Nottingham University Hospitals NHS Trust

Quality report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system' and information given to us from patients, the public and other organisations.

Overall summary

Nottingham University Hospitals NHS Trust is the fourth largest acute trust in England and provides services to more than 2.5 million residents of Nottingham and its surrounding communities. It also provides specialist services to between three and four million people from neighbouring counties. The trust is based in the heart of Nottingham on three separate sites around the city: Queen's Medical Centre, Nottingham City Hospital and Ropewalk House. Queen's Medical Centre is the emergency care site, where the emergency department, major trauma centre and the Nottingham Children's Hospital are located. Nottingham City Hospital is a specialist and planned care site, where the cancer centre, heart centre and stroke services are based. A range of outpatient services are provided at Ropewalk House, including hearing services. There are 1,690 beds across the trust and it has a budget of £824 million. The trust employs more than 14,000 people. Of the population of Nottingham, 34.6% belong to non-white minority groups; of this people from the Asian Pakistani groups constitute the largest ethnic group with 5.5%.

We chose to inspect Nottingham University Hospitals as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. When we announced our inspection, we described the trust as a high-risk provider. By the time we carried out the inspection, our risk methodology had revised that assessment to a medium risk provider. The trust has had a total of 10 inspections since 2010.

The trust scored better than the national average for the CQC 2012 Inpatient Survey and the NHS Friends and Family Test, which asks patients if they would recommend services to people they know. We found some good examples of caring and compassionate care.

In general, we found that Nottingham University Hospitals NHS Trust was providing safe care. Most areas had good processes for recognising, investigating and learning from patient safety incidents. The trust responded well to the needs of its patients. Patients said that there were good interpreting services.

The trust calculated nurse staffing levels for services (with the exception of children's care services) using a recognised dependency tool. The trust was currently developing a staffing dependency tool for children's services.

Summary of findings

Overall summary

Generally, we found some good examples of leadership in the hospital, and most staff felt very well supported by their managers. Many staff reported excellent training and development opportunities. Doctors in training also felt well supported, and the consultants provided effective supervision.

We found that there was a backlog of maintenance of clinical equipment. The trust was already aware of this and it was on their risk register. We found they had taken steps to manage this risk by ensuring the highest risk equipment, such as ventilators which are used to breathe for patients, were serviced according to manufacturers' instructions. We also found that about 40% of staff were not up to date with their mandatory training. Again, the trust was already aware of this issue and had a plan in place to address the shortfall. We found they were making good progress against their plan and we did not find any impact on patient care.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Services were safe in the hospital because there were systems for identifying, investigating and learning from patient safety incidents and there was an emphasis in the trust reducing harm to patients. We found nurse staffing levels were calculated using a recognised dependency tool in the adult wards, which we considered to be good practice. However, we were concerned that this was not the case on the children's wards.

Are services effective?

The services at Nottingham University Hospitals were generally effective and were focused on the needs of patients. We saw examples of some very good and excellent work. Outcomes for patients were mostly within the nationally calculated normal limits but in some cases they were better than expected. This meant that patients got either the same or better results from their treatment at the hospital when compared with treatment given at other hospitals in England.

We did find some areas that were less effective. We found that there was a backlog of maintenance of clinical equipment. The trust was already aware of this and it was on their risk register. We found they had taken steps to manage this risk by ensuring the highest risk equipment, such as ventilators which are used to breathe for patients, were serviced according to manufacturers' instructions. We also found that around 40% of staff were not up to date with their mandatory training. Again, the trust was already aware of this issue and had a plan in place to address the shortfall. We found they were making good progress against their plan and we did not find any impact on patient care. We found there were a significant number of follow up appointments in the opthalmology department that had not been allocated. This meant there was a risk that patients who had undergone surgery were not being checked to make sure there were no complications.

Are services caring?

The vast majority of people said that they had positive experiences of care. We saw some good examples of compassionate care. Both the National Patient Survey results and Friends and Family Test results were better that the national average. We saw good interactions between staff and patients on the wards we visited and we found staff to be hard working, caring and committed. We noted many staff spoke with passion about their work and were proud of what they did. Staff knew about the trust's commitment to patients and the values of the organisation they worked for.

Summary of findings

The five questions we ask about hospitals and what we found

Are services responsive to people's needs?

In general, the trust responded to people's needs. We found the trust actively sought the views of patients and their families but they did not always inform children they wanted their views. We found that there was good access to interpreting services, and all information leaflets could be requested in other languages.

There was a dedicated ward for patients who had dementia which was providing good person centred care. However, the trust recognised that patients with dementia were cared for in all areas of the hospitals and attempts were being made to offer the most appropriate care for these patients. Initiatives such as the completion of an "About me," document and access to a falls prevention team were in place. Some staff raised concerns about the difficulties they faced caring for patients with dementia on general wards and felt there was more work that could be done to improve the experience for these patients.

There were initiatives in place for the trust to work with the local community such as a partnership with a local school for young adults with learning disabilities and supporting the Princes Trust to offer work experience.

Are services well-led?

The trust was well-led. The trust's board showed a good understanding of the key issues facing the trust. The executive team was well respected by staff. There were clear organisational, governance and risk management structures in place.

Staff said that they generally felt very well supported and they could raise any concerns. Many staff told us they thought it was a good trust to work for and student nurses, allied health professionals and doctors in training all told us they would want to work at the trust upon qualifying.

There was a very positive commitment to the development of complaints handling in the trust and it was evident the trust had carried out a great deal of work to improve the complaints process.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

Attendance at the A&E department was increasing year on year. In 2011/12, there were 184,745 attendances at A&E. This was an increase from 181,433 from the previous year. The department was originally built to treat 120,000 patients. When A&E became busy, patients on trolleys waited in the middle of the more public major treatment area. This area often became full with patients very close together on trolleys and wheelchairs. Staff told us that this had led to regular observations not being carried out, omissions in the provision of medication and treatment, and difficulty finding patients quickly. Staff also told us that some patients felt uncomfortable answering questions because of discomfort/embarrassment in this uncurtained public area. There was also a small waiting area nearby, and people in this area could overhear these conversations. There were short-term plans to improve the A&E environment by creating more space and proving additional cubicles.

