</td>
<td>34</td>
<td>26.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults (level 3)</td>
<td>0</td>
<td>34</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>0</td>
<td>34</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
</tbody>
</table>

There were processes in place to ensure the right person received the right radiological scan at the right time. The Society of Radiographers “pause and check” system was used across all areas. Pause and check refers to the Society of Radiographers operator checklist which prompts radiographers to confirm the patient and the investigation using set prompts. Patients were asked to confirm identity, by giving their full name, date of birth and address.

The World Health Organisation (WHO) Surgical Safety Checklist was used only in interventional procedures in computerised tomography (CT) and in the catheterisation laboratory (cath lab). This is designed to allow time to pause and check prior to and during any procedure. The trust adapted this checklist to better reflect the specialist procedures done. Data submitted following this inspection showed there was 94% compliance with all aspects of the checklist between April 2018 and March 2019. Steps of the safety checklist most frequently omitted were pre and post procedure checks and team brief. We were told there was work in progress to embed prompts in the electronic patient record.

The trust had Local Safety Standards for Invasive Procedures (LocSSIPs) processes written for computerised tomography, catheter laboratory and bronchoscopy.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The Royal Papworth Hospital was fully operational from April 2019, six weeks prior to this inspection. All furnishings and privacy curtains were new and in good condition. All clinical and waiting areas were clean and well-maintained. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and equipment was labelled to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were adequate hand washing facilities and hand gel for use at the entrance to each of the modalities and clinical areas. Paper towels were readily available in areas where people washed their hands. We observed staff adhering to good hand hygiene practices. Patients we spoke with corroborated this.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff were aware of the procedures to follow if a patient had a communicable disease, such as tuberculosis or flu and described what they would do if a patient required isolation due to infection. This was important given the high attendance of patients with cystic fibrosis and chronic heart disease who were especially susceptible to infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. Staff had an application on their telephones which they used to photograph and send to the estates department to report any areas which required improvement or repair.

The service had suitable facilities to meet the needs of patients. The environment was planned in such a way as to ensure in-patients had a separate waiting area from scheduled, non-acute patients. There was direct lift access to the imaging department from the wards. Rooms where ionising radiation exposures occurred were clearly signposted with warning lights. These were in place in all relevant modalities to warn people about potential radiation exposure. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated no-entry signs were clearly visible and in use throughout the department at the time of our inspection to ensure that staff or patients did not enter rooms whilst imaging was taking place. There were strict security controls within the unit. Access to the MRI unit and nuclear medicine was by means of swipe card. Some staff said it would be helpful to have an intercom system which patients could use to announce their arrival.

Magnetic resonance imaging (MRI) equipment was secured behind locked doors and devices were clearly labelled within the MRI environment. This was in accordance with Medicines and Healthcare Products Regulatory Agency (MHRA) (2015) recommendations. MRI safe wheelchairs were readily available. Scanning rooms were equipped with oxygen monitors to alert staff to any helium gas leakage (quench). They were also fitted with an emergency quench switch which protected against accidental use and initiated a controlled quench and turned off the magnetic field in the event of an emergency. Staff we spoke with knew what actions to take in the event of an emergency quench situation.

Fringe field maps (the peripheral magnetic field outside of the magnet core around the MRI scanner) for each scanning room were clearly displayed. This reduced the risk of magnetic interference with nearby electronic devices, such as pacemakers.

Radiographers performed adequate screening by means of safety questionnaires to ensure anybody entering these areas were kept safe from the high magnetic field. For example, the safety
questionnaire asked female patients if they were pregnant prior to any scan. A control/observation area allowed visibility of all patients during CT and MRI scans. There was enough space around the scanners for staff to move and for scans to be carried out safely. All patients had access to an emergency call/panic alarm, earplugs and ear defenders during scanning. There was a microphone that maintained constant contact between the radiographer and the patient.

The nuclear medicine department had designated ‘hot’ and ‘cold’ facilities, including waiting and toilet areas. Hot and cold facilities refer to patients who are awaiting administration of the radiopharmaceuticals (cold), and those who have been given the radiopharmaceutical (hot). A member of the senior leadership team told us cleaners for ‘hot’ areas were given specialist training and were told when rooms were safe to enter. The trust procured their radionuclides for nuclear medicine imaging from a local hospital and had a standard operating procedure for the safe collection each day. We observed the safe handling and preparation of these radionuclides.

The service had enough suitable equipment to help them safely care for patients. Staff carried out daily safety checks of specialist equipment.

Staff in each area had ready access to the resuscitation equipment. We looked at records and confirmed there were no gaps in daily checks. There were two resuscitation trolleys, both of which were tagged with tamperproof seals when not in use. We checked the contents of one with a member of staff and confirmed it contained all necessary equipment.

Acceptance and safety testing was undertaken by the medical physics team prior to first patient use. Staff regularly carried out and recorded quality assurance (QA) processes in line with manufacturers recommendations for each piece of equipment. These tests included beam alignment and collimation QA; this related to the restriction of the x-ray beam or emitted radiation to a given area of interest. Dose radiation levels (DRL) were currently based on manufacturer’s standard dose reference levels and a comprehensive dose audit to set internal DRLs was planned for September 2019. This will be overseen by the Radiation Protection Advisor from the medical physics team. This data would then be benchmarked across the geographical region in line with best practice.

Risk assessments were carried out which addressed occupational safety, as well as risks to people who used services. The Staff wore radiation badges to monitor any occupational doses and to ensure they were not over exposed. Lead aprons were also new, and we saw staff wore them as required.

The trust had an appointed radiation protection advisor (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) and Ionising Radiations Regulations (IRR) 2017. They were available on site two days per week as part of their service level agreement. There was a medical physics expert (MPE) appointed as MRI safety advisor as well as an MPE who monitored compliance with Environmental Permitting Regulations (EPR) radioactive waste disposal.

There were three adjacent radiologist reporting rooms, each divided into four radiology reporting workstations. Radiologists told us this arrangement was different from the old site, where they had separate offices. They said the background activity of the ‘open plan’ room was especially distracting when they were reporting on images. This was particularly noticeable when visiting medical teams came to discuss findings or a new case.

The radiologists also raised the poor functionality of the Picture Archiving and Communication System (PACS). This system was built specific to the needs of RPH and they told us there were limitations; for example, it was not possible to demonstrate patient images in all planes to the multidisciplinary meeting. This meant the body was not able to be viewed in transverse, horizontal or vertical planes at the same time.

We raised this with members of the senior leadership team. They were aware that the current PACS needed to be updated and understood the frustrations expressed by radiologists. It was necessary to balance increased demand on the service and therefore increased reporting
requirements with the currently available technology. An action plan to develop the current PACS was agreed with the IT department.

The service had a 24-hour Picture Archiving and Communication System (PACS) support. There was a 24-hour helpline which helped with IT problems. The hospital had two servers (not co-located) to provide contingency in case of failure. There was a business continuity plan in place in the event of an IT or PACS failure.

Staff disposed of clinical waste safely. Cleaning materials were stored appropriately in locked cupboards, in line with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the legislation that requires employers to control substances, which are hazardous to health. This meant unauthorised persons could not access hazardous cleaning materials.

Waste was separated into different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations. All sharp boxes were correctly assembled, labelled, dated and had temporary closures. They were all under half full, which reduced the risk of needle-stick injury, in accordance with HTM 07-01: Safe management of healthcare waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival and used recognised tools. Risk management plans had been developed, in line with national guidance. For example, in the MRI and CT unit, we saw evidence of safety questionnaires used to risk assess a patient before they received a scan.

