Special Measures Improvement Plan Update
Cambridge University Hospitals NHS Foundation Trust
December 2015
Background & Summary

- The Trust entered the special measures programme following a CQC inspection which rated the hospital overall as inadequate. The Trust was rated inadequate specifically in the well-led, safe, and responsive domains.
- The Trust has been given 15 “must do” recommendations following the CQC inspection.
- The published CQC report can be found on the CQC website: http://www.cqc.org.uk/provider/RGT
- The Trust agreed an improvement plan to deal with these 15 recommendations, maintain progress and ensure actions lead to measurable improvements in the quality and safety of care for patients. We recognised all of the recommendations and are addressing them to improve the quality of services.
- This document provides a summary of Trust progress against our published Improvement Plan http://www.cuh.org.uk/news/corporate-services-finance/trust-improvement-plan-published - which provides further detail. While we take forward our plans to address the CQC’s 15 recommendations, the Trust is in ‘special measures’.
- Oversight and improvement arrangements have been put in place to support changes required. The Trust Board of Directors is accountable for delivery of the totality of the Improvement plan with day to day responsibility sitting with the Trust Chief Executive. The Trust is using best practice tools supported by the single Trust-wide Programme Management Office (PMO) to support teams in developing fully costed plans with detailed milestones, key performance indicators and timelines, assessed for quality impact and risks. The Board will review progress on a monthly basis following scrutiny by the Board’s Quality Committee and Management Executive. In addition, a fortnightly Delivery Quality Board has been established under the leadership of the Chief Nurse to provide assurance to the Trust Board of the approval and on-going monitoring of the Trust’s Improvement plan.

Who is responsible?

- Our actions to address the CQC recommendations have been agreed by the Trust Board.
- Our Chief Executive, Roland Sinker is ultimately responsible for implementing actions in this document. Other key staff are the Chief Nurse, Ann-Marie Ingle and the Medical Director, Jag Ahluwalia, as they provide the executive leadership for the three domains of quality:- patient safety, patient experience and effectiveness of care.
- The relevant Regional Team at Monitor will ensure delivery of the improvements and oversee the implementation of the action plan overleaf. Should you require any further information on this please contact specialmeasures@monitor.gov.uk
- Ultimately, our success in implementing the CUH Improvement plan will be assessed by the Chief Inspector of Hospitals, upon re-inspection of our Trust.
- If you have any questions about how we’re doing, contact Ciara Moore, Deputy Director of Recovery, PMO@addenbrookes.nhs.uk

How we will communicate our progress to you

- We will our Improvement Plan every month while we are in special measures, which will be reviewed by the Board and published on our website. This section of the Board meeting will be held in public. Monthly Stakeholder Assurance Meetings will be held with a range of key organisations including the CQC, the Cambridgeshire & Peterborough Clinical Commissioning Group and Healthwatch Cambridgeshire.
- We will continue to share regular updates with our staff through team meetings, staff newsletters and weekly staff drop-in sessions with the Senior Management Team.

Chair / Chief Executive Approval (on behalf of the Board):

Chair Name: Jane Ramsey

Chief Executive Name: Roland Sinker

Signature: [Jane Ramsey]

Signature: [Roland Sinker]

Date: 9.12.15

Date: 9.10.12.15
# Cambridge University Hospitals NHS Foundation Trust – Summary of progress against improvement plan