Staff were observed to be caring and compassionate, and the Friends and Family Test results for the department were above the national average. Staffing levels seemed to be appropriate during our inspection. There were some nursing and medical vacancies, but there were plans to fill the gaps as soon as possible. Senior management told us they were looking for more staff for A&E, particularly the resuscitation area.

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies. The department had a number of clinical pathways for care. We saw that there were protocols displayed near the initial assessment triage area for the most frequent conditions that patents present with at A&E. We also saw NICE/ Resuscitation Council guidelines clearly displayed in the resuscitation area.

We saw that emergency re-admissions following an A&E discharge were lower than the national average. However, we saw from the findings of audits carried out by the trust that patients' treatment was not always timely and effective. The College of Emergency Medicine fractured neck of femur audit stated that delivery of timely analgesia required improvement.

Trusts in England are tasked by the government to admit, transfer or discharge 95% of patients within four hours of their arrival in an A&E department. The data shows that the Nottingham University Hospitals NHS Trust performed consistently below the national average from April 2012 to May 2013 and that it did not meet the target of 95% for A&E admissions in less than four hours. However, from May to October 2013, the trust performed consistently better than the national average and frequently met the target of 95%. Between September and October 2013, the trust fell slightly below the national average to 92%.

We saw that the trust had carried out lots of work with different external providers such as the East Midlands Ambulance Service and the Clinical Commissioning Group as well as within the hospital, to improve the time in which people were treated within A&E. Commissioners told us that there had been a vast improvement in the trust's A&E performance.

We saw staff wearing personal protective equipment and washing their hands appropriately. However, we saw some areas of concern. Parts of A&E, such as the patient toilets in the reception area, required refurbishment to ensure they can be cleaned effectively. We saw a sharps bin that was over-filled, and clinical waste was not stored securely at all times. We also saw that some alcohol gel dispensers were empty and there were not enough dispensers to ensure that effective infection control measures were taken at all times.

Some large clinical waste bins that were in corridors were unlocked. This meant there was a risk that people had unauthorised access to contaminated waste.

Summary of findings

What we found about each of the main services in the hospital continued

Staff explained how they would support people with learning disabilities or autism. They told us that they had specific plans of care in place for people who regularly attended A&E and that they could access support from a specialist learning disability team when required. This meant patients with specific needs received care that was more individualised for them.

We saw staff considering a person's capacity appropriately and discussing actions that would be taken in their best interests. Staff demonstrated a good knowledge of the Mental Capacity Act 2005. This meant staff were checking that patients could use and understand information to make an informed decision.

We found the A&E department to be an open and honest learning environment, and staff had an obvious respect for each other.

Medical care (including older people's care)

An analysis of the trust's incident reporting revealed that it was reporting incidents as expected. This meant staff were identifying and reporting patient safety incidents appropriately. We saw 'safety huddles' and 'safety briefs' being used daily on the wards we visited. These were being used to identify the patients who were at risk of falls, pressure ulcers, or patients who had an increased early warning score which could indicate their condition was deteriorating.

In general, care on the medical wards was caring and compassionate. We saw some good examples of staff caring for patients who were very frail and vulnerable. We saw that the wards were taking proactive action to reduce the number of patient falls such as the use of a falls prevention team to provide one to one care, and we saw that the trust had prioritised the prevention of pressure ulcers.

The trust calculated staff levels using a nationally recognised dependency tool, (The Association of UK University Hospitals), and the wards displayed their staffing levels for patients and visitors to see. Many patients and visitors commented on how busy the staff were. We saw staff working very hard, and the wards were busy. However, we did not find evidence that patients' needs were not being met because we saw patients received care when they needed it.

The trust used an early warning score tool which was designed to identify patients whose condition was deteriorating. The tool was designed to be more sensitive to physiological changes in the patient's condition and alerted staff by the use of a trigger score. Staff could then call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and staff understood how to use it. The trust monitored the use of this tool and reported on it every month. A nurse educator team worked with nursing and medical staff to ensure that staff understood the escalation process. There are occasions in hospitals when patients have to move wards. This is usually due to pressure on beds. Both hospitals had to move patients, but this was attempted to be done at reasonable times. We found that there was some confusion amongst staff about when patients could be moved. We found there were good systems in place to ensure that patients who were moved onto another ward remained under the care of the appropriate medical team.

There was an effective hospital at night team in place at both hospitals. The hospital at night team triaged referrals using the early warning score and the situation, background, assessment and recommendation tool to provide clinical advice. We observed the hospital at night handover at the end of a night shift, and we found that all the jobs were completed and feedback was given to the individual doctors about activity overnight. Doctors and nurses expressed satisfaction with the system.

Summary of findings

What we found about each of the main services in the hospital continued

Surgery

We found that surgical services were generally safe and effective. Theatre teams were always using the World Health Organization safety checklist and there were regular audits to review this. We saw staff in the surgical department were frequently evaluating the quality of the service staff were providing and were learning from patient safety incidents. Regular meetings were taking place to discuss safety improvements and patient safety information was displayed on television screens in the operating theatres.

The trust provided the region's major trauma centre. People with major trauma were receiving safe care because their outcomes were better than the nationally calculated expected standards.

In patient records we found that staff had documented risk assessments to identify potential problems such as venous thromboembolism (VTE), falls and pressure ulcers. Wards displayed information for patients and visitors about any falls or pressure ulcers that had occurred. There was a low incidence of falls within surgical services, even in the orthopaedic wards, where frail, elderly people were being cared for.

We found nurse-led pre-assessment clinics were staffed by experienced and competent nurses. There were systems in place for frail, elderly patients with more complex needs to be assessed by a specialist clinic prior to surgery. This meant these patients were given additional guidance and rehabilitation to prepare for their surgery.

We found that multidisciplinary teams communicated and worked well together to ensure coordinated care for patients. Elderly care specialists worked alongside surgical services to undertake detailed pre-assessment of the frail elderly to ensure patients had the best preparation for any operation. Patients and families in the burns unit were supported by a multidisciplinary team that included counsellors and clinical psychologists. On the short stay surgical unit, nurses could discharge patients, following clear protocols and policies which meant they did not have to wait for medical staff to attend.

We found that the wards and theatres were generally clean, and we saw staff using appropriate hand-washing techniques.

We saw that patients were well cared for in surgical wards. Patients and relatives told us they were very satisfied with the service. In many clinical areas we saw display boards with patient feedback. In two areas, nobody had raised a complaint in the past 12 months. Before our inspection, we received many positive comments about the surgical services from patients.

Patients on surgical wards told us that they had been given a clear explanation of their surgical procedure. They said that before they had signed their consent form, staff had explained their treatment and care. In the records we examined, we saw that staff had clearly documented discussions about consent. We saw that consent was checked during different treatment stages.

We saw that staff made patients preparing for their surgery in the operating theatres comfortable, and they reassured them and explained procedures to them. Staff in theatres spoke with children kindly as they checked their comfort and condition.

Summary of findings

What we found about each of the main services in the hospital continued

Intensive/critical care

The critical care departments in both hospitals were providing safe and effective care. They had sufficient numbers of competent staff in place to meet patients' needs, which were in accordance with national guidance. Outcomes for patients were better than the national average and the mortality rate for the department was significantly better that the national average.

Staff demonstrated a caring approach and patients and relatives spoke highly of the care they had received. We saw staff delivering care that was compassionate. Care was planned and was based on people's individual needs. We also found the service was responsive to patient and relatives' feedback.

The critical care service was well-led and we did not find any concerns with the services.

Maternity and family planning

Maternity services were effective. Outcomes for patients were better than the national average, and the majority of women told us they felt involved in their care. The maternity service used a dashboard to monitor and review key performance indicators within the service. The dashboard showed that the hospitals both had a ratio of midwives to patients of 1:29.5, which was slightly above the standard rate of 1:28. This meant there were fewer midwives to patients than the national standard.

The maternity service senior management team confirmed that it had recruited 20 new midwives across both City Hospital and Queen's Medical Centre, and these midwives were due to start work soon. However, staff we spoke with raised concerns with us that the staffing skill mix and levels might not be appropriate. This was because the recruitment of new midwives was for Band 5 roles, which they felt might not provide adequate skills coverage.

We looked at data for the rates of the different types of delivery methods at the hospitals. Between April 2012 and June 2012, there had been 9,261 deliveries across the trust. Of those deliveries, 22.2% were performed by caesarean section. This rate is lower than the national average. The trust's rate of emergency caesarean sections is almost 3% lower than the national figure, which indicates there is good practice within the maternity service.

Guidance from the National Institute for Health and Clinical Excellence (NICE) states that women should be offered an induction of labour if their pregnancy goes beyond 42 weeks. However, it allows women who want to avoid intervention to continue with their pregnancy with increased monitoring. There were 85 deliveries in a 14-month period that went beyond 42 weeks. We had no concerns about this rate.

In the maternity service we found procedures and practice for infection prevention and control were not always effective. At the Queen's Medical Centre we found there was dust on low and high surfaces in patient bays and dust on equipment in labour suite. At both hospitals, we found specimens were not being stored in accordance with the trusts own policy.

Medicines were not always being managed appropriately in the maternity service. At City hospital, we found that staff had left ampules of medicines in labour rooms instead of locking them away. At both hospitals not all entries in the controlled drugs book were recorded properly and there were some gaps and in a small number of cases where we found missing signatures to say that controlled drugs had been administered by two members of staff.

Summary of findings

What we found about each of the main services in the hospital continued

Staff in all the maternity areas we visited were welcoming towards patients and supported them in a professional and sensitive manner. We noted that there were good working relationships between different professional groups, and there was an apparent mutual respect between staff. Before our inspection, we received a comment from a woman who had used the maternity service. She told us that her same sex partner had not been given the same rights to visit the maternity ward as male partners. This meant this person felt that she was not treated with respect.

Parents whose babies were being cared for in the neonatal unit said that they felt supported and staff were keeping them very well informed. One patient told us, "Staff have been very responsive to my needs in neonatal." Another person said, "It is fantastic here, the staff are so kind all of the time."

The labour suite at City Hospital had a delivery room dedicated to supporting bereaved patients and their relatives. Queen's Medical Centre did not have the same facilities to support bereaved patients and there was no dedicated room. Staff told us they tried to accommodate the needs of bereaved parents and relatives by using the generic facilities within the suite.

Most staff we spoke to, including doctors in training, felt well supported by their managers. Staff also told us that the trust had encouraged them to develop professionally. However, we also spoke with some staff who felt that management had not always sought or listened to their opinions. In particular, staff expressed their concerns about the plan to move patient inductions away from Lawrence Ward, a postnatal ward, to the City Hospital hotel on the top floor. The hotel is located immediately above the maternity department but staff were concerned that patients and staff would not have adequate support if the trust implemented this plan. They were worried that the trust had not fully considered potential safety issues. Staff said that they felt that the trust had not taken their views into account or adequately addressed their concerns.

We discussed the staff survey results for obstetrics. The last staff survey results had been published two months before our inspection. The maternity services senior management team acknowledged that staff had reported concerns about staff bullying, staff being unable to take breaks and staff who felt they were working under pressure. The senior management team confirmed that it was working on the issues which had been raised and that it was reviewing the process for capturing staff opinions on an ongoing basis.

Children's care

Children's services were caring, and we saw some excellent examples of care. People's views of the care they and their child had received were mainly very positive.

We found the flow of communication from 'board to ward' was inconsistent in children's services, and this meant that there was a lack of assurance that key messages and learning were being disseminated to frontline staff. Some wards were more proactive than others in sharing information. For example, information-sharing was good in the paediatric intensive care unit and paediatric outpatients, where there were regular team meetings. On the children's assessment unit, nurses did not get any feedback following completion of an incident form. But on wards D33 and E39 nurses outlined how they received feedback and how changes had taken place as a result of incidents. Therefore, there was a lack of assurance that learning and key messages were being fully implemented. A further example was the inconsistent performance in relation to nursing indicator targets. For example, wards D33 and E37 and the neonatal intensive care unit scored 'red' or 'amber' for these targets in most months since April 2013. This indicated inadequate performance. In the small number of cases where performance had reached the required threshold to score 'green', this improvement had not been sustained the following month. This meant that the department was not implementing learning consistently to ensure patient safety.

Summary of findings

What we found about each of the main services in the hospital continued

Children's A&E was open 24 hours a day and had good medical staffing arrangements in place. In general medical staffing was good across all of the children's services. The department produced weekly rotas that included good assistance from consultants. Consultants were on call at night and over the weekend on the general wards. We had some concerns about the nursing staffing levels in some of the areas.

In the Children's Assessment Unit Ward E38, the nursing to patient ratio was given as one nurse to four children during daytime, and one nurse for six patients during the night. Although the day time levels did meet national standards, the night time levels did not meet the did not meet the 2013 Royal College of Nursing's standards. These standards state that there should be one registered children's nurse for every three children under the age of two and one registered children's nurse for every four children over the age of two. The trust did not routinely adjust its staff numbers when caring for children under two, and there was no dependency tool in place to help with staff planning. However, the trust told us that they did adjust staffing numbers according to the needs of children in all ward areas. This was based on the judgement of the site matron. The clinical lead for nursing said that the trust was not yet using the Association of UK University Hospital staffing dependency tool to calculate minimum staff numbers. However, the trust was currently evaluating the use of a recognised children's dependency tool and aimed to implement this within six months.

We visited a number of the children's wards during our unannounced visit to the hospital. We saw that ward E37 had two registered nurses for the night shift. The ward had eight babies under the age of two plus two older children to care for. They expected more admissions overnight as the children's A&E unit was very busy. The children under the age of two and all had breathing problems. We saw a baby who did not have any parents/guardians with them. This baby was crying and was very distressed. A relative of another child told us that the staff had spent time with this child earlier but they felt the nurses were too busy to be able to stay with the child all of the time. The crying of this baby was distressing, not only for the child, but for the other parents and children on the ward. While this child did not require one to one care of all of the time, they did require care when they were distressed. The trust told us they did not rely on children's parents or carers to be present at all times.

We were unable to talk with any of the nursing staff on ward E38 because they were too busy delivering patient care. Again, there were two registered nurses for the night shift on this ward. We saw a young baby who had been admitted from A&E with breathing problems. The baby had an oxygen mask to its face. The parents of the baby told us they had been on the ward for about half an hour but they had not seen any of the nurses or doctors as yet. We were concerned that staff were not actively monitoring this young baby. Young babies with breathing difficulties require careful monitoring, as they can deteriorate quickly. We raised this with the staff during our visit.

We visited the oncology ward during our unannounced visit and found there were two registered nurses on duty for the night shift. The staff told us they could meet the needs of the patients with that level of staff. We did not find evidence to suggest this was not the case.

We found that there was generally good collaborative working across the paediatric areas. Our interviews with matrons and staff in the community nursing team showed good joint working with the community paediatricians and physiotherapists to keep children with complex needs out of hospital and facilitate early discharge of children requiring dressings, intravenous drugs or suture removal. However, the community team said it did not have access to the local authority's system to check on safeguarding issues, which it felt stopped them achieving the best outcomes for patients. The team had raised this with senior management, who had been unable to resolve the concern because it was a national data sharing issue.

Summary of findings

What we found about each of the main services in the hospital continued

As a regional centre for specialist children's services, the trust treated a number of children from outside of the Nottingham area. In an attempt to reduce travel pressures on parents a pre-assessment service was offered by telephone, where feasible. Facilities for parents staying overnight were cramped, and nurses on wards D33 and CAU said it is not always possible to provide single sex sleeping arrangements for parents staying with their child. Those families that were from out of town spoke highly of the care their child received and of the staff. However, they said that they were unhappy that the hospital restaurant closed at 2.30pm on weekdays and that it was not open at all at weekends. This prevented them from obtaining freshly cooked food. One father said that he did not want to eat in front of his child if his child was not allowed to eat before undergoing a procedure. There was an alternative café in the hospital that served hot food, such as jacket potatoes, soup and toasted sandwiches. This was open until 11pm.

End of life care

There were dedicated end of life inpatient wards/units at Nottingham City hospital which we found safe, effective, responsive, caring and well-led. The trust action plan for palliative care services indicated that the speciality had the highest levels of patient satisfaction in the patient experience surveys. When we looked at the complaints data collected by the trust over the past year, it confirmed that there were very few complaints about oncology services and wards, which also indicated patients were generally happy with the service. At the Queen's Medical Centre, patients requiring end of life care were cared for on the general wards but there was input from the specialist palliative care team. The specialist palliative care nurse did not express any concerns about the end of life care on general wards, but they told us that if there were any concerns they would provide feedback to the matron on the ward. They said they would on occasion arrange for the patient to be transferred from a general ward at Queen's Medical Centre to an oncology or the palliative care unit at City Hospital to ensure effective symptom control. This was because services at City Hospital had access to medication which would control symptoms but needed careful monitoring by the palliative care specialists. We were assured that patients were monitored to ensure effective symptom control when they were nearing the end of their life.

We looked at Do Not Attempt Cardio-pulmonary Resuscitation (DNACPRs) orders on all of the wards we inspected. In all cases, staff had completed these in line with guidance published by the General Medical Council (GMC). The trust had systems in place to audit all DNACPR forms. The resuscitation team undertook this on behalf of the resuscitation department, and it recorded any issues of concern and fed back to the relevant consultant in writing. The consultant was invited to reflect on the DNACPR form they had completed and review the order to make sure it met the standards expected.

Staffing levels were higher on the oncology and palliative care wards to give patients the care and support they needed when they were at the end of their life. Several of the patients we spoke with commented positively on the staffing levels on the wards we inspected.

All of the staff we spoke with were highly motivated and committed to meeting patients' preferences about where they ended their life, often going to some lengths to enable this to happen. A consultant on the palliative care ward gave an example of a patient with a very complex condition whose pain was not under control and who wished to return home to die. The team researched and were able to obtain a new medication for the patient which enabled their pain to be managed and their end of life preferences to be met. This was an example of outstanding end of life practice.

Summary of findings

What we found about each of the main services in the hospital continued

We looked at the staff survey results and saw that the levels of staff satisfaction for the end of life speciality were very high. The service was ranked sixth out of 31 specialities in terms of job satisfaction. All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed to end their life with dignity and without pain. We heard of many instances of exemplary practice, and the patient feedback about the service and the staff who worked on all of the wards we inspected was very positive. We saw some good examples of practice as well as excellent support services for bereaved families.

Support services comprised the bereavement centre, the multi-faith centre (which provided specific areas for prayer and reflection for people following the faiths of Islam, Judaism, Hinduism, Sikhism and Christianity) the chaplaincy service and a chapel of rest. There were strong links with other community-based faith leaders, if other additional support was needed. All of the support services were run by combination of paid staff and volunteers.

Hayward House had a day and outpatient service available for patients. A range of complementary therapies were provided in a purpose built section of the service. These included aromatherapy, reflexology, Indian head and neck massage, relaxation techniques, hypnotherapy and simple massage. The therapies were available to patients (both in patient and community based), their families and staff free of charge. The purpose of the therapies was to help patients relax and to assist with symptom control. Several therapies were provided by staff who had funded their therapy training and had completed it in their own time, as they believed these therapies helped patients cope with their illness and diagnosis.

We were impressed with the care provided on the Lyn Jarrett unit at the Queen's Medical Centre where six weeks after every death in the emergency department, bereavement nurses sent a handwritten letter to relatives. This letter offered condolences and invited recipients to speak with a bereavement nurse or senior doctor, who would be able to answer any questions they may have. This was an area of real compassionate practice.

Staff continued to treat patients with dignity and respect following their death. Staff who worked in the mortuary referred to people as "the patient" or "the deceased" at all times. We saw that personal items were kept with the patient, if relatives had requested this or it formed part of the patient's end of life care plan.

Summary of findings

What we found about each of the main services in the hospital continued

Outpatients

We received mixed feedback about the care patients received in outpatients and found some differences across the two hospitals. Many people were negative about the waiting times for appointments, and many patients were frustrated that they were not given information about how long they would have to wait once they were in the clinic. At the same time, some patients who were attending different clinics, such as breast or urology, felt they were seen quite promptly and felt well informed if the clinic was running late.

Data on the number of patients who did not attend (DNA) their booked appointments show that rates were very high in some clinics. We identified pockets of excellent practice where some clinics had used reminder calls and texts to get their DNA rates down from 30% to 5%. The trust had not identified this good practice or shared it with other clinics which were not achieving good rates of appointment attendance.

We visited two of the clinics at City Hospital with high recorded rates of patients who did not attend their appointments. In both cases we identified there may be errors in recording the data, as the clinic managers attributed most non-attendance to patients not being able to attend (cannot attend) as a result of ongoing complications with their illness, condition or with problems with allocated transport. These figures should not be recorded in the DNA rates.

Neither of the managers was aware that their service had high DNA, rates and they told us the DNA rates were not routinely fed back to them at clinic level to enable them to manage the situation proactively. They talked us through the work they did to try to make sure patients attended their appointments as planned.

Data on reported outpatient incidents for the trust between May 2013 and October 2013 revealed that the second highest number of incidents at City Hospital arose due to difficulties with the transport arrangements to and from outpatient appointments. The incidents reported concerned patients being brought too late for their appointments and having to re-book. A number of incidents concerned patients waiting excessive amounts of time to be transported home following their appointment. All patient transport issues were escalated to the commissioners at regular contract meetings. The commissioners were aware of these difficulties.

The trust used a patient transport service to get patients to and from hospital if they were unable to travel themselves. It told us that there was an escalation procedure if there were significant delays in transport to or from hospital. Analysis of the outpatient incidents indicated this was not always successful at resolving the issues.

Patients and staff consistently told us that the delays in transport were a significant issue on patient satisfaction and service efficiency. Staff also raised concerns and did not think the patient transport service was satisfactory. They told us this affected the running of the clinics, as patients arrived late and missed appointments. Our evidence demonstrated that the patient transport systems were not always providing an effective service and this had a potential knock on effect on the effectiveness of outpatient services.

Most of the patients we spoke with told us the consultant and nursing staff had explained in depth any diagnostic tests and treatment which were needed, including the risks and benefits of any proposed treatment. All of the patients we asked said they had signed a consent form before they had any tests or treatment. Our evidence demonstrated that staff were giving patients the information they needed to make informed decisions about treatment.

Summary of findings

What we found about each of the main services in the hospital continued

We observed some exemplary multidisciplinary working in the clinics we inspected. We attended a multidisciplinary meeting in the breast clinic which was extremely well organised. We saw each patient's diagnostic tests were discussed in depth, and patient notes about diagnosis and treatment were updated contemporaneously to ensure they were accurate. We saw that at the meeting staff had discussions about situations which were complex, and they agreed on treatment and how to communicate results to the patient.

One clinic was managed by a physiotherapist, who received input from many others to ensure positive outcomes. Another was nurse led and provided education for patients about managing and living with their condition as well as offering treatment.

The Hayward House clinic was on the same site as the inpatient, day service and complementary therapy services. Here, there was real multidisciplinary team input to provide patients with the care they needed to effectively manage their symptoms at the end of their life.

We received mixed feedback about the care people received in outpatients at Queen's Medical Centre. Many patients were frustrated with the waiting times. Some patients thought that, despite the wait, they received good care from the staff. Other patients felt less satisfied, and the term 'conveyor belt' was used a number of times to describe how services were run.

Trust data on reported outpatient incidents for May 2013 to October 2013 showed that there were twice as many incidents about patients being unhappy with delays at Queen's Medical Centre as City Hospital. Queen's Medical Centre also had a greater number of incidents in which clinicians were not present to cover clinics. Our interviews with senior managers from the trust provided evidence that waiting times when in outpatient clinics were not consistently monitored across the trust and was not seen as a key performance indicator for outpatient services. This meant that not all outpatient clinics kept patients informed of delays and the reasons delay.

There were a significant number of ophthalmology outpatient follow up appointments that were not allocated for patients which placed them at risk of not receiving effective care.

We spoke with clinic staff and managers, and they were not sure who was ultimately responsible for the quality and oversight of outpatient services across the trust. There was no one person in the trust with overall responsibility for assessing and monitoring the effectiveness of the service.

Nottingham University Hospitals NHS Trust scored 80 in the October inpatient Friends and Family Test, which was above the national average of 71.

The trust's results in the CQC Adult Inpatient Survey for 2012 were in line with the national picture. The trust scores were within the expected range for all ten question areas. Compared with 2011, the trust's performance had deteriorated in two areas (noise at night from other patients and time to get help after using the call button) and increased in one area (copies of letters being sent between the hospital and the GP).

The Cancer Patient Experience Survey is designed to monitor national progress on cancer care. The survey is made up of 64 questions. In the 2012/13 survey, the trust performed within the bottom 20% of trusts for six questions and within the top 20% for one question. For the remaining 57 questions, it scored about the same as other trusts nationally.

Summary of findings

What people who use the hospital say

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Areas for improvement

Action the hospital MUST take to improve

- Ensure preventative maintenance is carried out on clinical equipment.
- Ensure all staff receive mandatory training.

Other areas where the trust could improve

- Review the process for the recording of controlled drugs in the maternity and gynaecology departments so records are accurately maintained.
- Review the staffing requirements for the paediatric wards and departments.
- Ensure there is management oversight of the whole outpatient service and processes to ensure shared learning and consistent practice.
- Ensure action is taken to address the outpatient follow up appointments for ophthalmology.
- Address the privacy and dignity issues that patients may face when the A&E department has reached capacity and patients have to be cared for in corridor areas.
- Ensure all areas of the trust are free from dust and hand gel is always available in all dispensers.
- Review the length of time patients are waiting for outpatient appointments and ensure people are given information about how long they will have to wait.
- Review the facilities for visitors to have access to a hot meal after 2pm, particularly for those visitors who are further away from home and need to stay for long periods at the hospital to be with their relative.
- Review the availability of information so that it is accessible for people who find it difficult to access.
- Ensure children are given opportunities to give feedback on their experiences of care.

Summary of findings

Good practice

- The bereavement nurse on the Lyn Jarett Unit sending a hand-written letter to relatives of deceased patients. The letter was sent six weeks after a patient's death. It offered condolences and invited the family to speak with a bereavement nurse or senior doctor and ask any questions they had.
- The Hospital Threshold Comprehensive Geriatric Assessment for Frail Older People which was providing an improved experience for people who were older, frail and vulnerable.
- The QMC trauma centre which were providing effective care delivered by a strong multi-disciplinary team. This had improved outcomes for patients sustaining major trauma.
- The effective care being provided by the critical care unit. Outcomes for patients were better than the national average, with the mortality rate for the department being significantly better than the national average.
- The care being provided to patients on the dementia ward was person centred and based on evidence based practice.
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work and felt proud of the trust and what they did. They understood the hospitals values.
- The bereavement care that was offered in the trust by the multi faith centre and the compassion shown by the mortuary staff towards relatives/friends of deceased patients.
- The care and range of services offered at Hayward House.
- The medical staffing levels within the trust and the support given to doctors in training by senior medical staff.
- The quality of the senior leadership was good, particularly that shown by the executive directors.

Nottingham University Hospitals NHS Trust

Detailed findings

Hospitals we looked at: Queen's Medical Centre and Nottingham City Hospital

Our inspection team

Our inspection team was led by:

Chair: Dr David Levy, Regional Medical Director, NHS England

Team Leader: Carolyn Jenkinson, Care Quality Commission.

The team of 43 included Care Quality Commission (CQC) inspectors and analysts, doctors, nurses, allied health professionals, patient 'Experts by Experience', patient and public representatives and senior NHS managers. Experts by Experience have personal experience of using or caring for someone who uses the type of service we were inspecting. We were also joined by four members of the Patients Association, who were developing a model for evaluating NHS complaint handling and learning processes.

Why we carried out this inspection

We chose to inspect Nottingham University Hospitals as one of the Chief Inspector of Hospitals' first new inspections, due to risks identified by our 'Intelligent Monitoring' of the trust. The trust was considered to be a medium-risk provider.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Children's care
- End of life care
- Outpatients.

Before our inspection we looked at a variety of information we held about the trust and asked other organisations to share what they knew about it.

Detailed findings

We carried out an announced visit on 26, 27 and 28 November 2013. During our visit we held focus groups with different members of staff as well as different groups of people who use services. We looked at the personal care and/or treatment records of people who used the service, observed how people were being cared for and talked with people who used the service. We also talked with carers and/or family members, talked with staff, and reviewed information that we asked the trust to send to us.

We held two listening events on the 26 and 27 November 2013 where members of the public came and talked to us about their experiences of being cared for in the hospitals and shared their feedback on how they thought the trust needed to improve.

We carried out an unannounced inspection to Queen's Medical Centre (QMC) on Sunday 8 December 2013, but we did not inspect Nottingham City Hospital. As part of the visit to QMC we looked at how the hospital was run at night, what staff were available and observed how people were being cared for.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

Services were generally safe. There was evidence that staff learned from patient safety incidents. Arrangements to minimise risks to patients were in place, including measures to prevent falls, pressure ulcers and venous thromboembolism. Staffing levels were generally safe in the adult areas but we were concerned about the nursing staffing levels in the children's services.

Our findings

Patient safety

The trust's incident reporting levels were in line with what one would expect for this trust. The rates of never events (mistakes that are so serious they should never happen) were within expected range. There had been two never events in the previous year. Both of these involved surgical errors. We found that there was good quality monitoring and learning taking place in the operating theatres. The trust was found compliant with NHS Litigation Authority risk management standards at level 1 in February 2012.

Managing capacity

Like many trusts in England, Nottingham University Hospitals NHS Trust was caring for an increasing number of emergency admissions to the hospital. This meant that the hospitals within the trust were frequently under pressure. There were systems to ensure that patients who were on wards that were not the correct speciality for their medical condition still received safe care.

Medicines management

We were concerned about the management of controlled drugs within the maternity unit, because we found that some of the records where there should have been two staff sign the record were not complete. We did not find any evidence of an impact to patient care, but the trust needed to ensure that staff completed controlled drug records accurately. We noted that the level of input from pharmacists was lower for the maternity unit than for other specialities in the hospital, although this is to be expected.

At Queen's Medical Centre, the trust had invested in an electronic automated storage system for medicines within the resuscitation area of A&E. This had reduced the amount of time it took to prepare drugs such as controlled drugs, as nurses did not have to complete hand-written records. This had released time for nurses to care for patients as well as providing a robust audit trail.

Whistleblowing

We saw there was a whistle blowing policy in place, and we received mixed feedback from staff. The vast majority of staff felt listened to and able to raise any concerns with their line manager. A number of staff also told us that they felt the executive team was visible within the hospital. The staff survey results for 2012 were better than expected (in the top 20% of trusts nationally) for the percentage of staff experiencing harassment, bullying and abuse from other staff. They were also better than expected for support from immediate line managers. Nevertheless, some members of staff said that they did not feel they were always listened to, and they raised concerns with us.

When we had permission from the whistleblowers to speak with the trust about their concerns, we found the trust to be responsive. Both the lead commissioner and our own inspectors who were responsible for the relationship management with the trust also reported the trust responded quickly and thoroughly to any concerns that were raised with them. The trust is not complacent, and it is aware that they continually needed to work to ensure that all staff felt listened to.

We saw the trust ran a course for staff called 'Assertiveness and the art of speaking'. This was designed to empower staff to speak up. We considered this to be good practice, as it meant the trust was supporting its staff to feel confident in challenging practice and speaking up.

Staffing levels

We looked at whether the hospital had safe staffing levels. Many patients commented that staff, particularly nurses, were very busy. We observed this on the wards we visited. It was particularly evident on the older people's wards or other areas of the hospital where patients were elderly and frail. In adult services, the trust calculated nursing staffing levels using a recognised dependency tool which we considered to be good practice. The trust also demonstrated openness and transparency by publicising the daily staffing levels on the wards. We did not find evidence to suggest that staff were not meeting patients' needs. However, we did observe that staff were very busy. They told us they could request additional staff if the

dependency of their patients had increased. However, we were very aware that the trust faced significant difficulties recruiting new staff due to a shortage of registered nurses in the area. This was a problem affecting other hospitals in the East Midlands. The student nurses who were in training all told us that they wanted to work at the trust when they qualified. We also saw the trust had just undertaken a nursing recruitment drive in Portugal to find resources for the additional beds that had been opened to assist with winter pressures.

In the Children's Assessment Unit Ward E38, the nursing to patient ratio was given as one nurse to four children during daytime and one nurse for six patients during the night. Although the day time levels did meet national standards, the night time levels did not meet the 2013 Royal College of Nursing's standards. These standards state that there should be one registered children's nurse for every three children under the age of two and one registered children's nurse for every four children over the age of two. The trust did not routinely adjust its staff numbers when caring for children under two, and there was no dependency tool in place to help with staff planning. However, the trust told us that they did adjust staffing numbers according to the needs of children in all ward areas. This was based on the judgement of the site matron. The clinical lead for nursing said that the trust was not yet using the Association of UK University Hospital staffing dependency tool to calculate minimum staff numbers. However, the trust was currently evaluating the use of a recognised children's dependency tool, and aimed to implement this within six months.

The Executive Director of Nursing monitored nurse staffing levels on a daily basis. She received a twice-daily report to inform her about the staffing levels and where the hot spots were. The Director of Nursing told us that she made it a priority to visit the wards that were under pressure. Staff on the wards confirmed this. This demonstrated the accountability of the Executive Director of Nursing for ensuring wards were adequately staff.

Medical staffing levels were safe. Doctors in training told us they received good levels of support from consultants, and there was consultant presence in the hospital out of hours.

Reducing harm

There was a lot of work underway across the hospital to reduce harm to patients. This included work to reduce the number of patient falls, pressure ulcers and cases of venous thromboembolism.

Infection prevention and control

The trust had good systems in place to manage the prevention and control of infection. Infection rates for Clostridium difficile (C. difficile), MRSA and MSSA were satisfactory when compared with rates for other trusts. The trust investigated any incidence of MRSA and C. difficile and used root cause analysis to identify the causes and understand what needed to be done to prevent it reoccurring. The vast majority of the wards and departments we visited were clean, although we did find surface dust in the maternity wards and the general outpatients disabled toilets. Staff used appropriate hand hygiene techniques, and we saw them washing their hands between treating patients. We saw plenty of hand hygiene gel dispensers throughout the hospitals, but some of them were empty.

We saw good hand washing techniques in the operating theatres.

Safeguarding vulnerable adults

Staff had an understanding of how to protect patients from abuse. The trust had undertaken a safeguarding of vulnerable patients benchmarking initiative at the end of 2012. This was an annual benchmarking process against set criteria. For the general adult benchmark, the key changes were to assess whether staff were aware of indicators of abuse and whether they were able to demonstrate how to assess a patient's mental capacity. Wards and clinics were awarded gold, green, amber or red status. Year on year analysis showed significant improvements in the scores, indicating that the trust's actions to ensure staff had the knowledge to safeguard adults appropriately were having an effect. Over 50% of wards achieved gold or green status.

The trust had analysed the reasons why some areas had achieved lower benchmarking scores, and it had discovered that scores were related to whether staff attended relevant

training. The trust had set out actions to address this. The use of benchmarking provided the trust with an overview of their employees' understanding of safeguarding and their roles and responsibilities in protecting vulnerable patients.

We saw that some patients were having one-to-one observations, because they were at risk of falls. We checked to ensure that staff were not depriving them of their liberty to move freely, and we had no concerns about how staff were caring for these patients.

Medical equipment

The trust had many pieces of clinical equipment that were being used but were in need of assurance and preventative maintenance. The trust had identified this problem in its risk register, and an improvement plan was in place. However, it was making slow progress against this plan. Equipment had been risk assessed and prioritised and was being maintained according to risk. We found that the medical engineering department did not have the capacity to carry out all of the assurance and preventative maintenance that was required. The trust needs to address this issue to ensure that patients are not at risk from unsafe equipment.

Accident and emergency

The A&E department was safe. We found there were pressures placed on the department because it was not big enough to cope with the increasing number of patients. Staff told us that when the department was very busy, it became difficult to carry out observations on those patients who were being cared for in corridor areas. We also noted that clinic 1 was under significant pressure. This was a ward for people who were being sent into hospital by their GP and was separate from the A&E department. Staff told us they were concerned about the number of patients attending this unit, given its capacity and the number of staff who were available to provide effective care.

Are services effective?
(for example, treatment is effective)

Summary of findings

The trust's services were generally effective. Outcomes for patients were mostly as expected, but in some cases they were better than expected. This meant that patients got either the same standard of treatment or better treatment at the hospital when compared with other hospitals in England.

The A&E department faced continuing challenges in meeting national targets.

We found that there was a back log of maintenance of clinical equipment. The trust was already aware of this and it was on their risk register. We found they had taken steps to manage this risk by making sure the more high risk equipment, such as ventilators which are used to breathe for patients were serviced according to manufacturer's instructions. We also found that about 40% of staff were not up to date with their mandatory training. Again, the trust were already aware of this issue and had a plan in place to address the shortfall. We found they were making good progress against their plan and we did not find any impact on patient care.

Our findings

Intelligent Monitoring data

Prior to our inspection we reviewed the data we had about the effectiveness of the care provided at Nottingham City Hospital and Queen's Medical Centre. The data showed that the care provided was mostly effective.

We looked at mortality data for the trust and saw that the rates for a range of areas were within expected ranges, with the exception of two indicators that showed an elevated risk. One of these was the mortality rates at weekends. We carried out an unannounced visit on a Sunday evening/night to check the arrangements that were in place for out of hours care at the Queen's Medical Centre. We found there were enough suitably trained medical staff to meet the needs of patients. The critical care outreach team provided care at weekends and there was an effective hospital at night team. We were told that there were the same arrangements in place at the Nottingham City Hospital.

The second mortality outlier was for cardiological conditions: coronary artery bypass graft (CABG). We looked at the care given to patients undergoing a CABG and did not identify any problems with this. The trust had completed an analysis of the care given to patients who died following a CABG. This response was considered by the CQC's Mortality Outliers Panel in December 2013 and further clarification about the review the trust carried out had been requested. The trust had a mortality review group in place that systematically reviewed all deaths and mortality alerts.

Hospital at Night

The Hospital at Night team used technology to effectively manage patient care at night. The electronic systems had led to major improvements in patient care as well as to staff satisfaction and efficiency.

Policies and guidelines

A range of policies and clinical guidelines were in place across the trust. These were based on best practice and were evidence based. At the time of our inspection we found many of the policies and clinical guidelines had passed their review date and had not been reviewed. The trust had identified this on its risk register. There was an action plan for improvement, and it was being monitored. Significant progress was made in addressing this following our inspection and as at 2 January 2014, the trust confirmed 100% of clinical guidelines were up to date and 86.5% of the clinical policies were up to date. There were 10 policies which had been identified as higher risk that were still requiring review. This represented 3.1% of the total policies in use at the trust. A plan was in place to address this. We saw no evidence of an impact on patient care, but it did mean that there was a small risk that patients could receive care that was not appropriate or effective.

Medical equipment

The trust had many pieces of equipment that were being used but were in need of assurance and preventative maintenance. The trust had identified this problem in its risk register, and an improvement plan was in place. However, it was making slow progress against this plan. