

<p>Royal Papworth Hospital FT Internal Mock CQC report October 2018</p>	Safe	Good	●
	Effective	Good	●
	Caring	Good	●
	Responsive	Good	●
	Well-led	Good	●
	Overall	Good	●
Overall - Summary		Good	●
<p>Overall the mock inspection team reported very positive engagement from staff across the Trust. Staff were willing to share thoughts and comments, both positive and negative. As always, the purpose of these inspections are to ensure we have knowledge of any issues that need addressing and strive for further improvement.</p> <p>Since the previous inspection in February 2018 the team has seen positive change in RTT performance, Executive visibility, introduction of a positive incident reporting system, improved focus on staff well-being, improvements in Registered nurse vacancy figures, improved nurse turn over, introduction of the 'Our Big Move Briefing', improved engagement in equalities and inclusivity, theatres well led, including training and education has moved to 'outstanding' and improved consistency across outpatients. There was evidence that all areas had improved in medicines storage. There was evidence both from staff accounts and through review of documents of good learning from incidents, complaints and patient feedback. The patient experience remains excellent across all areas, and the introduction of the SIERP (serious incident review panel) is a positive step to ensure no learning opportunities are missed. The main focuses to improve areas identified as RI are within; diagnostics, safe, completing the loop on incidents and Well Led in terms of there being scope for senior leadership to be further improved (February 2018 reported RI in diagnostics in terms of engagement), CCA, around effective use of MCA assessment, Theatres, Safe in terms of medicines management.</p> <p>This resulted in 9 'must do' actions for the Trust.</p>			

<b>Trust Wide</b>	Safe	Good	●
	Effective	Good	●
	Caring	Good	●
	Responsive	Good	●
	Well-led	Good	●
	<b>Overall</b>	<b>Good</b>	<b>●</b>
<b>Overall - Summary</b>		<b>Good</b>	<b>●</b>
<p>The team visited Finance and HR areas and spoke to the CEO, COO, Chief Finance Officer, Director of Workforce &amp; OD, Deputy Clinical Governance manager, Chief Nurse, Director Of IM &amp; T Chief Information Officer, Trust secretary and x2 non-executive directors</p> <p>The engagement of the Executive and non-executive team members was excellent and all the members that were interviewed spoke very well. There was consistency in the answers received from them all. They all spoke up honestly and were aware of the current challenges that Royal Papworth Hospital is facing and plans that have been put in place. In addition it was very apparent that the team were very complimentary and proud of the workforces who are working 'above and beyond' to provide the excellent patient care.</p> <p>The Trust wide element has been rated as 'good', however there are elements that require improvement in 'well led' with regards to Board engagement and visibility with front line staff.</p>			
<b>Safe</b>		<b>Good</b>	<b>●</b>
<p>The inspection team found that all the executive team members that were interviewed were engaged with the safety agenda across the organisation. The biggest safety issue of the ageing estate was a key priority and that regular and frequent estate rounds were carried out to make sure current site is meeting the needs and activity is sustained due to the delay in the move. In addition the risk of reduced workforce was highlighted and the actions that are being taken to try and improve this, however there was evidence of measure being taken such as closures of beds/ areas so that patient safety was not compromised when number of staff were low.</p> <p>There was an escalation of concerns process with different grades of on call and where needed to the executive team and the board members. The 'Board Assurance Framework' was mentioned repeatedly in the different interviews and the team were reassured that this framework was being followed.</p>			
<b>Effective</b>		<b>Good</b>	<b>●</b>

The team heard that the executives and non-executive were very proud of the clinical outcomes, and the ‘world-renowned’ reputation that Royal Papworth has with many highly skilled teams that work with them. Looking at the skills mix and providing training and development of staff members was talked about. There was a mention of the recent cancer survey results and how these were amongst the best in the region. ‘In your shoes programme’ and visiting patient environment by the executive team members was highlighted. An open and honest culture was pointed out alongside the ‘Freedom to speak up Guardian’ recently recruited and is being promoted to help raise any concerns that the workforce have.

The team spoke about the collaboration with the wider stakeholder both regionally and nationally. An outward looking trust, benchmarking and always looking to improve. There was a mention of two health tech award nominations that the digital team have been put forward for.

**Caring**

Good



The team heard a consistent message on how vital it is to care for the staff well-being during these challenging times. Mindfulness, resilience workshops have been put on. NHS benefits, bus services, accommodation needs, subsidies and enhanced rates of overtime were mentioned. Staff morale is taken seriously and answering concerns about the NPH is actively managed. The weekly ‘Big move meetings’ were put into place to communicate with the staff regularly and address any issues, concerns and answer questions directly, ‘Keep listening and responding’ was said. There was recognition from the Executive that there was always room for further improvement in this crucial area of supporting and engaging staff.

The team were told about the ‘Laudix’ that has been introduced to recognise and reward staff for their hard work. The pulse survey was mentioned to make sure all messages are heard. Understanding of different cultures and diversity was brought up. The executive team were disappointed in that the Trust had not previously had an appropriate focus upon the Workforce Race Equality Standards however they did explain that a BAME group has now been launched and they recognise and found real engagement from the staff. Discussions about setting up and looking at disability group were also mentioned.

The team heard from the non-executives that patient stories are shared at the board meetings to enable focus on the patient throughout the meeting. In addition an executive member spoke about the walk round they did recently and how they spoke to patients who could not fault the care they received in any way.

**Responsive**

Good



The team heard of many examples of responsiveness. The main one of timely access to treatment was discussed by many. The booking team review in particular its booking efficiency has been looked into depth and actions put in place were discussed. There was clear evidence of making sure there is sustainability in this review and that the processes are embedded.

Cath lab 6, the portable lab was another example of this and the response due to the increasing workload and meeting demands.

There was clear evidence of the response the leadership team had on the delay to move. The impact this would have on the staff, accommodation, travel arrangements and 1 to 1’s were arranged with those that required it to assist in these challenging times. Communication with the workforce was a very common theme that all executives spoke about. The big move weekly gathering and also going to the wards to deliver this where workforce members could not attend. One of the challenges the team spoke about was the need to improve the cascade of this message to try and capture everyone, hence the different methods of communication used.

The team heard how work was being carried out to roll out a standard template for minute taking of meetings

across the trust. This was to make sure recording and evidence is consistent of the discussions taking place and work being carried out.

A few of the executives mentioned how the recruitment and retention work was being carried out. Innovative ways of recruitment and attracting new staff members by making the roles attractive and matching salaries were some that were mentioned. Focus on retention of current staff was also a key priority and awareness of the challenges they were facing. Safer staffing levels, skills mix and regular bed rounds meetings were discussed.

The chief executive mentioned that all the complaints that came through were being reviewed by him and his insight meant that not only could these be responded to efficiently but also made them aware of actions needed or areas to look at to prevent this happening again.

**Well-led**

Good 

There was clear evidence of regular communication amongst the executive team member and the non-executive team. Buddying up a non-executive with an executive team member and being assigned to specific areas was highlighted. Patient stories, PIPR report, tracker and movement of the Board assurance Framework were referred to several times. However the non-executive team did mention the list to the board was too long, 50+ and so the phrase 'woods for the trees' was brought up and too much airtime was spent on things that could be dealt with outside the board room and freeing up time to be spend on the important things board need to focus on.

One of the key things that resonated in each senior leadership interview was the importance of visibility within the hospital. Although efforts were being made when the inspection team collaborated with other members of the inspection team from different areas there appeared to be discrepancies about this. Some ward staff did not feel they saw the executive team or could name certain members of them. This may be due to recent changes in titles such as 'Chief Nurse' from 'Director of Nursing'. A concerning message from a ward member was that the executive team were only visible when they needed the beds and wanted them to discharge patients. One member of staff mentioned that bands lower than 7 would not really know the executive team. These examples came from 2 members of staff reporting visibility and style as an issue. This must be balanced by the positive feedback received from staff that the Trust Wide team spoke with, who describe an improved style from the executive team and greater level of visibility.

The values of the organisation were mentioned through role modelling and seeing in the workforce and not regurgitation of the words. The executive and non-executive team member felt these were truly embedded and gave various examples of them being demonstrated.

There was great emphasis on reporting culture within the organisation driven from bottom upwards. 'High level of reporting with low impact' was said by one member that was interviewed. The team heard of the solid infrastructure in place through the datix reporting and internal audits and coding of the risks. Ownership of risks within areas was given and regular reviews of risk at business unit level were discussed. Closing the feedback loop was spoken about and the escalation to the Q & R group where needed. No Blame culture with debriefing, pre- SI meetings were mentioned. Being proactive and trying to deal with situations beforehand was also highlighted. Where needed, lessons learnt disseminated and educational packages put in place and an example of the deteriorating patient SUI was mentioned. It was good to hear about the 5 year forward planning of the audit team becoming and moving to a QI team.

**Areas of OUTSTANDING practice**

- The use of Laudix to celebrate positive incidents
- In your shoes by the Exec team
- Patient stories used at the Board
- Mindful and resilience workshops for staff
- Staff well being during challenging times – move postponement support to staff.

- ‘Our Big Move’ weekly briefing
- Implementation of the SIERP

**Areas for improvement**

**Action the hospital MUST take to improve**

None

**Action the hospital SHOULD take to improve**

- Implement the suggested Disability group for staff
- Continued improvement WRES agenda
- Improve governance in terms of minute taking, standardising practice and improving recording of actions
- Executive and Non-Executive visibility needs to continue to improve further.