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<th>CQC Key Question</th>
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<td><strong>Safe</strong></td>
<td>April 2015-May 2016</td>
<td>Ensure the Trust meets safety requirements, including having sufficiently robust safety systems and processes, and appropriate staffing levels.</td>
<td><strong>On track to complete all outstanding planned preventative maintenance of high risk devices to be undertaken by 18th December 2015.</strong></td>
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<td><strong>Inadequate</strong></td>
<td></td>
<td><strong>Regular checks embedded into local practice for resuscitation trolleys</strong></td>
<td><strong>Identified compliance risks across Fire, Water quality, Heating &amp; Ventilation. Detailed action planning setting out actions required for next 3-24 months and next 3-5 years. Clear prioritisation in place to ensure risks to patients and staff minimised within financial constraints.</strong></td>
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- On track to complete all outstanding planned preventative maintenance of high risk devices to be undertaken by 18th December 2015.
- Identified compliance risks across Fire, Water quality, Heating & Ventilation. Detailed action planning setting out actions required for next 3-24 months and next 3-5 years. Clear prioritisation in place to ensure risks to patients and staff minimised within financial constraints.
- Remedial plan agreed for secure storage issues identified in the Emergency Department and Critical Care.
- Risk management review included in the broader Quality Governance review (see well-led domain below).
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| **Safe** (continued) | | • Delivered refresher training to over 100 senior staff on effective and efficient rota writing.  
• 2 beds in the John Farnham Intensive Care Unit have been closed to support safe staffing. A review of patient acuity and staffing levels has been embedded into a three times per day review across the critical care units.  
• Operational policy for the management of acute respiratory patients reviewed, and escalation process for the management of patient acuity and staffing levels on Ward N3. These will be ratified in December. Establishing ongoing monitoring of patient acuity on N3 to inform staffing establishment reviews.  
• Patient dependency in the intensive care unit is reviewed and staffing monitored against this on a day-to-day basis to ensure compliance with the Faculty of Intensive Care Medicine / Intensive Care Society core standards for ICU (Ed1) 2013.  
• All Maternity staff have mandatory training in foetal heart rate monitoring reviewed at annual appraisal. Supervisors of midwives assess compliance with training at annual reviews. Clinical development team monitor attendance and compliance with mandatory training.  
• Midwifery staffing review completed. Following a review of options, the Board of Directors decided on 11 November 2015 to increase staffing by 9 whole time equivalent (wte) registered midwives and 6 wte maternity support workers immediately. | Key area of concern is ensuring safe staffing levels within challenging financial environment. |

**Assurance:**  
High Risk Equipment KPI compliance (scheduled data + 90days) = 96.4%  
Annual PLACE audit  
Staffing levels published or NHS Choices
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| **Effective**    | April 2015-June 2016               | • Roll-out of mandatory Deprivation of Liberty Safeguards & Mental Capacity Act training began in Nov 15 for all clinical staff.  
• ICNARC data submitted & monitored.  
• Currently 4% of Trust documents have an overdue date – these are being followed up.  
• New document management system due to go live in early 2016 – plan in place.  
• The Trust Audit Policy has been revised to ensure more robust governance in place around clinical audit.  
• The Trust audit plans are showing improvement quarter on quarter in 2015.  
• The Trust Policy Implementation of National Clinical Guidance has been revised to ensure more robust governance in place in monitoring NICE Guidance Implementation.  
• An analysis of serious incidents and associated guidelines is planned to ensure these guidelines are embedded in practice.  
• Sepsis bundle is being piloted in the Emergency Department (ED) as of November.  

Assurance: Mandatory training compliance monitored. | • Changes to EPIC proposed, including generation of weekly/monthly sepsis performance reports. |

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| **Caring**       | Ongoing                           | **Ensure outstanding levels of caring are maintained.**  
• Trust-wide Staff Engagement & Experience Plan in place overseen by the Workforce Experience Committee reporting to the Workforce & Education Committee.  
• Staff engagement results from the 14/15 Quarter 4 Trust Staff Engagement Survey showed a return to their position prior to Quarter 3 National Staff Survey levels (which took place during the go live period for eHospital when the Trust workforce was under enormous pressure.)  
• Weekly executive-led drop-in sessions have been established and are offered to all staff to provide dedicated opportunities for staff to speak to the senior executives.  
• Specific engagement sessions have been held for the consultant body to share development of the Trust’s Improvement plan and receive feedback.  

External assurance: National Staff Survey results | • There is a risk that the recent negative publicity surrounding the CQC report and Trust being placed in Special Measures will have had a negative impact on staff morale and lead to a dip in performance in the 15/16 Quarter 3 National Staff Survey. |
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| Responsive       | April 2015-March 2016               | **Take all reasonable steps to ensure that the Trust’s services are as responsive as possible on a sustainable basis.**  
* Outpatient Board established – meets monthly.  
* Quarterly Outpatient governance board with senior divisional representation.  
* Outpatient dashboard produced to deliver trust wide visibility of outpatient metrics.  
* Trust-wide Patient Flow Programme launched, including:  
  * Medical Decisions Unit (MDU) opened 24/7 in September 2015.  
  * Launch of the SAFER bundle across the hospital to improve safe discharges with added focus on discharge before noon. Packs developed and now on every ward across the hospital.  
  * Winter plan and contingency plans to maintain a safe bed pool and improve flow during winter.  
  * Ambulatory Care expanded from November 2015 to include the first surgical patients.  
  * 4x Discharge Planning Specialist Nurses now in post. 1 vacancy remains & out to advert. Discharge Planning Specialist Nurse allocated to fast-track review.  
  * Delayed Transfers of Care sub-group of System Resilience Group established and regularly attended.  
  * Choice policy amended and implemented.  
  * Pilot ‘home for assessment’ scheme due to go live early December.  
  * Significant progress has been made to separate children & young people (CYP) from adults in the Ophthalmology Theatre, with only one outstanding list in the eye unit. A Children’s Champion has been identified.  
  * All pre-op and post-op CYP pathways are being reviewed in all theatre areas to determine the number of times CYP are sharing recovery with adult patients.  
  * Daily data report being developed to identify where CYP are being cared for in an adult environment.  
  * Temporary fridge to improve mortality capacity by 12 body spaces for 15/16 winter now delivered. Expected to be operational by 14/12/2015.  
  * Case of need for 7 day working by specialist palliative care team submitted to commissioners in Sept 2015. Drafted end of life nursing care plan for build within EPIC.  
  * Two upgraded fully sound proofed dedicated en suite bereavement rooms available at the entrance of the delivery unit with separate entrance.  
  * Number of patients discharged from critical care units to the wards after 10pm to be monitored as a key performance indicator at unit governance meetings.  
| Inadequate       |                                     |                                                              | A&E 4hrs performance below the 95% national standard since September 2014. |
|                  |                                     |                                                              | Cancer 62 days from urgent referral performance below the 85% national standard since Q3 2014-15. |
|                  |                                     |                                                              | The Trust has failed to achieve the 92% incomplete Referral to Treatment standard since December 2014 due to data quality, reduced activity resulting in the Hospital implementation and high levels of elective cancellations. |

Assurance: Audit of practice (Universal Form of Treatment Options).  
New Trust pain assessment standards being drafted that can be audited against based on national standards.  
National standards performance – reported to Trust Board monthly.
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| Well led        | April 2015-March 2016             | Ensure the Trust is well-led, and that all governance issues highlighted in the CQC report and elsewhere are fully addressed.  
\[bullet\] Review of Quality Governance structure underway:  
\[bullet\]Quality Committee's Terms of Reference reviewed & agreed.  
\[bullet\]Quality Committee revised work plan for the remainder 2015/16 drafted.  
\[bullet\]Review of current Divisional Quality Management role underway.  
\[bullet\]Quality Committee's Service Advisory Sub-committees reviewed; all revised committees mapped to fundamental standards and standardisation of all terms of reference underway.  
Risk Management review underway:  
\[bullet\] New Operational Safety group to be implemented, terms of reference drafted.  
Quality & Safety Supporting Functions work plan underway:  
\[bullet\]QSiS Safety Reporting System launched successfully September 2015.  
\[bullet\]Proposal for QSiS programme acceleration submitted to Quality Committee.  
\[bullet\]OD/Leadership lead in post.  
\[bullet\]Initial programme of work focusing with the Divisions underway.  
\[bullet\]Workshops for the Trust's leaders called "Leading with Values" taking place September - December to improve key leadership skills particularly relating to giving feedback and holding to account. | CEO Roland Sinker and Board Advisor Sir Ron Kerr in post from 16 November 2015. |