Staff knew about and dealt with any specific risk issues. There were medical physics experts and a radiation protection advisor readily available to advise on radiation protection for medical exposures in radiological procedures. This was in line with IR(ME)R guidance. The service had named Radiation Protection Supervisors (RPS) in each modality to ensure patient safety and radiation risk was minimised. RPS supervisors received the appropriate training and achieved 100% attendance.

There were processes in place, to ensure that women who were or may be pregnant always informed a member of staff before they were exposed to any radiation, in accordance with IR(ME)R.

Many patients attended RPH for chronic disease management and staff were usually aware of pre-existing clinical conditions they may have which could impact on the ability to perform the investigation. For example, patients with an impaired kidney function received a different dose of contrast media. Contrast media are substances which increase the contrast of structures or fluids within the body used in certain types of radiological investigations. Staff checked that patients who required a contrast media were not allergic to any substances prior to administering the medicine. An anaphylaxis box was readily available should patients reacted to any substance. Anaphylaxis is a serious, life threatening allergic reaction which can be triggered by medicines.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff told us what action they would take if a patient became unwell or distressed while waiting for or during an investigation. They provided examples which showed they would take appropriate action relevant to the situation. Patients whose condition deteriorated whilst in the department received initial care by the staff in the department and could be quickly transferred to, for example, the catheter laboratory in the event of a suspected cardiac arrest. One staff member described how colleagues attended from other parts of the department in response to the alarm being rung when a patient fainted.
There were procedures in place to remove a patient from the MRI scanner in an emergency. The emergency evacuation procedure was tested three times since the hospital moved to the current site six weeks prior to this inspection.

Staff shared key information to keep patients safe when handling over their care to others. Staff who were trained in cannulation explained to us the need to monitor cannula sites for extravasation. Extravasation is the accidental leakage of certain medicines into the body from an intravenous drip in the vein. Staff could describe the process if a patient was to experience extravasation. Cannulas were left in situ for 10 minutes after injection of contrast in case the patient should experience a delayed contrast reaction. We saw all extravasation occurrences were reported as incidents. We reviewed the trust extravasation standard operating procedure and saw it was fit for purpose, with a focus on good communication with the patient.

There was a system of justification in place where radiographers justified chest x-rays and radiologists justified all others. Justification is where the practitioner must review clinical information provided by the referrer and consider the appropriateness of the request for imaging to reduce unnecessary radiation exposure.

Dose reference levels (DRLs) were displayed in all x-ray rooms. The Ionising Radiation Medical Exposure Regulations 2017 (IR(ME)R17) employer’s procedures were up to date and available. We saw local rules were available for all staff to follow in imaging areas which were in accordance with ionising radiations regulations (IRR)17. We also saw the Ionising Radiation Medical Exposure Regulations (IR(ME)R17) employer’s procedures handbook was referenced current legislation and was fit for purpose.

We noted there were no ‘Pause and Check’ posters on display around the department to act as a reminder to staff. A senior member of staff told us the building was not owned by RPH and the contractors did not permit any items to be hung on walls. In the meantime, there was a ‘pause and check’ computer screensaver and alternative ways to remind staff were under consideration.

At the time of inspection, there was no standard operating procedure (SOP) to monitor dose levels for relatives or friends. This was in instances where they were repeatedly present during an x-ray examination to offer reassurance to the patient. These were known as ‘Carers and Comforters’ under IR(ME)R 2017 and defined as ‘individuals knowingly and willingly incurring an exposure to ionising radiation by helping, other than as part of their occupation, in the support and comfort of individuals undergoing or having undergone exposure’. Whilst dose limits do not apply for ‘Carers and Comforters’, they will receive a small dose of radiation. We were told the ‘Carers and Comforters’ dose was recorded in the clinical record interactive computer system for the supported patient. This was not audited and would be difficult to locate without a unique identification for the carer.

Following inspection, the trust submitted an action plan to address this. They told CQC the radiography team had since introduced a dose exposure log for ‘Carers and Comforters’. A SOP was being drafted with a view to it being launched two weeks post inspection.

**Allied health professionals staffing**

The service had enough allied health professionals with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough imaging staff of all grades to keep patients safe

The trust reported the following whole time equivalent (WTE) allied health professional staffing numbers for the periods below for diagnostic imaging.
<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>28.6</td>
<td>38.8</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the allied health professional staffing rate within diagnostic imaging was 79.1%. The staffing rate has increased from the previous period, March 2017 to February 2018, where it was 73.7%. There was an increase in both the number of planned staff and the number of staff in post.

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

Vacancy rates

The service had higher vacancy rates than the trusts target. From March 2018 to February 2019 the trust reported a vacancy rate of 21.1% for allied health professionals in diagnostic imaging, this was higher than the trust target of 6.0%.

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

Turnover rates

The service had low turnover rates. From March 2018 to February 2019 the trust reported a turnover rate of 12.3% for allied health professionals in diagnostic imaging, this was lower than the trust target of 15.0%.

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

Sickness rates

The service had a higher sickness rates than the trusts target. From March 2018 to February 2019 the trust reported a sickness rate of 5.5% for allied health professionals in diagnostic imaging, this was higher than the trust target of 4.0%.

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

Managers accurately calculated and reviewed the number and grade of imaging staff and healthcare assistants needed for each shift. Members of the senior leadership team acknowledged there were current challenges to radiography staffing. Some of this reflected the national shortage of radiographers. The recent move to the new site also led to a high attrition rate. The new site was 17 miles from the original site and included unavoidable travel on a very busy road with frequent traffic jams. Some radiographers told us the move added up to an extra hour to their travel time in the morning and understood this was a major factor for some of their colleagues who left the service.

The manager could adjust staffing levels daily according to the needs of patients. The leadership team outlined to us planned measures to recruit staff; for example, adapting a new model of working. Currently, radiographers rotate around and were competent in each modality. This high skill level made it harder to recruit to since radiographers were more often competent in one or two modalities. In the future, it was likely that recruited radiographers would not rotate. Other plans included making direct links with universities to highlight what RPH would offer newly qualified radiography students as well as a recruitment fair run in conjunction with Cambridge University hospital. The leadership team told us they were initiating a career development pathway for band 4 radiology assistants to ‘grow’ their own radiographers.
Managers limited their use of bank and agency staff and requested staff familiar with the service. They made sure all bank and agency staff had a full induction and understood the service. We looked at a random sample of induction booklets which were signed off as competent and dated by the radiation supervisor. A locum member of staff told us they received a high level of support as soon as they entered the department. They said there was always a permanent member of staff on whom they could call for advice or assistance.

Data submitted by the trust outlined a review of induction processes for new staff. This aimed to reduce the length of time new starters spent in induction as well as to ensure training delivered training necessary for their role. This new process took into consideration the introduction of eLearning and register learning already done prior to starting at Royal Papworth Hospital.

One radiographer told us they believed the recent increased vacancy rate contributed to lower staff morale. There were fewer senior radiographers to cover the out of hours rota which meant the more experienced radiographers covered the on-call more frequently. Another told us a new shift system of longer days, with a day off every second week was introduced. However, staffing shortages meant is was often difficult to ensure a safe skill mix on each shift so more experienced staff covered on what should be their day off in the second week.

Staff told us patients sometimes waited over an hour before being imaged because of staffing shortages. However, each member of staff we spoke with told us they did not believe patient safety was compromised.

### Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The trust reported the following whole time equivalent (WTE) medical staffing numbers for the periods below for diagnostic imaging (including junior doctors in training posts).

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>13.0</td>
<td>12.4</td>
</tr>
</tbody>
</table>

From March 2018 to February 2019 the medical staffing rate within diagnostic imaging was 112.0%. The staffing rate has increased from the previous period, March 2017 to February 2018, where it was 104.8%. There has been an over-establishment of medical staff in both periods.

Excluding junior doctors in training posts the trust reported the following WTE medical staffing numbers.

<table>
<thead>
<tr>
<th>Location</th>
<th>March 2017 to February 2018</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual staff</td>
<td>Planned staff</td>
</tr>
<tr>
<td>Royal Papworth Hospital</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

There was one staff member in post for both time periods, which was in line with the planned staffing level.

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

The service had enough medical staff to keep patients safe.
Vacancy rates
The service had a negative vacancy rates for medical staff. There was an over-establishment of radiologists in the service which meant there was no vacancy rate.

From March 2018 to February 2019 the trust reported a vacancy rate of -15.0% for medical staff in diagnostic imaging (including junior doctors in training posts), this was lower than the trust target of 6.0%. The negative vacancy rate is due to an over-establishment of medical staff.

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

Turnover rates
The service had low turnover rates. From March 2018 to February 2019 the trust reported a turnover rate of 21.1% for medical staff in diagnostic imaging; however, this included junior doctors in training posts. The adjusted figure was 10.1% and was lower than the trust target of 15.0%.

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

Sickness rates
Sickness rates for medical staff were low. From March 2018 to February 2019 the trust reported a sickness rate of 0.4% for medical staff in diagnostic imaging (including junior doctors in training posts), this was lower than the trust target of 4.0%.

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

Bank and locum staff usage
The service had low usage rates of bank or locum staff. The table below shows the numbers and percentages of medical hours in diagnostic imaging at the trust from March 2018 to February 2019 that were covered by bank and locum staff or left unfilled.

Of the 18,598 total working hours available 0.7% were filled by bank staff and none were covered by locum staff to cover sickness, absence or vacancy for medical staff. In the same period, all the available hours were able to be filled by either bank or locum staff.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total hours available</th>
<th>March 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bank usage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hrs</td>
</tr>
<tr>
<td>Radiology (senior)</td>
<td>18,598</td>
<td>124</td>
</tr>
</tbody>
</table>

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

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends. Consultant on call was from 5:00pm to 9:00am Monday to Friday and 24 hours on Saturday and Sunday.

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

Patient notes were comprehensive, and all staff could access them easily. The service used two electronic record systems. The Computerised Radiology Information System (CRIS) and the Picture Archiving and Communication System (PACS). CRIS was a password protected record which allowed reception staff and other clinical users to manage the patient journey across the
department. PACS was the system for storing completed images and the associated reports, which was password protected and accessible to radiology staff for reporting and clinicians who had requested the image. We saw that services did not maintain written patient records; details of all investigations and their findings were recorded electronically.

Patients’ individual records were written and managed in a way that protected patients from avoidable harm. We reviewed five patient records. All records reviewed contained relevant information, such as patient details, medical history, referral details and allergies. All records seen had been completed appropriately.

Records were stored securely. The staff we spoke with in diagnostic imaging had a good understanding of patient confidentiality and data protection and had attended information governance training. Throughout all areas, care was taken to ensure that computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff stored and managed all medicines and prescribing documents in line with the provider’s policy.

There were suitable arrangements in place for the management of medicines, including contrast media, that protected patients from avoidable harm.

Staff followed current national practice to check patients had the correct medicines. The Society of Radiographers (SoR) recommended “Paused and Checked” system was used to check medications prior to administration. Care was taken to ensure the right patient received the right medicine. Patient’s identity was checked, confirmed and then checked against their prescriptions.

Arrangements were in place for managing radiopharmaceuticals that protected patients from avoidable harm. There were processes in place to ensure the right radiopharmaceutical was injected, and appropriate checks were in place when the radiopharmaceutical was dispensed, drawn up and level of radioactivity measured. A second member of staff checked the dosage prior to administration.

Staff maintained a record of medicines being stored and used. Medicines, including intravenous fluids, were stored securely. Medicines requiring storage within a designated room were stored at the correct temperatures, in line with the manufacturers’ recommendations, to ensure they would be fit for use. Contrast media was stored appropriately and was accessible only to key members of staff.

Staff were trained on the safe administration of contrast media including intravenous contrast. We reviewed staff competency files and saw all staff had received this training and contacted the pharmacist if in doubt.

Room temperatures were recorded as part of the daily checks by staff. The temperature records showed temperatures had been checked daily and were within the required range. Staff knew what to do if the temperatures were not within the required range.

Patient Group Directions (PGD) were in place throughout the imaging department. Patient group directions are written instructions to help with the supply and administration of medicines to patients, usually in planned circumstances. These included saline and iodinated intravenous and oral contrast agents. We reviewed five in detail and found them fully compliant with NICE guidance Medicines Practice Guidance (MPG2) 2018 and were signed off by the trust pharmacist and lead radiographer.

It is worth noting that PGDs for some radiographers in computerised tomography (CT) extended their scope of practice. They were trained and approved to administer a beta blocker and a vasodilator. This enabled them to run a cardiac CT angiography list independent of the radiologist. This enhanced patient experience as they spent a shorter time on the CT table, as well as increased patient flow.
The Ionising Radiation Medical Exposure Regulations (IR(ME)R) requires employers and practitioners to hold a licence for the administration of radioactive substances for a specified purpose at any given medical radiological installation. We confirmed there was a designated radiologist who was the Administration of Radioactive Substances Advisory Committee (ARSAC) license holder.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had no 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 April 2018 to March 2019, the trust reported no incidents which were classified as never events for diagnostic imaging.

(Source: Strategic Executive Information System (STEIS))

In accordance with the Serious Incident Framework 2015, the trust reported one serious incident (SIs) in diagnostic imaging which met the reporting criteria set by NHS England from April 2018 to March 2019.

(Source: Strategic Executive Information System (STEIS))

Staff reported serious incidents clearly and in line with trust policy. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

All staff knew what incidents to report and how to report them. There was an electronic reporting system in place to allow staff to report incidents. Any radiation incidents would be reported using agreed procedures. Staff would report to the team lead who would inform the Radiation Protection Supervisor (RPS), who would inform the Radiation Protection Adviser (RPA) and the Radiation Protection Service in Cambridgeshire which would decide whether to refer the matter to CQC.

Staff understood their responsibilities to raise concerns, to record safety incidents and near misses. The service had an incident reporting policy and procedure in place to guide staff in the process of reporting incidents. There were 141 incidents recorded between May 2018 and April 2019. Of these, 94 were categorised as no harm (66.7%); 20 as near miss (14.2%); 22 as low harm (15.6%) and 1 severe (0.07%). Four incidents (2.8%) were not yet categorised at the time of data submission. We saw the incident log which included a description, immediate action taken, action taken as a result of an investigation, and lessons learned.

There were no radiation or radioactive incidents reported between May 2018 and April 2019. Arrangements were in place if a radiation or radioactive incident occurred, such as radioactive spillage, whilst carrying out nuclear medicine imaging. The radiation protection advisor and/or the medical physics expert would be contacted to seek advice. Staff told us they could not remember when a spillage last happened, but they were aware of the procedures to follow if this were to occur.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were reviewed each month at the radiology directorate meeting. There was a positive incident reporting culture in the department; all staff spoke with had received training and were encouraged to report incidents, which was a simple one click action. Staff knew how to access the
system and their responsibilities to report incidents and felt confident to do so. All staff could give examples of when they had or would need to report an incident.

There was evidence that changes had been made as a result of feedback. The serious incident was a diagnostic incident including delay meeting SI criteria (including failure to act on test results). This related to the inappropriate use of personal protective equipment by three members of staff. We spoke with staff who were aware of this and told us of a significant change in response to learning from it. A ‘no switch on’ policy was introduced which meant radiographers did not switch any equipment on until all radiology and radiography staff were wearing full personal protective equipment, including lead apron and eye protectors.

Managers debriefed and supported staff after any serious incident. Staff met to discuss the feedback and look at improvements to patient care. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through daily team briefings as well as staff meetings and in the chief executive’s weekly report.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were local arrangements in place for ensuring that patients were kept informed of incidents and any investigations and their outcomes. Staff told us information regarding duty of candour was available on the trust intranet.

We saw minutes of the Serious Incident Executive Review Panel and noted application of Duty of Candour to a family member was confirmed. Following inspection, the trust submitted evidence of fulfilment of Duty of Candour regulation.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff protected the rights of patient’s subject to the Mental Health Act and followed the Code of Practice.

At handover meetings, staff told us they routinely referred to the psychological and emotional needs of patients, their relatives and carers. They told us there were processes in place to ensure the right care and treatment decisions were made which ensured there was no discrimination towards patients on the grounds of their protected characteristics including age or disability.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The diagnostic and imaging service delivered care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R), the Royal College of Radiologists (RCR), the Society and College of Radiographers (SCoR).

There was a range of indicators used to monitor performance against national and local targets. This data was reported monthly to the radiology business unit meeting.

Guidelines and pathways from the National Institute for Health and Care Excellence (NICE) were followed. These included NICE guidance cg169: Acute kidney injury: prevention, detection and management; NICE guidance cg95: Chest pain of recent onset: assessment and diagnosis; NICE guidance qs61: Infection prevention and control; NICE guidance qs56: Metastatic spinal cord compression in adults; NICE guidance qs15: Patient experience in adult NHS services; NICE guidance mpg2: Patient group directions.
The clinical lead told us they performed approximately 380 patient assessments per 100,000 where NICE guidance cg95: Chest pain of recent onset: assessment and diagnosis, recommends 550 per 100,000. Whilst this was below the recommended standard, we were told it was higher than other hospitals.

Relevant clinical guidelines and standard operating procedures were readily available for all imaging tests which staff showed inspectors.

The Ionising Radiations Regulations 2017 (IRR17) is the main legal requirement enforced by the Health and Safety Executive. In line with IRR17, the diagnostics department appointed radiation protection supervisors whose role was to ensure staff followed the trust standard operating procedures and adhered to the radiation protection procedures. IRR17 requires employers to keep exposure to ionising radiations as low as reasonably practicable (ALARP) and exposure must not exceed specified dose limits.

The hospital had a named radiation protection advisor (RPA) whose role was to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The medical physics team provided scientific support, advice and guidance on IR(ME)R regulations concerning the use of imaging equipment. It also monitored the radiology equipment and staff radiation dosages.

Staff doses were monitored as required under the Ionising Radiation Regulations 2017 by the medical physics team. They were analysed monthly and we saw in most instances were below the annual constraint for non-classified workers. CQC was informed of a serious incident where the dose levels of three members of staff exceeded the acceptable safety level. We discussed this with the leadership team who told us of the measures taken to address this, which included placing the three staff members on restricted practice for a period of time to minimise further radiation exposure.

The Society and College of Radiographers safety check, ‘Pause and Check’ was implemented throughout the department.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs as required before or following a procedure.**

Patients who attended the department were not routinely provided with food or drinks. There were processes in place for vulnerable patients, including those with diabetes, who required pre-examination fasting or drinking before treatment. This was applicable to patients seen in nuclear medicine. They were advised on whether they could eat or drink prior to their treatment in their appointment letters and were given a leaflet to this effect.

**Pain relief**

**Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.**

Pain relief was not routinely used in diagnostic imaging, except for when patients were attending for invasive procedures. Staff provided patients with pain control specific to the investigation being undertaken. Staff told us some patients were advised when procedures may be uncomfortable, and time was taken to reassure the patients and keep them informed of the length of time remaining for procedures.

Patients received pain relief soon after requesting it.

Staff ensured patients were comfortable during diagnostic tests including ultrasound scans and x-rays. We saw patients were assisted to reposition themselves if they reported they were uncomfortable. Radiographers offered reassurance during procedures and updated patients on time remaining to the end of the procedure.

**Patient outcomes**
Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers carried out a comprehensive audit programme. Members of the senior leadership team told us a gap analysis was completed and the department was working towards ISAS accreditation. The Royal College of Radiologists and College of Radiographers developed the Imaging Services Accreditation Scheme (ISAS) to support diagnostic imaging services to manage the quality of their services and make continuous improvements. This is a way to ensure patients receive consistently high-quality services delivered by competent staff working in safe environments.

Managers used information from the audits to improve care and treatment. Information about the outcomes of patient’s care and treatment was routinely collected and monitored. The service regularly reviewed the effectiveness of care and treatment through local audit and national audit. They took appropriate action to monitor and review the quality of the service and to effectively plan for the implementation of changes and improvements required.

There were engagement meetings and/or follow-up of audit outliers. The Royal College of Radiologists recommends that discrepancy meetings should be held to discuss errors that have been reported for learning and reflective purposes. Radiologists held monthly learning from discrepancy meetings which trainees attended. Errors were categorised, and actions agreed; for example, application of the Duty of Candour regulation. Minutes of these meetings were stored electronically and available to all staff.

Senior radiographers and team leaders reviewed images and scans produced by junior and trainee colleagues. Image quality issues are fed back to the individual as part of their ongoing learning and development. Radiologists also gave feedback to lead radiographers where there were specific image quality issues for investigation. These included equipment issues; staff competency and patient related issues for example, their clinical condition.

**Competent staff**

**The service made sure staff were competent for their roles.**

**Appraisal rates**

From April 2018 to February 2019, 93.7% of all staff within diagnostic imaging at the trust received an appraisal. This was higher than the trust target of 90%.

The breakdown by staff group can be seen in the table below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Number of staff received appraisal</th>
<th>Number of required staff</th>
<th>Appraisal rate</th>
<th>Trust Target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>32</td>
<td>33</td>
<td>97.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Nursing and midwifery registered</td>
<td>24</td>
<td>25</td>
<td>96.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>20</td>
<td>21</td>
<td>95.2%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>30</td>
<td>34</td>
<td>88.2%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Total</td>
<td>118</td>
<td>126</td>
<td>93.7%</td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In diagnostics medical staff and allied health professionals were the only two staff groups that did not meet the 90% target.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)
Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Staff members told us there was an expectation that they attended team meetings, the minutes of which were distributed to all staff via e-mail. We were also told that the move onto the new site meant there was disruption to the regular pattern of team meetings. It was expected that normal team meeting schedules would be resumed by the end of June 2019.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals for medical and allied health profession staff were just below the trust standard of 90%. We discussed this during inspection and were told that all staff appraisals were scheduled to be completed by the end of June 2019. Four of the staff we spoke with told us they had either recently been or were soon to be appraised.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. The Radiation Protection Advisor provided Radiation Protection Supervisors with training appropriate to their role which was updated annually. They also provided ‘Acquaintanceship’ training to non-radiation workers on radiation protection and Ionising Radiation (Medical Exposure) Regulations. These included cardiologists and catheter laboratory staff.

The service had processes in place to identify training needs and compliance, which ensured staff were confident and competent to undertake their roles. All staff were systematically trained to use the different equipment on the new site in the six weeks prior to the move. Staff told us this reduced their anxiety levels and meant they were able to operate the equipment effectively from the beginning.

Managers gave all new staff a full induction tailored to their role before they started work. We saw the training pack provided to radiologists new to the department. This included an orientation programme and competency pack. We saw that competency in each modality took approximately six weeks to achieve and that they were signed off by the lead radiographer.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All eligible staff had their professional registration verified in the last 12 months. All radiographers were HCPC (Health & Care Professions Council) registered and met the standards to ensure delivery of safe and effective services to patients. All medical and nursing staff had revalidated their professional registrations in a timely manner.

 Whilst there is no regulatory requirement for MRI safety qualifications in any country, we were told the MRI lead is soon to undertake an internationally recognised accreditation MR safety officer course, the first cohort in the UK.

Non-medical referrers are registered healthcare professionals who are trained according to local guidelines and competent to provide appropriate clinical data when requesting an x-ray. These were approved by the chair of the consultant radiology group. There was a current list of non-medical referrers with robust ways by which to confirm the referral was within their scope of practice. Inappropriate referrals were reported on the trust electronic incident reporting system.

A member of the senior leadership team told us the most recent staff survey in the diagnostics department showed that staff were not satisfied with the staff appraisal. In response to this, there was an action plan put in place to restructure the appraisal methodology and introduce one similar to that used for doctors’ appraisals.

Managers identified poor staff performance promptly and supported staff to improve. We were told that additional training was provided for those who struggled in their job. The trust ‘Performance and Capability’ policy was initiated in cases where performance did not improve.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff worked across health care disciplines and with other agencies when required to care for patients. The radiology department was part of the Clinical and Diagnostic Services directorate
and there was close working with others in this directorate, as well as with chest physicians, oncologists, transplant and surgical teams.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service contributed to joint multidisciplinary team meetings with other specialities within the trust, for example, with cancer specialities. We saw evidence of collaborative working between radiographers, radiologists, medical physics experts, cardiologists and nurses to improve the patient experience.

The department also shared expertise with external organisations and healthcare professionals, to provide the best possible patient outcomes. For example, visiting cardiologists were hosted and expertise and learning was shared. We were told there was a very good working relationship between RPH radiologists and Cambridge University hospital. The diagnostic department also considered best practice in other trusts. A radiographer told us they spent time with another trust exploring their use of a different isotope. This learning was implemented in RPH and led to better and safer patient experience.

Royal Papworth Hospital radiologists did specialist reviews for other hospitals on pulmonary hypertension, oncology and interstitial lung disease reports.

Patients could see all the health professionals involved in their care in one-stop clinics. The service provided one-stop screening services involving different disciplines of staff working together. Patients were imaged and biopsied during the same appointment. There was a pulmonary hypertension one-stop clinic run in conjunction with other disciplines. The clinical lead told us members of the diagnostics and imaging department were engaged in the start of all new services to ensure radiology was embedded into that service in the most effective way.

Throughout our inspection, we observed good interactions between medical, nursing and support staff in the radiology department. Staff confirmed there was good multidisciplinary team working within the service and with external organisations.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

The Radiology department was open 8:00am to 6:00pm five days a week for elective and non-elective patients. The catheter laboratory was operational between 9:00am and 1:00pm on Saturday. Emergency cover was provided by an on-site radiographer outside these hours, including weekends.

There was a consultant on-call between 5:00pm and 9:00am Monday to Friday and 24 hours Saturday and Sunday. On call consultants were mandated to be able to arrive at the hospital within 30 minutes of being called.

**Health promotion**

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles in the form of leaflets which were usually sent out with radiological appointment letters.

Patients who required a bone density (DEXA) scan had a falls risk assessment when they attended. They were given health information on calcium intake; foot care; diet; smoking and drinking cessation.

Information was given by individual specialisms specific to the treatment and condition; for example, cystic fibrosis; coronary heart disease; lung cancer.
Members of the diagnostics imaging department attended Cambridge National Public Health week in April 2019 and contributed to public discussions. We were told the communications department held tools and resources which members of staff could borrow and take in to other environments to explain the role of the diagnostic and imaging department. One radiologist told us they did an education session with children of a local primary school.

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

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent.

The trust set a target of 90% for the completion of Mental Capacity Act (MCA) training.

A breakdown of compliance for the MCA training module from April 2018 to February 2019 at trust level by staff group in diagnostic imaging is shown below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>April 2018 to February 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Qualified nursing staff</td>
<td>24</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>33</td>
</tr>
<tr>
<td>Medical staff</td>
<td>14</td>
</tr>
</tbody>
</table>

In diagnostic imaging qualified nursing staff and allied health professionals met the 90% target for MCA training. Medical staff did not meet the 90% target with two eligible staff not having completed the training. During inspection, we were told medical staff were fully compliant with this training.

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and recorded it in the patients’ records.

Staff made sure patients consented to treatment based on all the information available

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance and we saw consent was clearly recorded in the patients’ records.

When patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions. There was a standard operating procedure for those patients who were unable to consent; for example, patients who were on the critical care unit under sedation. In such circumstances two doctors were necessary to review what was in the patient’s best interest. The decision-making process and final decision was documented in detail.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
Staff were discreet and responsive when caring for patients. We observed patients being treated with respect and compassion throughout our inspection. We spoke with eight patients and relatives, all of whom spoke positively of the care and treatment they received. They told us staff were professional and friendly and did not make them feel rushed, despite being busy. Comments we received from patients included: “the staff are really professional yet manage to be kind, friendly and helpful”. A senior radiographer told us “it almost hurts to see how deeply staff care about patients”.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff took the time to interact with patients and relatives in a respectful and considerate manner. They told us it was very important to make patient experiences as positive as possible. We saw they were always discreet when speaking with patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when we discussed patients with mental health needs.

Staff followed policy to keep patient care and treatment confidential. Patients checked in at the outpatients reception area. Since Royal Papworth hospital was a tertiary referral hospital, all patients came for pre-booked appointments. They did not have to explain their condition when checking in. We spoke with receptionists who showed us additional notes added by consultants. One additional patient note indicated they had extreme anxiety; the receptionist told us this patient would be directed to a consulting room immediately.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We observed positive interactions between staff, patients and their relatives. We saw staff respecting patients’ privacy and dignity, for example by knocking on doors to rooms, ensuring curtains were drawn, and closing doors to protect patients’ privacy. All patients we spoke with, were satisfied with the standard of care provided by staff and told us their privacy and dignity were respected always. Chaperones were available in all departments if patients required them.

Patients said staff treated them well and with kindness. A relative told us ‘I was very touched by the level of staff kindness and consideration shown to my parent; it made them feel as if they really mattered.”

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us, if a patient became distressed, staff could take them in to a private room to talk to them to assist them to maintain their privacy and dignity. A patient told us, “staff recognise that I am a very nervous patient and they manage to make the process as stress free as possible.”

Doctors and radiographers could add additional notes to the electronic patient booking record where a patient had additional needs. We saw some of these on the patient booking-in screen such as noting a patient with a hearing loss or acute anxiety.

The service provided information leaflets which were usually sent out with radiological appointment letters. Patients who required a bone density (DEXA) scan were given health information on calcium intake; foot care; diet; smoking and drinking cessation.

Other information was given by individual specialisms specific to the treatment and condition; for example, cystic fibrosis; coronary heart disease; lung cancer.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff told us most patient’s understood the nature and prognosis of their condition, since they were usually in long term treatment. They kept a patient’s emotional as well as physical welfare to the forefront of their practice.
Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We saw staff ensure patients understood the purpose and process of the investigation they were due to undergo. Patients told us they felt well informed and listened to. They were comfortable to ask questions about their care and had enough time with staff to ask questions, without feeling rushed or patronised.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff told us when they had patients who were unable to communicate clearly, they used creative ways of communicating better with them, including writing things down or doing simple drawings. They said they did not use any additional physical tools. If they encountered particular difficulties, they requested support from the trust social work team or the learning disability team both of which was readily available.

We heard staff tell patients their results would be sent to their referring consultant.

The diagnostic and imaging service was part of clinical and diagnostic services. As well as radiology, the division also included anaesthesia and theatres, catheter laboratories, critical care, microbiology, pathology and severe acute respiratory failure (ECMO) service.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The NHS Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care. The service participated in the trust-wide FFT, but responses were not specific to care within the imaging service. The patient experience form held in the department did not include a section where patients could record their experience of the diagnostics department.

We raised this with the senior leadership team who acknowledged this was the case. For this reason, the department gathered their own information. They told us this had challenges as patient feedback responses were low. Patients frequently attended several other hospital departments and completed patient experience forms in these departments; they often suggested staff refer to these rather than complete another one. We were told a more bespoke survey to capture feedback from patients to the radiology department was being developed.

We saw evidence of a staff member working together with the trust volunteer team and the patient experience team to improve patient feedback on the diagnostic imaging service. Volunteers went to the wards to interview patients who had been to the imaging department; there was a bespoke questionnaire designed for the purpose. Volunteers also provided this service in the other hospital imaging sites.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of patients from local communities as well as those from further away. It also worked with other specialist facilities in the wider system to plan care.

Facilities and premises were appropriate for the services being delivered. The facilities and premises were new and carefully designed to best meet the services delivered. The diagnostic and imaging services were clearly signposted as patients entered the hospital and were situated close to outpatients reception area on the ground floor. The department was all ground floor level and accessible to all patients. Patients in wheelchairs easily accessed all areas.
Royal Papworth hospital is a tertiary referral hospital and all patients have booked appointments. They booked in at outpatients reception and waited in an area outside the imaging department. Their name came up on large screens positioned around the area. We asked receptionists about this who said patients were told their name would come up for others to see. If they were uncomfortable about this, they could choose an alternative name of their choice. We saw this guidance was on display at the reception desk and on the self-service check-in system.

The hospital provided a range of diagnostic and imaging services, which included computerised tomography; DEXA; fluoroscopy; general radiography; MRI; nuclear medicine and ultrasound. The trust provided a pulmonary hypertension one-stop clinic as well as one-stop screening services. For example, patients were usually imaged and biopsied during the same appointment.

All departments had appropriate facilities to meet the needs of patients awaiting appointments. This included comfortable seating, access to bathrooms and water dispensers. Additional drinks and snacks were available in the main hospital building. Each examination room was assessed for suitability prior to its use and provided privacy and dignity. There were separate inpatient and outpatient designated waiting areas. Inpatients arrived in the department in a lift which only opened into the imaging department.

Managers monitored and took action to minimise missed appointments. Patients told us they received appointment letters which explained the purpose of their diagnostic test and any advance preparation required for the test.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service used innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs.

The radiology department worked with the thoracic oncology and pathology teams to triage referrals; agree admission date for biopsy; be part of the team which performed the biopsy and produced results within 5 working days. This ensured new referrals for possible lung cancer were diagnosed as soon as possible and could have an agreed treatment plan within one week.

Speech and language therapists worked with radiographers in the diagnostic and imaging department to assess patient’s swallowing through a video fluoroscopic swallowing examination. Staff members told us availability of this specialist technique was particularly helpful for patients in the critical care unit who may have been intubated for a long period of time. It was also beneficial for patients with complex needs such as ataxia and stroke.

Patients with pacemakers have additional complex scanning needs. To ensure enhanced safe scanning opportunities for this patient group, MRI sessions were run in conjunction with the pacemaker team, which included a cardiac physiologist.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. RPH was a tertiary referral hospital and it was usual that a patient’s needs, including learning disability, safeguarding or mental health concerns were already known and therefore flagged on their patient record. Members of staff told us they contacted the hospital social work department or trust safeguarding lead in cases where they required additional specialist support. They said whilst they did not usually access communication aids to help patients, they engaged with them in other ways. This included writing or drawing instructions, to help them become partners in their care and treatment.

We observed one staff member gain consent from the patient, so they could ask their family member to support them during a radiological test. The radiographer gave clear instructions to the family member on how to relay instructions to the patient. The patient later indicated to the CQC inspector that they felt their needs were considered throughout the process.
The new site was designed to ensure facilities and premises met the needs of a range of people who used the service. Reasonable adjustments were made so patients living with a disability could access and use services on an equal basis to others. Patients with mobility difficulties had easy access to the waiting areas and examination rooms as all departments were located on the ground floor and were laid out sequentially. The corridors were wide which meant there was easy access for wheelchair users. There were patient toilets located in all clinical areas, and all were suitable for the use of patients who had reduced mobility and required mobility aids or wheelchairs. Bariatric equipment could be accessed if required. We saw bariatric examination couches, and wide-bore scanners that were compatible with heavy weights. Wide-bore MRI scanners were also used for claustrophobic patients.

Staff made patients comfortable with padding aids, ear plugs and ear defenders to reduce noise during their MRI scan. Patients were given an emergency call buzzer to allow them to communicate with staff should they wish. Microphones were built into the scanner to enable two-way conversation between the operator and the patient.

Since the move to the new site, staff were able to refer directly to plastic surgeons in the event of a reaction to extravasation which had the potential to cause tissue damage. Extravasation is the accidental leakage of certain medicines into the body from an intravenous drip in the vein. We were told that patients were seen by a plastic surgeon within a matter of a one or two days to minimise long-term damage. Patients were given a leaflet which explained potential complications of extravasation and signs to look out for.

In rare cases, contrast agents caused kidney damage. Radiographers did point of care testing in the department for patients with risk factors such as diabetes, kidney impairment and older patients to determine where there was a risk in using contrast agents. Test results were immediate and enhanced patient experience and safety as well as the efficiency of the department. Additionally, as a result of benchmarking with other services, radiographers administered varied amounts of contrast agent related to the weight of the patient.

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, and patients, relatives and carers could get help from interpreters or signers when needed. There was access to a telephone translation service, and a translator could be requested to come to the department at short notice. One radiographer told us when the secondary referrer omitted to tell them the patient required an interpreter, this could result in having to rebook the patient until an interpreter was available some 24 or 48 hours later.

Staff had access to communication aids to help patients become partners in their care and treatment. Hearing loops were installed at the reception desks for patients with hearing difficulties. Information leaflets were sent to patients with their appointment letters. These leaflets included information about what the scan would entail and what was expected of the patient before and after the appointment.

We sat in the waiting area and confirmed patients knew when to make their way to the imaging department door. Their name flashed up on the electronic display boards positioned between each bank of seating, with instructions about which door to go to. As they went towards the door, the radiographer met and greeted them and accompanied them into the department. One patient we spoke with whose first time it was to the hospital told us this system was “flawless”, despite their unfamiliarity with the department.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with national standards.

Diagnostic waiting times (percent waiting 6+ weeks)

From March 2018 to February 2019 the percentage of patients waiting more than six weeks to see a clinician was consistently lower than the England average. The England average is the mean value from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers in England.
The chart below shows 6+ weeks percentages over time

(Source: NHS England – Diagnostic Waits)

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The clinical lead told us it was the departmental policy never to cancel anything, including patient lists or multidisciplinary team meetings. They said it was of the utmost importance that patient flow was not disrupted.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We were told the contact centre, which administered all patient appointments kept a list of patients willing to take up appointments at short notice. There was also an option of filling last minute cancellations from an outpatient list.

Members of the senior leadership team told us to ensure good patient flow, a proportion of MRI work was outsourced to a mobile facility operated by an independent provider. The trust provided data on this following inspection which showed 19% was outsourced between May 2018 and April 2019.

Following inspection, the trust submitted data on turnaround time for reports by radiologists. These included non-cardiac computerised tomography; cardiac CT; ultrasound; fluoroscopy and angiogram where the reporting time should be within three days. Report turnaround standards for magnetic resonance imaging and nuclear medicine

The tables below show separate reporting times for out-patient and in-patient for March 2019 and May 2019. The results for May show all outpatient results were reported within the expected time frame, despite the potential disruption to service of the move to the new site.

We discussed in-patient reporting with radiological staff. We were told how in-patient reporting could not always be completed within the time frame due to the complexities of patient conditions. In many cases, further imaging and multidisciplinary discussions were necessary before a conclusive report could be made.

<table>
<thead>
<tr>
<th>Out-patient reporting</th>
<th>Total Complete Patient Reports</th>
<th>% Complete &lt;= 3 Working Days (Complete &lt;= 5 working days for MRI and &lt;= 10 working days for nuclear medicine)</th>
<th>% Complete &gt; 3 Working Days (Complete &gt; 5 working days for MRI and &gt; 10 working days for nuclear medicine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2019</td>
<td>1,877</td>
<td>71</td>
<td>29</td>
</tr>
</tbody>
</table>
In-patient reporting

<table>
<thead>
<tr>
<th></th>
<th>Total Complete Patient Reports</th>
<th>% Complete &lt;= 3 working days</th>
<th>% Complete &gt; 3 working days</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2019</td>
<td>2,406</td>
<td>60</td>
<td>89.4</td>
</tr>
<tr>
<td>May 2019</td>
<td>1,659</td>
<td>65.6</td>
<td>85.7</td>
</tr>
</tbody>
</table>

(Source: RPIR)

To ensure that new referrals for possible lung cancer are diagnosed as fast as possible the trust worked with the thoracic oncology team and pathology team to triage referrals; agreed admission date for biopsy; be part of the team performing the biopsy and results within five working days. This means a patient can be referred on Wednesday and by the following Thursday have a treatment plan.

An audit was carried out to assess the impact on service delivery where radiographers administered beta blockers and vasodilators for cardiac CT. The results showed there was a 24% reduction (six minutes per scan) in scanning time. This increased patient flow and meant that patients spent a shorter length of time on the scanning table.

Patient waiting times were displayed on the electronic display boards and most patients we spoke with told us they were seen on time or within 15 minutes of the appointment time.

**Learning from complaints and concerns**

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

**Summary of complaints**

From March 2018 to February 2019 the trust received six complaints about diagnostic imaging (10.7% of total complaints received by the trust). Three complaints related to communications; two to patient care and one to access to treatment or drugs.

All complaints for diagnostics were closed at the time of reporting. The trust took an average of 13.8 working days to investigate and close complaints, this is in line with their complaints policy, which states complaints should be dealt with within 25 working days.

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

Managers investigated complaints and identified themes. They shared feedback from complaints with staff and learning was used to improve the service. Staff understood the complaints policy and knew how complaints were handled. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. They told us learning from complaints and feedback was shared with staff through a variety of means such team meetings, clinical governance meetings and ‘learning from discrepancies’ meetings. As part of the complaints process, outcome and learning was shared with individuals involved and any action to support development put in place. This included additional training for staff, revision of standard operating procedures and updated training guides.

Patients, relatives and carers knew how to complain or raise concerns, although none of the patients we spoke with during our inspection felt the need to complain Members of staff understood the role of the Patient Advice and Liaison Service (PALS) and told us they had an effective working relationship with the service. The service clearly displayed information about how to raise a concern in patient waiting areas.
Number of compliments made to the trust

From March 2018 to February 2019 the trust received 5,963 compliments in relation to all areas at Royal Papworth Hospital. The trust did not provide a ward or core service breakdown of the compliments. However, the trust has confirmed that they plan to record compliments by ward and department on the new site.

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

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The diagnostic and imaging service was part of clinical and diagnostic services and was led by a clinical and diagnostic services clinical lead and deputy director of operations. The local leadership team had a radiology and catheter laboratory operations manager, radiological clinical lead and radiological clinical governance lead. Each modality had a lead and a deputy. Nursing staff in the catheter laboratory were line-managed by a matron, sister and the head of nursing.

The leadership team planned and executed of the move to the new hospital site. This move was complex and included the procurement and installation of new machinery, as well as ensuring staff were competent to operate the machinery before business as usual commenced on the new site.

Staff and managers alike were proud to tell CQC that the diagnostic imaging department was up and running for business on day one of the new hospital opening. This was attributed to strong leadership and good teamwork.

The leadership team demonstrated knowledge of the service’s performance. They understood the challenges to quality and sustainability the service faced and had pro-active ongoing action plans in place to address them. It was generally agreed that staffing, especially of radiographers, was the biggest current challenge.

All staff reported there was strong leadership within the diagnostic and imaging departments. Managers at all levels were strong, visible, supportive and approachable. Staff commented that the radiology manager and clinical lead had strong presences within the department. They had a deep understanding of how the department worked. Their ambition to promote and maintain exceedingly high standards was obvious and motivated staff to share this ambition.

Staff were familiar with who the chief executive was, some of whom met with him when he visited the department from time to time.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Royal Papworth Hospital NHS Foundation Trust vision was to provide excellence in specialist heart and lung services with a focus on value, effectiveness and growth, and a commitment to providing the best possible standards of personalised care to patients.

The key clinical vision for the clinical and diagnostic service was to improve efficiency; increase support to frail patients and expertly trained colleagues; increase use of computer aided diagnostic work; development of services to others and the creation and funding of academic positions within Papworth.
Staff we spoke with shared both the trust and divisional vision. They said they were made aware of strategic developments through their line management. They felt positive and proud to work for the Royal Papworth Hospital which was an innovative and progressive hospital and at the forefront of major research and development.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The culture across the diagnostic and imaging service encouraged openness and honesty at all levels, including with people who used services, in response to incidents. The trust had systems and processes to ensure staff met the duty of candour (DoC). 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.

Managers told us they encouraged a culture of openness and honesty, which included application of the DoC. We saw DoC responses to patients and family members which were explicit in detail. Staff told us they understood their responsibility with regards to DoC. We did not speak with anyone who had been part of its application; however, all those whom we spoke with considered it was a priority to be honest and open with patients and relatives when something went wrong with their treatment and caused or had the potential to cause, harm or distress.

Staff worked collaboratively and responsibly to ensure high quality patient safety and care was maintained. They told us the patient was at the heart of all they did and was their motivation to be the best they could be. They told us they felt supported and listened to, and there was a collective desire to drive quality and improvement. They said they were actively encouraged to raise any concerns and learning from incidents was a positive part of the culture.

We observed good working relationships across the service and it was evident that staff morale was good in most areas we visited. Staff spoke with pride about the new hospital, the importance of the world-renowned work it did and their contribution to this. They told us they felt respected and valued by their managers and senior management team. They told us of a recently introduced positive feedback mechanism where a member of staff could electronically record any aspect of a colleague’s good practice and mirrored CQC domains of safe, effective, caring, responsive and well-led. This feedback was distributed to the nominated staff members and their line managers.

Staff at all levels told us there was good team working throughout the service. They worked together to provide the best possible care for patients. During our inspection, we observed positive and respectful interactions, which were focused on meeting patients’ needs and providing safe care and treatment.

The service had mechanisms in place for providing all staff at every level with the development they required, including appraisal and career development conversations. Some radiographers told us they had extended scope of practice where they were trained and approved to administer a beta blocker and a vasodilator. Managers told us RPH trained staff were highly sought after by other trusts.

Governance

Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
There were governance frameworks to support the delivery of good quality care. The service undertook several quality audits. Information from these assisted in driving improvement and staff were told when things went well, as well as how to address when things needed to be improved.

There was an established and robust clinical governance structure. Members of the senior leadership team said they worked hard to ensure the governance structure met the needs of the service. There was a ‘floor to board’ route which they believed was effective and uncomplicated.

The service had an on-site radiation protection committee with membership made up of leads from each modality, as well as the clinical lead and operations manager and which reported into the divisional governance structure. This committee met to discuss any issues related to radiation protection. Minutes of the September 2018 radiation protection committee covered arrangements for the move to the new site as well as matters raised by each modality. Radiation protection was discussed at the heads of department weekly meeting as well as the department monthly business meeting.

The trust serious incident executive review panel met weekly and discussed each potentially serious incident and rated it. The meeting identified good practice and confirmed application of Duty of Candour regulation where relevant.

This was achieved through a series of weekly and monthly meetings with different groupings and levels of staff.

Information from these was reported at the radiology directorate monthly meeting which reviewed incidents and risks, key performance indicators, quality metrics and audit results. The resultant radiology report culminated in an overall performance review and was reported to the monthly clinical and diagnostic services divisional board meeting and then to the trust board.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had arrangements in place for identifying, recording and managing risks. There was a radiology risk register which identified key risks. The radiology operations manager reviewed all risks each week with modality leads and then separately with the clinical lead and divisional deputy director of operations. These risks were reviewed at the monthly radiology directorate meeting where the risk register was updated, and this was brought to the quality and risk management committee board each month.

Staff were aware of the main risks within the service, which reflected those raised during a meeting with the senior leadership team. These were shortage of radiography staff; increasing demands on radiology, both locally and nationally and information technology maintaining pace with this increase. We were told there was 25% year on year increased activity in cardiac computerised tomography.

Information regarding the service’s risks, incidents and complaints was shared with staff through regular team meetings.

There was a systematic programme of internal audit to monitor quality which included audits of patient records; equipment; patient safety checklists and x-ray quality.

The hospital had two servers to provide contingency in case of IT failure. There was a business continuity plan in place in the event of an IT or Picture Archiving and Communication System failure.
Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff told us they were able to access the information they needed to provide safe and effective care. The intranet was available to all staff and contained links to current guidelines, policies and procedures. All staff we spoke with knew how to access the intranet and information relevant to their role.

There were enough computers available to enable staff to access the system when they needed to. They accessed patient electronic records appropriate to the needs of the investigation being completed. Electronic patient records were kept secure to prevent unauthorised access to data, however, authorised staff demonstrated they could be easily accessed when required.

The service had information governance policies and procedures to ensure information was stored securely and protected patients’ privacy and security. Staff were aware of their responsibilities in relation to data protection and making sure information was accurate and managed securely. We saw data protection principles followed throughout the department.

Senior staff understood the requirements for reporting serious incidents to external bodies. This included the Care Quality Commission IRMER for IR(ME)R17; Health and Safety Executive for IRR17. They also reported to the Environment Agency and Administration of Radioactive Substances Advisory Committee via Public Health England for nuclear medicine standards related to their gamma camera.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Members of the senior leadership team acknowledged regular team meetings were held less frequently during the period of planning and preparation for the move to the new site. This was soon to change, and we were told team meetings would be reinstated within weeks of this inspection. In the meantime, individual modality team briefings were held at 7:30am each morning. The service manager met with individual team leads every week and maintained a visible presence throughout the department each day.

Some staff told us they thought certain aspects of the site move could have been communicated more clearly; for example, the loss of individual office space meant there was an expectation that staff ‘hot desked’. They acknowledged that this was decided at a divisional level rather than a local leadership level, but they were still trying to adjust to what was a significant change to working practice.

We reviewed minutes of selection of directorate meetings and found them to be of a good standard. There was a separate action list distributed after each meeting which included actions to take forward and the person responsible.

Results of NHS Staff Survey for 2018 survey for diagnostic services directorate scored better than the overall trust results in certain areas. These included health and wellbeing; immediate managers; morale; quality of appraisal; safety culture and staff engagement. The areas which scored worse included equality and diversity; quality of care; and safe environment – violence. Trust and directorate score was the same for safe environment – bullying and harassment.
An action plan in response to the staff survey was submitted following inspection. All radiology staff were scheduled to complete unconscious bias training. This was already completed by radiology leads in March and all other staff were due to complete it by August 2019. To address response to quality of care, the department was working towards gaining accreditation with the Imaging Services Accreditation Scheme. This was designed to manage the quality of diagnostic services and make continuous improvements; and to ensure patients received consistently high-quality services delivered by competent staff working in safe environments. To address the safe environment, radiology leads, and the leadership team committed to sharing feedback on incidents with all staff groups.

**Learning, continuous improvement and innovation**

*All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.*

Staff of all disciplines were committed to improving service provision and the patient experience. When we met with the senior leadership team, they made it clear the continued development and improvement of the service was central to their role. They said radiology was an ever-evolving field and it was their intention to be at the forefront of innovation. They said the state of the art design of the department in the new hospital underpinned this.

It was apparent to CQC inspectors how each member of staff we spoke with shared this approach. They told us how safe innovation was encouraged and celebrated by managers. They said they were facilitated to pursue an area of interest. For example, a radiographer told us they had spent time in the radiology department of another hospital to learn about the use of a different isotope in nuclear medicine. This was now implemented at Royal Papworth Hospital.

Other extended practices which radiographers were supported to develop included the administration of beta blockers and vasodilators for cardiac CT; stress testing and pacemaker scanning. This was outside the usual scope of practice and had a significant impact on enhanced patient experience.

The clinical lead told us members of the diagnostics and imaging department were engaged in the start of all new services to ensure radiology was embedded into that service. This multidisciplinary way of working provided a holistic approach to patient care from the beginning of the patient pathway.

The service contributed to joint multidisciplinary team meetings with other specialities within the trust, for example, with cancer specialities. We saw evidence of collaborative working between radiographers, radiologists, medical physics experts, cardiologists and nurses to improve the patient experience.

There is a strong record of sharing work locally, nationally and internationally. In addition to on-site multidisciplinary working, clinicians worked with other hospitals and agencies. For example, radiologists did specialist reviews for other hospitals on pulmonary hypertension, oncology and interstitial lung disease reports. They also hosted visiting cardiologists and shared expertise and learning.