<h1>Critical Care</h1>	Safe	Good	●
	Effective	Requires improvement	●
	Caring	Outstanding	●
	Responsive	Good	●
	Well-led	Good	●
	Overall	Good	●

In the narrative, **bold** = recommended actions

The team visited the Critical Care Area (CCA) twice during the day, first in the morning and then later in the day, during the afternoon. The visit was unannounced. The inspection team consisted of three members of Royal Papworth Hospital staff (who were not CCA staff) and two external reviewers. The Team spoke with numerous members of staff across the multidisciplinary team and of a variety of grades, patients and relatives. We interviewed members of the CCA leadership team and also staff from the leadership triumvirate.

The team would like to thank the staff, patients and their relatives for their openness and willingness to share their feedback and experiences of their time in the CCA at Royal Papworth Hospital.

<b>Overall - Summary</b>	Good ●
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The team rated the Critical Care Area as Good, however the team did note that as well as caring some domains were close to outstanding. The team found that effective was requiring improvements due to the lack of the use of the mental capacity act, its recording and application.

There are 2 **must do** and 3 **should do** actions required.

Safe

Good 

**Safe**

- Infection prevention and control: ‘Our Commitment to Cleanliness’ signs clear and visible on the wall.
- There was clutter in corridors (cages and broken chairs) walking towards the CCA. In one corridor this would potentially affect horizontal evacuation of patients should this be necessary in an emergency.
- On entry to the unit there was a cable hanging down from a unit and plug that could be considered a hanging risk. When raised with a member of staff, this was corrected immediately.
- ‘Laundry Store’:
  - Rubbish on the floor in clear bags. The floor would be very difficult to clean.
  - ‘Critical care beauty box’ appears to be for multiple patient use (i.e. large bottles of shampoo, rather than smaller bottles for single patient use). We spoke to the Matron on the day who agreed to review their use.
  - A tube of Doublebase gel was in this cupboard
  - There was a box of tubes of Octenisan
  - **The name on the door to this store needs to be changed to better represent what the store is being used for**
  - **There needs to be a review of what is kept in this store. Is it all appropriate?**
- There was a KPI notice board displayed near the Sisters Office. There were some notable changes month on month for example, what changed to turn ‘timely review of Datix’ into green; and why the step change in Sep 2018 for ‘bottle labelling’ (sudden deterioration in performance). We asked about the recent increase in Datix incidents regards labelling issues with blood samples. We were informed that this was related to R+R (within Lorenzo).
- During one of the interviews with senior staff we asked about the KPI noticeboard metrics – 34% drug omission. We were advised that on CIS it allows you to not give a prescribed drug and not document reason for. Generally they are laxative and diuretics. Education re completing reasons for not given is in progress. If it is a critical medication omission (immunosuppression for example) there is a Datix which is then investigated – “this is very rare”.
- During one of the interviews with senior staff we asked how they had achieved an improvement in overdue Datix from 29 to 1. We were advised that if an incident happens on a shift it is either the nurse in charge or consultant in charge that then is responsible for completing. They have a discussion reference all Datix at MDT and any outstanding are highlighted. Lessons learnt as a result of Datix, widely disseminated, safety huddles, email, boards. We saw evidence of this when in CCA and staff were also able to talk to us about examples.
- **On the KPI notice board: Could there be explanations alongside the tables? Who is this notice board aimed at?**
- The drug room was safe and secure. For such a busy room, it appeared well organised. Medicines that we checked were in date. Controlled drugs were secure.
- The Housekeeper maintained a detailed log of fridge temperature checking and when asked was able to provide clear evidence where a booklet is used. The Housekeeper was very professional and proud of the work she did in the unit and very clearly able to talk through the booklet they use. The Housekeeper also explained that these booklets are retained by the housekeeping manager for archiving when they are completed.
- **The paper recycling bin in the drug room was overflowing.** Is this the correct size for such a busy area and/or is it emptied regularly enough?
- ‘Nurse in Charge’ badge very clear and good idea to clearly indicate leadership role

- Unit busy, but well managed, calm not frenetic.
- The entry door to the unit where the relatives have to use a speaker system/phone to gain entry: the phone is seen as a priority for the whole team
- We witnessed a member of staff identify that there was a problem with a key pad on one of the doors going into the drugs area. We were impressed to see that this was handled very swiftly and Estates were on the unit very quickly to resolve the problem.
- While we were on the Unit, there was an emergency where the emergency buzzer was pulled for one of the patients. The response was immediate and appropriate. Key staff responded in a calm and professional way.
- We were informed that the unit has a waiting list of staff that wish to join as registered nurses. This was further illustrated when we spoke to a final year Student Nurse. She had completed the majority of her three year programme at Papworth and wished to work as a Staff Nurse on Critical Care when she qualifies in March 2019, however had been told that there was a waiting list. The Student Nurse had been offered work on a neighbouring ward so that she could stay at the Royal Papworth Hospital.
- We spoke to a senior manager. Regards safe staffing, we were advised that acuity can change really quickly and that they are responsive to that as required. We were told that if required, the senior manager of the day would 'pause a bed' to maintain safety. We were given an example of when this had happened recently. There was a clear escalation process in place which involved first speaking to the Critical Care Duty Sister, then the Critical Care Manager and then the Deputy Director of Operations. When asked how they monitor acuity and dependency on the unit, we were advised that this is done in accordance with the national Critical Care guidelines. Because of the type of patients on the unit, some require higher than 1:1 care.
- We checked the staffing levels on the unit. These were displayed as required in accordance with national requirements. The Safer staffing board was up to date with required and actual. Early required = 35 RN; actual = 39 RN. Late required = 37 RN; actual = 38 RN.
- Physiotherapy at 28% vacancy which they are finding a challenge.
- The Duty Sister was able to show us where they recorded acuity and dependency (on HealthRoster) and how this was fed into the site capacity meetings and onto the national Critical Care system. Described Duty Sister role in ensuring safe staffing levels and skill mix.
- We spoke to a Transplant Consultant. They were aware of the recent SIs within transplant and had seen the investigation documentation; unsure re lessons learnt but thought that all was in place.
- We spoke to the Duty Sister. We asked: *what are your most recent risks in CCA?* Described episode with T piece valve, tracheostomy equipment and pseudomonas in the some of the sinks. She was able to discuss all aspects of these, what was in place to mitigate against these risks, how they were communicated to all staff-safety huddle on a shift basis, email, safety board/MDT. Able to discuss a recent SI and how it had been investigated (still in progress). Able to demonstrate for those completed how actions were given to staff and the lessons learnt disseminated widely as above. All Datix discussed, themes highlighted and lessons learnt.
- All staff bare below the elbow.
- Actichlor in sluice in date.
- Commodes clean, **though the wheels and footpads could be given more focus.**
- Curtains clean.
- Clean inside Danicentres.
- All equipment clean and no dust identified.
- **Not clear as to the use of green I am clean stickers - in some places not all, what is the process?**
- Environment: gloves stored on desk not in Danicentre; in multiple areas.
- Clinell wipes were not clearly visible, though on questioning they were at every bed space.
- We saw that the resus trolley checklist was checked and signed twice daily. The chest opening checklist was signed regularly for the last four weeks.
- Holders on walls by trolleys contain equipment checking lists as well as other information for the HCSW. **What is the purpose of these holders?** (A member of staff's appraisal documentation was found in one of these holders which was brought to the attention of staff at the time).
- We spoke to the Matron who advised that they try not to transfer patients after 20:00 and before 07:00.
- We re visited the Critical Care Unit in the afternoon. On entry to the unit we were appropriately challenged

by a junior member of staff regards our ID.

**Effective**

Requires improvement 

- The Duty Sister came and introduced herself to us. She was welcoming and professional. She indicated clearly where the team couldn't go (one patient was in isolation; one patient and their family had just received some bad news)
- We observed numerous examples of very good team work;
  - Example: when the phone rang for secure entry (door to the CCA), if the Ward Clerk was not available, every member of staff near the phone saw this as a priority and made the effort to answer it so that visitors were not waiting
  - Example: member of the nursing team went to answer the desk phone on behalf of the ward clerk (who was busy) to help out
- The unit appeared well staffed and organised
- We asked to look at a patient's record on Lorenzo (the EPR). The Staff Nurse appropriately (and very courteously) clarified that we were allowed to see the patient's records. This shows a very good awareness of confidentiality and information governance. The Staff Nurse explained that when a patient is transferred from Critical Care to a ward the Critical Care records are transferred electronically to the inpatient records. We were also informed that the drug chart section is checked to ensure that any Critical Care only medicines are removed from the chart that will be used in the ward area. This was done so that the prescription is less complex for non-Critical Care staff.
- We observed a handover. Patient was one day post op from CRU to ward. Plan A patient – to a band 4 (pre reg) and RN (for medicines part of the handover). Medicines transferred and checked immediately on patient transfer. Printed out discharge from CRU paperwork; goes through all the systems and discharge plan clear. Electronic form on Lorenzo; ward nurse completes, very comprehensive document which included delirium, IPC, VTE, transfusion status, medicines, fluid status, drains, rhythm, pacing, wounds and social. (This matched what other inspectors on CCA had been told separately by another staff nurse).
- We spoke to a newly qualified Staff Nurse. She was "very happy" on the CCA. "The education team are brilliant and very supportive".
- We spoke to a Senior Staff Nurse who had been on the unit since qualifying. She explained that she had only intended to stay for one year however "I absolutely love it; fell in love with the place and stayed". If there have been incidents they get highlighted to staff. When asked: "what was the most recent incident?" the Senior Staff Nurse was able to explain a recent incident about a valve on a circuit that shouldn't have been used; "all staff are aware and staff have been emailed". One of the inspection team was from NHS Improvement (NHSI) and the recollection from the Senior Staff Nurse triangulated exactly with the detail that the Trust had shared with NHSI. The Senior Staff Nurse explained that "IPRs are better than they used to be" and she felt very motivated when talking about education and her personal responsibilities as a registered nurse. The Senior Staff Nurse also said that she felt very comfortable to escalate any concerns (if she had any) and that there was a very good team support mechanism in place in Critical Care.
- RN spoke of 5 year career plan and she was on track, appraisal up to date.
- We spoke to the Ward Clerk. She had been on the unit for seven months and "really enjoys" her job. Critical Care is her first job in the NHS and she said that the team are "a great team". The Ward Clerk was very welcoming and professional and extremely prompt and professional when answering the secure entry phone for the unit and when handling calls and any enquiries.
- We asked staff about documenting MCA for patients on Critical Care. We were advised that there is nowhere in the current clinical record for this to be documented. We spoke to the Matron who advised that she had also identified this having recently arrived on the unit and that she has had early discussions with the Trust safeguarding lead and the Trust Digital Team to have a solution in place. We were advised that staff were in date with their mandatory safeguarding training.



- Lots of positive feedback about the education team both regards the Trust team and the team based on the Critical Care Unit.
- There is an education programme linked to a Masters Degree pathway which has been accredited by a local university. This has proved to be very successful and is thought to have contributed to the units success with recruitment.
- There are a number of internally accredited courses: ECMO, CRU and CCA training. There is a good induction and supervised practice.
- A senior manager informed us that they “like to celebrate good things” and we were advised of a new innovative role that had just been introduced with three members of staff successfully qualify as Physicians' Assistants Anaesthetics (PAAs) at Royal Papworth Hospital and they are the first Cardiothoracic PAAs in the UK.
- **Highlighted need for quality board outlining the great work within the unit/you said....we did**
- During one of the interviews we asked about innovation and trials. We were told about a Dietician and work with NG tubes with camera that can be NG and NJ; this was done as a pilot and a poster presented at conference, now will be a bigger trial as a result. This means that patients will not have to be transferred over to Cambridge University Hospitals to have it done.
- During one of the interviews we asked about ICNARC and how they perceive they are doing: ‘Good’. One area of concern is the readmission rate within 48 hours of discharge. All these are investigated (Lead Critical Care Consultant looks at these very carefully) and they are discussed at MDT; they investigate the patients for 12 hours prior to transfer and ALERT team discuss what happened on the ward, lessons learnt identified and disseminated. The LOS for these patients when returning is short, data is compared with general ICUs. Lead Critical Care Consultant also reviews all of patients transferred out of CCA out of hours, this number is low, generally if beds are very tight they would highlight a patient in daytime hours as suitable to move.
- We were advised of another innovative post, whereby Critical Care had recently trained and appointed its own Healthcare Scientist, based in Critical Care. This had been so successful the unit had undertaken to train a second.
- We were advised of other trainees becoming expert in the use of devices/lines and implementing new technology. All these are inclusive of all MDT and discussed regularly at meetings.
- During one of the interviews we asked: *how is the communication between intensivists and transplant team?* Excellent, twice daily MDT, decisions to transfer complex transplant patients out of the unit to the ward was always discussed at these meetings, joined decision making; Able to challenge each other if disagreements re treatment plan; On transfer all medications are written up by transplant team to avoid errors; Good teaching environment within transplant.
- We spoke with a Cardiology Consultant (Transplant).
  - We asked how they find the care of cardiology patients on Critical Care. There is excellent communication; twice daily meetings between intensivists, cardiologists, surgeons and other staff. Everyone explains their plans.
  - We asked about discharge to a ward from Critical Care. Very well planned, good communication between intensivists and cardiology/respiratory team. There is a verbal handover with nurses and doctors.
  - We asked about the move to the new site. Although very positive for the clinical environment one of the concerns is the lack of clinical space for doctors and other clinical staff. If there is a defined office it is easier to communicate between staff teams.
  - We asked about how you tell patients about incidents. Straight forward honest and open. Able to explain the SI process. Also talked about the M&M process. Able to talk about distribution of lessons learned.
  - We asked about teaching and support for junior medical staff. There is a high consultant level and lots of training opportunities.
- This feedback regards junior doctors training was replicated through feedback to other members of the inspection team. We spoke to a student doctor. This was her fourth week at Royal Papworth. She had asked to come to RPH as her elective placement and she had “really enjoyed the placement”. Most of her placement had been in theatres, however she had specifically asked to also spend some time in the CCA and

she felt very supported and that she had had a very positive experience.

- **We asked staff about the allocated fire marshal. Some were unsure about who and how this works.**
- We asked staff about what they were proud of: “Great learning environment” and “Diverse team”. This matched the feedback that had been given by different staff on CCA to different members of the inspection team.

*Overall, Effective was bordering outstanding. However, the inspection team were concerned that there was no evidence of MCA for patients in critical care and as such it was necessary to rate Effective as Requires Improvement.*

Caring

Outstanding



- Photo boards outside and inside Critical Care showing staff pictures off all grades of doctors and of senior nursing team. These appeared very recently updated.
- The Invictus Games gold medal is displayed clearly and with pride on the Unit.
- A pre reg Staff Nurse made a point of coming to say hello and enquire as to what was happening and introduce herself.
- We were shown survey responses from the Family Satisfaction with Care in the Intensive Care Unit survey (Jul to Sep 2018). The comments were extremely positive and complementary about the clinical care and the staff on the unit.
- Good use of curtains for privacy and dignity
- We spoke to a patient and his son. The feedback was outstanding regards the care and all the staff. The son said “you will need a bigger book than that to write all the positive things down that I could say about this unit. If you could bottle this up; my dad has been in a number of hospitals and this is by far the best he has ever been in. My dad has been really poorly and wasn’t expected to make it, he nearly died a few days ago and the staff have been amazing, now look at him, sat up and alert in bed. The communication has been excellent; feedback has been excellent; personal interactions excellent...I cannot say enough positive things about the place.” The patient didn’t speak English and only spoke Italian. The nurse in charge had allocated a Staff Nurse to the patient who spoke fluent Italian. The interactions observed between the Staff Nurse and the patient was an example of nursing at its best.
- We witnessed a telephone call answered by a Staff Nurse at the nursing station that showed very good awareness of confidentiality and sensitive communication. The Staff Nurse introduced herself and began the conversation with “can you tell us the last piece of information that you are aware of?”
- While we were on the unit, a DCD (Donation after Cardiac Death) patient returned to the unit three weeks after his operation to bring a card in for the staff to say thank you. This clearly meant a lot to the staff who were there. As the patient was leaving the unit, one of the junior doctors recognised him and spoke to him saying “sir, you look very well, it is great to see you”.
- Amongst all the activity, the nurses and staff around each patients’ bed space, were totally committed to their patients. There appeared an air of calmness, with total focus on that one patient only. It could be described as almost peaceful at the bedside despite all that was going on.
- During one of the interviews, we asked ‘What are you doing well/proud of?’ We were told: Excellence in care with the complexity of patients for all staff at every level of the MDT. Everything is done in the patients’ best interest. All staff want to help and always do their best for the patients. Great example, young man wanted a card to give his Mum on Mother’s day, this was put out to the staff and the following day there were multiple cards, gifts and flowers that the staff had brought in for him to give.
- A relative explained that they were paying £5 per day for parking. They weren’t complaining, however they hadn’t been advised that there were discounted parking options available for families.
- We spoke to a patient in the CRU area. The patient was one day post op. They have been coming to Papworth for 20 years. Very satisfied with level of care. Communication excellent. Understands plan of care, felt the care was excellent. “Nothing to improve”.
- We observed compassionate attentive care of a distressed relative.
- We had been advised that the unit has a ‘quiet time’ in the afternoon (14:00 to 15:00). When we re-attended the unit that afternoon, this was evident with the lights dimmed and less activity.

<p><b>Responsive</b></p>	<p>Good ●</p>
<ul style="list-style-type: none"> <li>• We were advised that the complaints rates were low. This was verified in the PIPR report (a monthly reporting process: Papworth Integrated Performance Report).</li> <li>• We asked about how are complex patients prepared for transfer from the Critical Care Area (CCA)? We were advised that this was thought about very carefully. From a medical perspective, look at medications-rationalise, IVs to oral, remove lines that are not needed, move bed area in CCA to a quieter area; Involve relatives; Matron reviews; Plan for ACPs (Advanced Clinical Practitioners) to become part of review process, see patient, prescribe ward drug chart (there have been previous errors with ICU drs who do not know Lorenzo system); Plan for nursing staff to start following patients out of CCA, structured questions, including the psychiatry team to ensure the correct support measures can be put in place for these patients if needed; Plan for 'All about me' screen saver and diaries</li> <li>• We were advised that there are differing IT systems from CCA to ward and asked what is in place to manage this. We were advised that the issue is documented as risk on the risk register (especially related to medical prescribing); Plan as above for surgical ANPs (Advanced Nurse Practitioners) to do the surgical prescribing; ANP to plan transfer of complex patients-to summarise the discharge summary on CIS (Critical Care system) onto Lorenzo (hospital wide system).</li> <li>• We observed a patient flow meeting/board round. It was well attended: two Consultants/Duty Sister/Sister in charge of each bay/CRU (Cardiac Recovery Unit) Sister in attendance; Twice daily; Safety aspects of patients care discussed for patients that may be suitable for transfer to the ward; The patients are highlighted red, amber and green using coloured magnets; For patients being repatriated the Consultant reminded medical staff to ensure all discharge paperwork completed; Patients for repatriation highlighted; Patients requiring complex ward transfer highlighted; Discussed unwell patients at other hospitals/patients on theatre list versus beds available and how to allocate considered. Any issues were addressed and there were checks to ensure that everyone understood tasks.</li> <li>• We spoke with a Cardiology Consultant (Transplant). We asked about how you tell patients about incidents: Straight forward honest and open. Able to explain the SI process. Also talked about the M&amp;M process. Able to talk about distribution of lessons learned.</li> <li>• Spoke with relative who said care was wonderful, a little overwhelmed and amazed at the 24 hour service.</li> </ul>	
<p><b>Well-led</b></p>	<p>Good ●</p>
<ul style="list-style-type: none"> <li>• We spoke with a Senior Staff Nurse who said that there are good opportunities to see the Chief Nurse and the Executive Team and that they are visible and accessible. She recalled a recent Coffee Morning with the Chief Nurse and that other members of the senior nursing team were also present.</li> <li>• We spoke with a senior manager who when asked what she was most proud of explained that it was the <i>"holistic care given to patients and their relatives. I am really proud of the staff and I genuinely believe that this is the best Critical Care that I have worked with."</i> The senior manager explained that the leadership triumvirate had listened to the staff and in response to feedback had increased the education team. Because this had worked so well in Critical Care, the same manager advised that they had replicated this recently in the Cath Labs with their own dedicated band 7 Clinical Educator.</li> <li>• The Directorate uses Business Unit reports. We were shown two examples 'Critical Care' and 'Workforce'. These Business Unit reports feed into the overarching Directorate Governance structure. We were advised that appraisals had recently 'dipped' however that the unit had made good progress with this recently and the recent appointment of a new Matron has helped. We were shown an overarching report regards training records however there was no breakdown in a more detailed report of individual compliance</li> </ul>	

regards training records. It was difficult therefore to be assured regards mandatory training at a local level.

- When asked about sickness we were advised that this is monitored closely and where there is any short term sickness they look for any patterns. They undertake return to work interviews as required and if necessary refer to Occupational Health. If there are difficult or poignant cases, then they seek additional support as necessary and we were informed that there is a new Chaplaincy Team in place who are also very supportive.
- We were advised that the leadership team are very happy to consider flexible working if this can be accommodated by the needs of the service.
- We asked a senior manager about the Trust Strategy. They said that they were aware of the Strategy and of the Trust Values; however they were not able to articulate what they were to us. (We were aware that the Trust had recently circulated a poster with this information on it, however we were not told about this poster when we asked about the vision and values).
- When asked about how information is cascaded to the team, we were advised that as a manager she makes every effort to be visible and that she undertakes regular rounds of her departments. An 'open door' policy is in place and the manager's office is closely located to the departments. We were advised that each area has a Clinical Lead and a Manager and that information is cascaded down through the Business Unit reports. We were advised there were staff meetings and that as a senior manager she checks at 1:1's with her direct reports that they are happening.
- During our visit, a Senior Staff Nurse talked to us about team meetings and that they know about them well in advance.
- We were told about an 'information corridor' in the staff area that has lots of information displayed that is useful for staff. We asked a member of staff on the unit about this 'corridor' and they were immediately able to take us to it. There was lots of information displayed, accolade emails and notes, safety briefings, useful handover information and information shared regards a recent clinical incident. There appeared to be a good balance of information and celebration. There was also evidence on the boards of information shared from an Executive level, for example a monthly Chief Nurse briefing was clearly displayed (and current) and the most recent 'Our Big Move' briefing was also clearly displayed.
- During one of the interviews with senior staff we asked about visibility of Exec and Non Exec team. Non exec-limited visibility; Exec-visible but not with CCA itself; If crisis would come to CCA or if beds tight, [\*\*] felt that undue pressure could be placed on medical staff to deem patients fit for the ward; [\*\*] felt that the nursing team know who the Chief Nurse is but would not know her face. Head of Nursing and Matron team very visible for all staff. Previous Deputy Chief Nurse very visible, the new Deputy Chief Nurse is new to the Trust and just completed induction and as such has been less visible so far.
- We asked what are the top three risks on the Risk Register at the moment that are the most important for the area. We were shown evidence within the governance reports of the risk register top three and the senior manager was able to articulate what each one was and what was happening to mitigate regards each risk. Number one was Pathology and we were advised that a solution has recently been reached; the second was the ageing infrastructure and we were given an example of how this was being mitigated against where blood gas analysers intended for the new Papworth Hospital site, were being brought onto the current site because of the delay in moving. The third risk was workforce and we saw a number of examples during the visit of how this was being mitigated against. We asked the senior manager to log onto their live Risk Register system which is located on Datix. We saw that while the risks were on there, the dates did not reflect the same updated position that we had seen in the written reports. **The live system also needs to be up to date and reflect the actions that are being undertaken.**
- We asked about Quality Improvement (QI) and whether this is being used at Royal Papworth. We were informed that one of the Critical Care Consultants is the medical lead for Governance at the Trust, but we were not given any examples of QI in practice specifically. We were later made aware that the Trust is embarking on building QI into its Quality Strategy and that there were four projects (In House Urgent patients, falls, the deteriorating patient and Red2Green) underway using the QI methodology with an external QI facilitator invited into the Trust to support the projects.
- We were advised that they had invested a lot in Human Factors training.
- We spoke to an ISS cleaner. They had worked in the unit since April 2018 and they were having an interview

for a HCSW role.

- We saw that there was a HCSW bulletin which was an excellent resource for communication. Nice bulletins for HCSW which were up to date, but **why being stored in the holders in the clinical area** (location on the CCA)?

### Outstanding practice

- **Caring:** We spoke to a patient and his son. The feedback was outstanding regards the care and all the staff. The son said *“you will need a bigger book than that to write all the positive things down that I could say about this unit. If you could bottle this up; my dad has been in a number of hospitals and this is by far the best he has ever been in. My dad has been really poorly and wasn’t expected to make it, he nearly died a few days ago and the staff have been amazing, now look at him, sat up and alert in bed. The communication has been excellent; feedback has been excellent; personal interactions excellent...I cannot say enough positive things about the place.”* The patient didn’t speak English and only spoke Italian. The nurse in charge had allocated a Staff Nurse to the patient who spoke fluent Italian. The interactions observed between the Staff Nurse and the patient was an example of nursing at its best.
- **Caring:** While we were on the unit, a DCD (Donation after Cardiac Death) patient returned to the unit three weeks after his operation to bring a card in for the staff to say thank you. This clearly meant a lot to the staff who were there. As the patient was leaving the unit, one of the junior doctors recognised him and spoke to him saying *“sir, you look very well, it is great to see you”*.
- **Caring:** Amongst all the activity, the nurses and staff around each patient’s bed space, were totally committed to their patients. There appeared an air of calmness, with total focus on that one patient only. It could be described as almost peaceful at the bedside despite all that was going on.

### Areas for improvement

#### Action the hospital **MUST** take to improve

- **Ensure that all fire exits and fire evacuation routes are clear.**  
There was clutter in corridors (cages and broken chairs) walking towards the CCA. In one corridor this would potentially affect horizontal evacuation of patients should this be necessary in an emergency. **[Of note ‘ensure that all fire exits are clear’ was a MUST do in the 2015 CQC inspection report].**

*Reference to:*

*Regulation 12: Safe care and treatment*

*Regulation 15: Premises and equipment*

- **Ensure that the process for seeking consent is understood, followed, monitored and documented. This involves assessing and documenting mental capacity.**  
We asked staff about documenting MCA for patients on Critical Care. We were advised that there is nowhere in the current clinical record for this to be documented. We spoke to the Matron who advised that she had also identified this having recently arrived on the unit and that she has had early discussions with the Trust safeguarding lead and the Trust Digital Team to have a solution in place. We were advised that staff were in date with their mandatory safeguarding training.

*Reference to:*

*Regulation 12: Safe care and treatment*

*Regulation 13: Safeguarding service users from abuse and improper treatment)*

#### Action the hospital **SHOULD** take to improve

- **De clutter storage areas and ensure that the floors are clear so that they can be properly cleaned.**

Store cupboard (next to room 26) was very cluttered. There was a mattress stored in there blocking the cupboard. In the same cupboard there were flu pandemic boxes, however there was no expiry date visible; a checklist on the wall that appeared to be used to monitor the expiry dates had dates expired on there for 2012 and 2014. The boxes were sealed so we were unable to check inside them. This was raised with the Manager of the area however we received no feedback on the day.

- **Sharps bins should be correctly labelled.**  
Not all the sharps bins have a label on them to say who has started them and closed them. Those sharps bins that did have a label on them, many did not have the label filled in as required. This means that there will be no audit trail which is required.
- **Ensure information regards discounted parking is readily available.**  
A relative explained that they were paying £5 per day for parking. They weren't complaining, however they hadn't been advised that there were discounted parking options available for families.

<b>Surgery</b>	Safe Surgery	Good	<span style="color: green;">●</span>
	Theatres	Requires improvement	<span style="color: orange;">●</span>
	Effective	Good	<span style="color: green;">●</span>
	Caring	Outstanding	<span style="color: blue;">●</span>
	Responsive	Good	<span style="color: green;">●</span>
	Well-led	Good	<span style="color: green;">●</span>
	Overall	Good	<span style="color: green;">●</span>
<b>Overall - Summary</b>		Good	<span style="color: green;">●</span>

The Team visited the Surgical in-patient wards (Mallard and Varrier Jones) and Theatres twice during the day, first in the morning and then later in the day, during the afternoon. The visit was unannounced. The inspection team consisted of three members of Royal Papworth Hospital staff (who were not from within the surgical directorate) and one external reviewer. The team spoke with numerous members of staff across the multidisciplinary team and of a variety of grades, patients and relatives. The Team interviewed members of the theatres and surgical leadership teams and also staff from the leadership triumvirate.

Overall the team felt that the service should be rated as good. Following discussion it was agreed to split this service into its parts of surgery and theatres, to enable actions to be owned by the appropriate directorates. The CQC must do and should do actions are highlighted at the end of this report. Accepting that the CQC formal inspection would rate this service as a whole on any subsequent assessment.

The team identified **2 ‘Must Do’** actions and **7 ‘Should Do’** actions which are outlined at the end of this report. Feedback has been provided to relevant management teams and local action plans will be formulated.

Safe  
Surgery  
Theatres

Good   
Requires Improvement 

**Surgery**

The surgical wards were deemed safe, with some areas of good practice and some areas for improvement. It was noted that the wards displayed their safer staffing numbers, and although the numbers of staff were good, skill mix is an issue. It was reported that this was being addressed. There was a report of high agency use also. Both skill mix and agency reliance were being countered with effective training and preceptorship. The training records for the staff were up to date. One patient reported that they felt there was a lack of nursing presence on the ward compared to previous visits.

The approach to managing vulnerable patients was well documented and care was planned and evaluated. Most staff could report what to do if they had a safeguarding concern however some senior staff who took charge did not know who was responsible for delivery of the safeguarding agenda or who to escalate to.

There were some reports to the Trust Wide inspection team of staff feeling pressurised to move patients on to free up beds, but they also reported that they felt empowered to advocate for the patient if it was unsafe to do so. It is acknowledge that appropriate challenge and support is sometimes needed to maintain patient flow.

There was an excellent understanding of managing incidents and falls risk management. The team were told of the learning from incidents and the feedback loop was completed. However there seemed to be little learning from incidents occurring in other directorates and therefore the inspection team were not assured that there was Trust wide learning to prevent reoccurrence. They reported that this was an MDT approach and that there had been, for instance, further training for the junior doctors had taken place on managing the deteriorating patient. The staff also reported that they received and shared the ‘hot topics’ report and got incident feedback from DATIX by email following reporting.

The wards displayed the Trust ward score card, but these seemed to be out of date. On checking these were the most recent available to them (July and August 2018).

The matron was able to articulate adequate governance awareness and demonstrated examples of how information is filtered down and up within the organisation. The ward sisters both reported feeling supported by their matron and were kept informed of key issues affecting them.

**Theatres**

The theatres area was deemed as requires improvement. There were many good practices reported, but there was improvement needed in medicines management.

The WHO check list was usually completed to a high standard and the current quality report states 100% compliance. A dip in June 2018 was noted, but this had clearly been addressed.

There was evidence of good consistent cleaning standards and ready access to PPE. Theatre caps are inconsistent in use, in terms of some staff have individual cotton caps instead of the Trust provided disposable ones. This was discussed with the senior leaders and although there were expected standards for laundry, there was no evidence of compliance. It was noted that this is being addressed as an issue in the Uniform policy refresh and is currently out for consultation.

There were excellent reports of training and the staff were very complementary of the education provision and support in theatres.

There was one fire door propped open to a store cupboard, which was rectified at the time of the visit. The team witnessed the practice of drugs being pre prepared for an unknown patient for an unknown procedure at the same time as a tray of prepared drugs for the existing patient in theatre being present in the room. There was no evidence of safeguards to ensure that the wrong drugs could not be used for the wrong patient. This was escalated at the time of inspection and it was recognised that the Matron was aware and was developing a plan for improvement. The team also found an anaesthetic room drug cupboard unlocked and ampules of drugs left out. There were 57 theatre cancellations in August 2018 and 262 year to date, the main reasons discussed with staff were shortage of critical care beds and list overruns. The Trust is looking to secure a business case for the development of theatre 6 in New Papworth Hospital to address the high cancellation rates.

It was noted that on the risk register there were delays in transferring patients from the theatre to the critical care area. Additionally a DATIX was submitted 9<sup>th</sup> October with over a 90 minute delay for a patient to transfer to critical care. On discussion with staff it was noted that they were aware of the process to keep patients safe (positioning and temperature control) and how to escalate but were unsure of the timeframe. It was confirmed with management that any delay over 30 minutes should be escalated and a DATIX completed. This should be shared with all senior staff in theatres by theatre management teams to ensure consistency and prevent harm to patients.


**Effective**

Good 

This area was rated as good. The surgical outcomes for RPH remain excellent. There was reported that the clinical / management working was good and that there were monthly business unit meetings. There was evidence of monitoring core business functions and standards were high. We were shown several reports presented at business unit meetings. The minutes reflected MDT attendance and adequate discussion.

The team noted the high readmission rate to the critical care area (2.95%) from the wards for month 5 and were informed a formal MDT review takes place monthly. In addition a working group was looking at formulating discharge criteria from critical care area to the wards.

**Caring**

Outstanding 

The team deemed this to be outstanding in both the surgical wards and the theatres area. Patients were treated with dignity and respect. The Friends and family data, PALs enquiries and complaints information were readily available in the quarterly quality report and displayed on the Know How Well you are doing boards. It was noted that there was a 7 day Matron service for the Trust which worked well for dealing with patient experience issues as they arose. It was reported that the Matrons also carried out weekly Matron Rounds on the wards. Patient feedback was overwhelmingly positive, and staff reported that patient stories were captured and used at many meetings in the Trust including the Trust Board.

**Responsive**

Good 

This area was rated as good. There has been significant work around RTT which is now improving. It was reported that RTT attracts daily monitoring and meetings with the Executive team 3 times a week. Two main actions were reported to be working; rebalance of surgeon's waiting lists and sustained critical care bed capacity. There was also work underway to improve the booking processes at Royal Papworth house. It was noted that not all patients are being seen in preadmission clinics and the impact resulted in additional night's stay for patients. It was also noted that the IHU patient's pathway is now a focus of the QI project, and there has been a recent improvement in the numbers of patients receiving surgery within 7 days.



There continues to be issues with cancellations in theatres. This has been picked up at each mock inspection. Theatres are booked to 100%, so when there is an emergency, cases are displaced. It has been noted previously by the CQC that there is a need for a 6<sup>th</sup> theatre. The new hospital has 6 theatres to allow for planned lists to progress without being interrupted. Although this isn't the only contributor was noted as a significant contributing factor. During the last mock inspection it was noted that some of the thoracic surgical instruments needed updating and replacing. This risk is on the risk register and it was reported that there was now a replacement program in place. It was noted that there had been a number of serious incidents regarding missed lung nodules on x-rays and CT scans. This had resulted in missed opportunities to diagnose lung cancers.

**Well-led**

Good

**Well Led (Surgery):**

The team rated this area as good. Staff reported that they really enjoyed working at RPH, and the team spoke with a member of staff that had recently returned to the Trust and stated 'staff friendliness' and 'career development' as the reason for coming back. It was reported that incident reporting was encouraged and that there was a 'no blame culture'. The staff reported that the ward leaders and leadership team were visible to staff and patients.

**Well Led (Theatres):**

The team rated the well led element as good to outstanding. There were good reports of staff engagement, and staff were actively encouraged to raise concerns. There was a reported zero tolerance of bullying, and it was reported that the leadership team were passionate to address any issues relating to poor behaviour of some consultant surgeons.

We observed examples of effective communication with staff, email archive files and noticeboards contained key service information and safety messages.

The senior team met weekly with TCCA manager and information was shared and updated if they weren't working. Leadership staff were visible within theatres and there was a flattened hierarchy and staff were approachable. There were clear roles and responsibilities reported, and the matron role was highlighted as working well. There had been new roles introduced including the new Physician's Assistant for anaesthetics, with 3 staff recently qualifying.

The department had introduced LOCSIPs which were working well.

Staff reported excellent education and leadership throughout.

**Areas for improvement**

**Action the hospital MUST take to improve**

- **Ensure that all 'keep closed fire doors' are closed.**  
There were fire doors propped open within the theatres store area which presents a risk from fire spread within this environment and potential impact into the critical care area.

**[Of note 'ensure that all fire exits are clear' was a MUST do in the 2015 CQC inspection report].**

*Reference to:*

*Regulation 12: Safe care and treatment*

*Regulation 15: Premises and equipment*

- **Ensure that medication is securely stored and prepared in line with Trust and National guidance for the safe storage of medication.** There were 3 incidents within Theatres where medication was not stored in a compliant and safe way.

1. Medication left unattended in two trays for different patients. ODP observed preparing medication for both cases as unsure which case they were getting in theatres. Verbally reported that they would commonly get things ready and leave a tray available for the subsequent case. The drugs being selected were different and one contained Propofol and one did not. This presents a significant safety risk where staff may miss-select the drugs required for the patient. Additionally the unsecured nature of the medication could lead to misuse and potential theft of high risk medication.

2. Drug Cupboard in Theatre 4 Anaesthetic Room – unlocked and unsupervised. This contained potassium chloride and several anaesthetic drugs which open presents a significant safety risk. It was explained to the inspection team that this is the emergency theatre and there is a requirement to keep it open.

3. Medication left on work bench in Anaesthetic Room was left unsupervised and contained muscle relaxants and anaesthetic agents. This was observed in the afternoon of the visit. The unsecured nature of the medication could lead to misuse and potential theft of high risk medication.

**[Of note 'preparation of medicines in advance of immediate use' was a MUST do in the 2015 CQC inspection report].**

*Reference to:*

*Regulation 12: Safe care and treatment*

**Action the hospital SHOULD take to improve**

- **Safeguarding Awareness**

Ensure all senior staff in-charge of clinical areas have an awareness of safeguarding leads and escalation processes for addressing safeguarding concerns within the organisation.

*Reference to:*

*Regulation 12: Safe care and treatment*

*Regulation 13: Safeguarding service users from abuse and improper treatment*

- **Well led**

Explore the issue surrounding the reported feedback from the Trustwide inspection team where frontline staff were feeling pressurised into moving patients by senior management and executive staff.

- **Sharps bins should be correctly labelled.**

Not all the sharps bins have a label on them to say who has started them and closed them. Those sharps bins that did have a label on them, many did not have the label filled in as required. This means that there will be no audit trail which is required.

- **Ensure ward scorecard for previous month is displayed within ward areas 'know how well you are doing' boards.** The scorecard displayed was August 2018 (Mallard) and July 2018 (Varrier Jones).

- **Improve compliance with Trust appraisal rate.** Varrier Jones (85%) Theatres (75%) were significantly below the Trust 95% compliance rate in this important area for staff development.

- **Further develop cross directorate learning from incidents/errors.**

It was felt that learning from incidents within other areas of the Trust was not widely shared within the directorate. this would be an opportunity to learn and prevent reoccurrence within surgery and theatres.

- **Delayed transfer to CCA from theatres with the post-operative patients.**

It was noted during the inspection that senior theatre staff were unaware of when to complete a DATIX and escalate delays in transfers. 30 minutes is the agreed standard and this should be shared with all staff to ensure adequate reporting.

**Areas of outstanding practice**

- Theatres leadership and education

- Surgical outcomes remain excellent

<b>Medicine</b>	Safe	Good	●
	Effective	Good	●
	Caring	Outstanding	●
	Responsive	Good	●
	Well-led	Good	●
	<b>Overall</b>	<b>Good</b>	<b>●</b>

<b>Overall - Summary</b>	Good ●
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The team visited the Chest Medical Unit, Cystic Fibrosis Unit, Thoracic day ward, Cardiac day ward, cardiac rehab, Hemingford Ward, Hugh Fleming Ward and Cardiac Cath labs.  
 The medical units were rated over all as Good with outstanding for caring. There are 3 must do actions and 9 should do actions.

<b>Safe</b>	Good ●
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The ward areas were clean, including the kitchens and 'I am clean' stickers were used throughout. Resus trollies checked, fridge temperatures recorded

Rosters demonstrated record of staff competence and staff knew how to record red flags and incident reports

Cardiac rehab are taking on many administrative task from the wards as they recognise how busy and stretched they are. They are happy to help and note they feel incredibly sorry for all of the wards as they can see the amount of pressure the ward nurses are under every day. They see lots of agency nurses on the wards, lots of junior staff, there is high acuity and the nurses are always overseeing Band 4 nurses. Cardiac rehab always attempt to answer phones and buzzers on the wards to assist in any way that they can to ensure safety of patients.

Junior doctors in cardiology felt very supported, and said they could escalate a concern to senior colleagues, there was an element of frustration expressed from 2 junior doctors about the access to some of the IT systems. The juniors expressed a concern about volume of discharge letters and asked about help with completing these. Severe staffing concerns on CF with only 8 x Band 5 nurses on the roster instead of the 12.89 WTE budgeted for. Ward Sister and Matron have escalated this and as a whole team they are looking at capping admissions to ensure safety

Patients with specific IC requirements were being cared for on the Thoracic Day Ward due to not enough single rooms on CF, the team recognised this was not the gold standard and these patients are now cared for on Baron Ward.

All medicine cupboards and main door to treatment rooms locked in all areas. One medicine fridge left unlocked, this has been reported due to their being no key for it. Princess Ward medications stored on top of POD locker as no room in locker

Safer staffing boards displayed and up to date in all inpatient areas

Specialist nurse removed all patient data from her computer screen prior to talking to the mock CQC inspectors.

Nurse openly told us of her frustrations of not enough equipment on the ward too enable her to do her job, everything has to be sent back to the Netherlands when it is broken

RSSC HCSW team ensure intentional rounding on sleep studies during the night

Sleep studies equipment installation for NRPH being installed on this site

CMU closes as many beds as possible on Duchess every weekend, patients cohorted onto Princess to respond to staffing concerns

RSSC shower screen had fallen off of its hinges – reported immediately – Estates came to fix but noted it ‘always happens’ – ageing estate

RSSC have 7 WTE RN vacancies, it has been noted that processes are not as slick due to a junior workforce

Princess – patient names not above all beds. Names not by bed numbers in kitchen which may cause confusion with dietary requirements

Thoracic day ward visibly busy and stressed. Fears of poor skill mix (2 CDW nurses on duty) and not being expert in the speciality although feel supported by vast number of Thoracic specialist nurse teams. Nurse in charge was the only regular member of staff in the area (been on TDW for a year) everyone else unfamiliar.

Thoracic day ward Actichlor sheet not signed for between 1-8<sup>th</sup> Oct

One consultant doing a ward round on a cardiology ward was not following safe IPC practice and was not bare below the elbows – jacket and long sleeves on.

Good compliance with radiation protection in cath lab nurses, but it was noted that the team were told the medical staff and physiologists need to improve compliance.

**Effective**

Good 

Cardiac rehab have received accreditation: BACPR/NACR Certification for meeting the minimum standards for Cardiovascular Rehabilitation

The team have presented at a conference for innovation in technology in Cardiac Rehab as they are one of the first to have a DVD, use Apps and fit bits.

Overwhelming theme that RPH had changed massively, nurses are now supervising Band 4's every day; they have to double check B4 and agency colleagues work all of the time. Some colleagues have been here for over a year and still have not passed their English exam.

CF patient feedback has become less positive due to a perceived reduction in expertise on the ward; being looked after by unfamiliar staff and medication errors by this staff group (Band 4's and agency nurses)

Good knowledge of safeguarding across medicine. CF nurses all have level 2 safeguarding with the aim of them enhancing this to level 3 when staffing numbers are acceptable.

Excellent run Sleep studies, pathway co-ordinator books in all patients and they leave with the result of their study.

Evidence of MDT's in all in-patient areas visited

No consistency with number of patients being booked to day wards – one day 20, the next 33 – it is difficult to ensure safe staffing levels and morale of staff as the will often be moved to support other areas.

Since day ward have moved to closing at nights they receive a great deal of resistance from transferring wards when trying to move allocated patients to them. They understand that the wards are under a great deal of pressure with other admissions however there appears to be a lack of understanding of the way the day ward work and the pressure they are also under to ensure patients move through their pathway. They fear the patients are not receiving the experience they should.

It was noted that the regular business units meetings for cath lab were highlighted as very useful as well as the Trust wide Sisters meeting.

Lorenzo was noted as both positive and negative, with some staff saying they could not imagine going back to paper, and others stating it slow care down and interferes with care delivery.

Excellent team work was noted in the cath labs, with good use of the 'who' check list and briefing, this was essential especially when dealing with the primary PCI patient group.

**Caring**

Outstanding



Spoke to a patient on VJ cardiology who said his whole experience had been wonderful; the nurses were 'little treasures', nothing too much trouble, 'feeling like I have been really pampered'; had to probe doctors for information and did not always understand due to jargon used but asked for clarification; radial procedure hurt much more than the femoral procedure he had a couple of years ago.

End of life patient on CMU, all appropriate supportive teams involved with him and his family. Support available for staff including new chaplaincy team as a long term patient. Psychologist is also available for staff and debriefs are set up after a traumatic event.

Excellent feedback from patients in every area visited stating things like: 'nothing is too much trouble'; everyone very kind, respectful and knowledgeable'

Thoracic team send a letter of condolence to all families of patients who have passed away, they receive lovely feedback from the families who say this is very comforting

**Responsive**

Good



RTT – hitting trajectory based on revised action plan; clinical fellow recruited; IMAS expert has been in the organisation to give recommendations; daily report trajectory; weekly access meetings; operational manager based with booking team ensuring the right patient is in the right slot; GA support in Cath labs; data validation; virtual clinics in attempt to reduce waiting times; access to directly bookable procedure dates when in clinic – Deputy Director of operations (AG) highly visible in all areas

RNSTEMI pathway has commenced, it has been a learning curve – 1<sup>st</sup> cath lab slot is now held every morning for a RNSTEMI patient – if not required a rollover ACS will take slot

Cardiac Rehab - Recognised early on following a survey of their patients, that many of their patients commute to NRPH would be unmanageable so proceeded to set up an outreach service in a leisure centre in Cambourne. This has been operational since July 2018, they have written all of their own policies and procedures and the service is going very well. They have a Psychologist attached to the team twice a week, it is their aim to extend this to include them visiting the Cambourne site

Infection control is an everyday challenge for CF team, they have purchased 3 UV machines to ensure their single rooms are clean and ready for the next patient. This is carried out by the nursing team.

Specialist Thoracic nurse - when asked what are you most proud of: the new admin/pathway co-ordinator is amazing; the turnaround for patients is if they are referred on the Wednesday afternoon, they will be discussed Thursday morning at the MDT.

Sometimes experience difficulties in repatriating patients back to their local hospital. They are now ensuring agreements from DGH's prior to patients being accepted for surgery.

Lots of overseas patients with English not being their first language, member of the nursing team often has to support with this taking them away from their day-to-day clinical work. They have an admission and discharge booklet which they have had produced in Portuguese.

Sleep studies beds are increasing to meet demand in NRPH

Home IV service, Outreach telephone service for Thoracic patients

CMU x-ray closed at lunchtime – there is no cross over to ensure patients can receive their treatment through the entire day

Washing machine facilities removed for long term patients – No provision in NRPH

RSSC manage all of their beds and prioritise appropriately

Outreach CPAP clinic in Manea opening 12<sup>th</sup> Nov – to capture Norfolk and Suffolk patients will be Assistant Practitioner (Band 4) led

A big concern raised by nurses in Thoracic and cardiac day ward is that patients are being examined in the middle of the 'lounge' area, they are not being taken to a private area. Doctors also discuss patients in this area. In NRPH the lounge is going to be much bigger and staff fear to patients privacy and dignity

Day ward also has concerns about the length of surgical patient pathway, especially when cancelled. They are located in the day room; not seen by anyone; nurses are often the ones who have to explain about cancellations; members of the operational team will come and explain if requested. Reluctant to ring surgeon as previously described, they have an abrupt manner and a 'don't bother me' attitude. Cardiology and thoracic Doctors very approachable.

There was a note that more needed to be done with the IHU pathway, both for the patients and the staff (education) and it was notes that this was now a Quality Improvement project.

Well-led

Good 

Regular team meetings are happening in all areas inspected with yearly appraisals documented

VJ Cardiology there is an information board in the staff room to read along with an information folder broken down into months. Ward sister makes a point of catching up personally at least twice a month with every member of staff. 3South meetings have taken place. WS shares information at hand over time, feedbacks on incidences, appraisals up-to-date. HCSW meeting arranged for 15th Oct. Ward meeting are arranged but attendance is poor, WS looking at different times to be able to capture as many of the team as possible

The nurse feels happy to speak up and contact consultants, however notes that some of her colleagues are not, due to the response they get (specifically from surgeons). This was a theme with all areas we visited, many will not ring the consultant surgeons because they feel on occasion they can be dealt with in an abrupt and rude manner.

Ward Sister on CMU currently not at work, all Band 6's have stepped up to ensure the service continues

Thoracic Matron is very knowledgeable about the whole service.

ANP led clinics in thoracic medicine; great team work between medics and nursing staff

Student nurse on TDW – substantive member of staff on VJ feels that students receive an excellent experience in RPH; flexible with hours; not used as HCSW as in other Trusts; work the majority of shifts with mentors; feel a part of all teams when they move placements.

Company reps were reported to have 'ready' access to the cath labs, with no system of notifying staff. As there isn't a planning process the reps then take bags / belongings into the cath labs

Good working relationships with medics and specialist nurses in Thoracic medicine – work as a team.

New Clinical Director for Cardiology.

Recruitment of new staff remains a priority and it was noted that the Trust had responded to staff requesting that the overseas recruitment be paused whilst the current band 4s move through the registration process.

Mortality and Morbidity review meetings have been cancelled due to RTT pressures, but these are now reinstated. The importance of these meetings has been recognised along with learning and training.

A staff nurse on Cardiac day was said that she felt very proud to be part of a brilliant team and reported that they had regular 1:1 with the band 6 nurse.

Privacy was a concern in the day ward, with 'check' taking place in an area that other patients may over hear.

Student nurses reported that they had a fantastic experience and wanted to return once qualified.

Junior medics (FYI) reported good support from the educational supervisors.

**Areas for improvement****Action the hospital Must take to improve**

Address staff being spoken to in a "rude abrupt manner".

Regulation 19: Fit and proper persons employed

Ensuring privacy and dignity when assessing/examining patients on Day wards

Regulation 10 : Dignity and respect



Princess – medication storage for long term patients with vast quantities of medicines  
*Regulation 12: Safe care and treatment*

**Action the hospital SHOULD take to improve**

IHU do not get the same level of information, no-one is prepping them appropriately for what to expect post operatively and education leaving them incredibly vulnerable post op. they need to know what to expect eg, lines, catheter, normal amounts of pain, recovery time.  
 Question needing to be asked: should it be ACS/IHU/CR nurse? Establishment may need to be reviewed in these teams to ensure this happens.

Working from home in NRPH and having access to the correct IT solutions to be able to communicate with the rest of the team.

Stairs from Private Patient clinic not welcoming – leaflet holder empty, HPV machine and hoover stored in from of hand gel. Hand gel station not in correct place to be easily accessible.

Lorenzo slow, crashes, locks out, doesn't save, PEG board misses out beds, not enough computers – continues to cause an immense amount of frustration and adding to nursing time.

Update dated staff photo boards  
 Improve process for company reps visiting cath labs.

Duchess dirty sluice door to be kept closed at all times  
 Improve day ward booking to utilise resources available



Princess – write names above patients beds  
 ANP's to be invited to relevant Junior doctor teaching

Increase same day admissions to improve surgical patient pathways

Improve junior doctor induction on IT systems / improve access  
 Explore the ANP roles to help with discharge letters (due to volume)

**Areas of outstanding practice**

Staff assisting in all areas of care across teams to maintain patient safety  
 Cardiac rehab are accredited by the BACPR/NACR  
 Outreach into the community for cardiac rehab  
 Excellent running of sleep studies work  
 Rapid NSTEMI pathway  
 ANP new roles in thoracic medicine (RSSC)  
 Good team working throughout thoracic medicine  
 Cath lab briefings

<h1>Out Patients and</h1>	Safe Out patients Diagnostics	Good	
		Requires improvement	

Diagnostics	Effective	Good	●
	Caring	Good	●
	Responsive	Good	●
	Well-led		
	Out patients	Good	●
	Diagnostics	Requires improvement	●
Overall			
Out patients	Good	●	
Diagnostics	Requires Improvement	●	

Overall - Summary	Good ●
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The team visited Varrier-Jones (VJ), CTBI, Thoracic and Transplant Out-patient departments (OPDs) and the Diagnostic Centre. They spoke with staff, patients and relatives and observed practice in all areas. For the purposes of grading, Outpatients and Diagnostics have been separated to highlight the differences between these services. Outpatients and Diagnostics received an overall rating of Good with outstanding for Caring. Diagnostics received a rating of Requires Improvement in the Safe domain in relation to documentation and dissemination of learning from incidents and closing the loop on serious incidents. Diagnostics also received a rating of Requires Improvement in the Well-led domain due to the concerns raised regarding the impact on staff wellbeing and communication as a result of senior leaders' management behaviour.

Safe	Good ●
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All areas were clean and met the Trust cleaning standards. 'I am clean stickers' were displayed on equipment and surfaces and on clinic doors in Thoracic and CTBI OPDs. Nursing, medical and administration staff in the Thoracic OPD displayed high levels of understanding and awareness of complex IPCC considerations for their patient group. Exemplary practice was evident in relation to cleaning, professional dress, patient segregation and attention to booking patients into clinic by staff in this department. Chaperone notices were prominently displayed in Thoracic and CTBI OPDs, they were also displayed in Transplant and VJ OPD and Diagnostics but were less prominent. Registered and unregistered staff in all areas were able to explain chaperoning and discuss why this was important for safeguarding patients. There was evidence that resuscitation trollies had been checked appropriately in all areas; these were clean and on charge. A clinic patient list was observed on the reception desk in VJ OPD, when this was highlighted to the reception staff, this was immediately removed and the receptionist volunteered to remind other colleagues of this without needing to be asked to do so. The receptionists were able to explain the importance of protecting patient data, their part in doing so and what they would do if they became aware of a potential IG breach.

Nursing, medical and administrative staff in all OPDs were able to explain how they would report an incident on the Trust Datix reporting system and were able to describe the types of incidents they personally had reported or investigated. These staff described how they received information regarding the outcome of incidents and related this to learning from these which were discussed at team meetings or other directorate or professional forums. A senior member of Radiology staff highlighted that it is perceived that learning from incidents is picked up in discrepancy meetings but that this is not formalised or disseminated. We looked at evidence that demonstrated the lack of closing the loop for serious incidents which prevented learning from incidents being embedded in practice. Safer staffing boards displayed current information Transplant and Thoracic OPD and relatives noted that this was reassuring. Staff in Thoracic and Transplant OPDs and in the Diagnostic Centre were able to explain how they would escalate a staffing issue and how they would mitigate staff shortages to maintain patient safety. Staff in the Diagnostic Centre were able to explain their business continuity plan in the event of equipment failure. Lorenzo was highlighted as a risk to patient care by medical staff. Examples were provided by medical staff of Lorenzo not being utilised correctly due to slowness of the system and difficulty finding required information. These staff acknowledged that they were not aware of all the capabilities of Lorenzo but had not accessed additional training since the system went live in June 2017. Small screens and only having a single screen for some work stations made viewing multiple pages together impossible and the delay of flicking back and forth between screens slowed consultations and reporting. Medical staff in Transplant and Thoracic OPDs highlighted that they had to access four different electronic clinical systems to retrieve all required patient information to complete a consultation. They were concerned that they may miss important information. It was also noted that information related to RPH patients appears on the CUH EPIC system before it appears on Lorenzo. An example was provided in Transplant of an MRSA result of an RPH patient being available on EPIC system two weeks before it was available on Lorenzo. This was discovered after the patient presented to the Transplant clinic which resulted in clinic rooms being unnecessarily being closed for cleaning which could have been avoided had the result been available in a timely way. Nursing and administrative staff also highlighted that Lorenzo was often slow, however they considered the advantages of being able to see the record from anywhere was an improvement on paper notes. An example was given of medical notes being retrieved from long term storage being returned damaged with pages torn and photographs missing.

**Effective**

Good 

Evidence based personalised care for patients with specific IPCC issues was explained by the nursing and medical staff in Thoracic OPD which also related to their patient group who are treated in CTBI clinic rooms although these were not in use on the day of inspection.

Staff in the Transplant OPD explained how they benchmarked their service with other Transplant services with regard to monitoring immunosuppression and End of Life Care. They were able to explain in detail the evidence to support their plans to improve EoL care for their patient group.

Advanced practice and non-medical prescribing skills have been developed within the Cardiac Support team who run nurse-led clinics in VJ OPD. Non-medical prescribing training is being undertaken by four Transplant Nurses within the coming six months.

Nursing staff in VJ, Thoracic and Transplant OPDs and Diagnostic Centre explained the training they had received in order to fulfil their roles. The OPD staff felt they were provided training in a timely way and were encouraged and supported to expand their skills. Staff in Diagnostics explained that training opportunities had been limited due to staff shortages but that this had improved recently. Several members of the diagnostics team are receiving professional coaching support their leadership development.

Members of staff who had joined the Trust during the past year described the recruitment and induction process as slick and felt they were kept well informed. They said they had been attracted to the Trust by its reputation and thought their experience since joining had exceeded their expectations, particularly in relation to the local training

and induction in their own areas.

Medical, Nursing and AHP staff in Transplant and Thoracic OPD described very strong multidisciplinary team working and were able to provide examples of regular interactions and ways of working that supported this. In Diagnostics, there was evidence of very recent efforts to improve multidisciplinary team working which focussed particularly on Cath Labs but it was not yet possible to see that this was embedded. In Diagnostics, the Radiography team meetings had very recently been restructured in discussion with the team; early signs are that this may have improved attendance and is expected to meet staff requirements for information exchange and discussion. Radiology medical staff meet as a group and other professions are not usually invited to attend.

There were examples given by medical and nursing staff in OPDs and Diagnostics of Trust level information from the Big Move meeting reaching staff by direct dissemination at team meetings and daily briefings but directorate level information was not consistently disseminated in all areas.

**Caring**

Good



The team observed multiple examples in all OPDs and Diagnostics of clinical and administrative staff demonstrating exemplary kind and caring behaviour. Staff were observed being friendly and approachable, introducing themselves, exhibiting kindness and respect for patients, relatives and staff. Feedback from patients and relatives, many of whom were regular OPD attenders over many years, was highly complementary about the care they had received from staff. They extended these compliments to staff beyond the OPD; one patient, who had been attending since the 1970s and had received care from multiple services at RPH, reported that she had only ever had excellent care on every occasion. A patient in Thoracic OPD explained how the staff had gone above and beyond to accommodate her disability so she could access care in the way that suited her needs and wishes.

Nursing staff in Thoracic and Transplant OPDs described how they involve patients and relatives in their care and this was evident from conversations with patients and carers in both areas. There are active support groups run by and for patients and carers for transplant and a number of respiratory specialities which have strong links with clinical staff and these are referred to in written patient information available in OPD areas.

Staff in all OPDs and Diagnostics were patient-focussed and considered the patient to be at the centre of all that they do. The team observed a member of clinical staff in the Diagnostic Centre ensuring the comfort and dignity of an elderly patient awaiting a procedure in a particularly attentive manner demonstrating great kindness.

**Responsive**

Good



Several patients attending VJ OPD highlighted the lack of instructions about how to get to their appointment. This was particularly problematic because some clinics were being held in the CTBI building or some patients needed to attend both VJ and CTBI for different parts of the same appointment. Appointment letters refer to a particular clinic name but do not always say where this is being held so when patients ask for directions, members of staff reported that they are not always able to help. CTBI is not signposted from VJ OPD. The current map of the RPH site does not reflect the current building usage. One patient suggested that a new map would be easy to produce from a Google Earth view.

Staff in all OPDs referred to the recent difficulties caused by changes in the booking system. Cardiology and Surgical pre-admission clinics were frequently under-booked and patients were being asked to arrive much earlier than required. An example was of a patient booked for clinic and asked to attend 50 minutes early for investigations but who only required an ECG which takes 5 minutes. Patients were asked to attend VJ OPD for tests but had to go to CTBI for a consultation, staff were concerned that many patients find it difficult to negotiate the walk to CTBI without assistance and there was no evidence that this is considered when making the booking. Thoracic clinics are

arranged to ensure patient groups with different IPCC needs are invited to separate clinics to reduce the chances of cross infection. Concerns were raised by medical staff that this would be more challenging to achieve in the combined OPD in the new hospital. There is evidence from the OPD DORAC documents that this has been prioritised and a plan for patient segregation is in place.

All waiting room areas had water dispensers and vending machines. The Transplant OPD had a range of comfortable arm chairs of varying heights other OPDs had less armchairs due to the restricted space available however, all said they could easily accommodate someone if they needed different seating.

Approximate waiting times were displayed at the Diagnostic Centre reception desk however these did not appear to correspond with actual waiting times. An example was provided of the wait stated being 45 minutes, however there was a 1.5 hour delay at that time.

**Well-led**

Requires improvement 

The Trust and department vision and values were displayed in VJ OPD and staff were able to explain the Trust values.

The Trust Ward and Department Scorecard for the month of August was displayed because at the time of the inspection the September scorecard had not been published. It was highlighted that the scorecard did not represent Ambulatory Care areas well as it was particularly ward focussed, there was evidence that work to improve this is underway by the Matron team.

Nursing staff in VJ, Thoracic and Transplant OPDs and Cardiac Rehabilitation were able to explain the nursing leadership structure within their department. There was evidence of team meetings and staff felt included in decision making within their team. They regularly saw the Matron for Ambulatory care and the Head of Nursing and considered them to be friendly, approachable and supportive.

Nursing, medical and administrative staff in VJ and Thoracic OPDs knew the operational managers for Ambulatory Care but were unclear of the senior management structure within which the departments were governed. The Transplant medical and nursing staff knew the senior Directorate and operational management team and found them to be visible, friendly and supportive. Examples were provided by Transplant staff that demonstrated how they were included in decision making, prioritising developments and activity at a directorate level.

Administrative staff in the Diagnostic Centre and Thoracic OPD were unclear of the team structure and did not know who their line manager was. They were all able to clearly explain how and to whom they would escalate an issue relating to patient care or staffing on a day-to-day basis but were unclear on how they would seek help to address an on-going service issue or an idea for quality improvement.

In Radiology, there was evidence of improvement since the last mock CQC inspection in March 2018, which highlighted that the department required improvement with regard to the well-led domain at departmental level. Although not fully embedded, there was evidence of improvements to the team structure which included devolved leadership responsibilities amongst the Radiography team. The leadership and organisation of team meetings appeared to be inclusive and early signs suggested improved engagement of the team. Dissemination of information from directorate level to front-line clinical and administrative staff was limited as directorate reports were not routinely shared with the team although highlights were included at team meetings.

There was evidence of improved cooperation and responsiveness between Radiology and other departments in relation to engagement in quality improvement initiatives.

There was evidence that the MRI reporting backlog highlighted in the previous mock CQC, has been addressed. It

was demonstrated that the MRI list can now be monitored and the system is clear and transparent. Significant concerns were raised by a number of senior clinical staff in Radiology regarding a 'top-down' management approach where staff felt they were not listened to by the Directorate senior management. There was a perception that there was insufficient consideration of the balance of quality and capacity of staff when an increase in activity was 'ordered' and that quality was being diluted or compromised in the pursuit of maintaining overall activity levels. There was a perception that risks were being highlighted by clinical staff but not being addressed by the Directorate senior management. It was acknowledged that they may be being addressed but that communication between the senior leaders and senior clinical staff was poor. The term 'it's non-negotiable' was described by senior staff as being used when staff attempted to highlight concerns related to a request or plan. Senior staff described feeling under considerable pressure to respond to requests whilst attempting to protect front-line clinical staff from pressures that were beyond their control. The staff interviewed were concerned that raising awareness of such concerns would negatively impact upon their wellbeing, worsen working relationships and that nothing would change if they did so. They were able to cite examples of such consequences which they felt deterred them and others from raising concerns.

**Areas of OUTSTANDING practice****Caring:**

Staff of all disciplines were observed demonstrating great kindness and outstanding personalised care to patients and relatives in all areas.

**Areas for improvement****Action the hospital MUST take to improve****Well led:**

- The Trust executive team **MUST** address concerns raised by senior clinical staff related senior leaders responsible for Diagnostics.

Regulation 19; fit and proper persons employed

**Safe**

- Discrepancy meetings in Diagnostics **MUST** be documented
- In Diagnostics, the loop **MUST** be closed on serious incidents to ensure learning is implemented

Regulation 12: safe care and treatment

**Action the hospital SHOULD take to improve****Safe:**

- The Trust **SHOULD** provide and encourage medical to staff access training on Lorenzo to maximise their ability to use the full functionality of the system
- Learning from incidents in Diagnostics **SHOULD** be shared and discussed in multidisciplinary forums
- The Trust **SHOULD** ensure that results are always available on Lorenzo in a timely manner

**Effective**

- Clinical teams **SHOULD** identify KPIs for Ambulatory Care areas to enable teams to reflect how well they are doing in a meaningful way on the Ward and Department Scorecard
- The Trust **SHOULD** publish the Ward and Department Scorecard within two weeks of month end to enable departments to develop actions and display these with the last months data

**Responsive**

- The Trust **SHOULD** improve signage around the site particularly in relation to accessing the CTBI building from other clinical areas
- The Trust **SHOULD** update the site map to reflect current building usage

**Well-led**

- The multidisciplinary team in the Diagnostic Centre **SHOULD** implement processes to ensure that Directorate and departmental information is disseminated to all levels of staff within Diagnostics.



**CQC Internal mock inspection members**

Josie Rudman, Chief Nurse  
Chris Seaman, EA to Chief Nurse  
Zilley Khan, Medical Education Fellow  
Jason Hollidge, Deputy Director of Finance  
Helen Watson (AM only), Dietitian and PSS Business Unit Manager  
David Begley (PM only) , Clinical Director Cardiology, Consultant Cardiologist  
Ivan Graham, Deputy Chief Nurse  
Nicky Moule, Matron  
Dr Uta Hill, Consultant Physician  
April Brown, NHSI  
Helen Mills, Kettering General Hospital  
Wayne Hurst, Assistant Director of Nursing & Ops  
Louise Palmer, Cambs Community Services  
Vicky Carr, Matron  
Shelley Hugill, Business Manager, Estates  
Lisa Steadman, Matron  
Alison Gibson, Deputy Director of Operations  
Roger Hall, Medical Director  
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Kate Waters (PM only), Head of Communications  
Joanne Pope, NHS England  
Hannah Purse, Student Nurse  
Anne White, Head of Nursing  
Janet Atkins, Governor  
Jonathon Lonsdale (am only), Clinical Education  
Natasha Lane (pm only), Education Team  
Sophie Harrison, Associate Director of Finance  
Raj Patel, Operational Service Manager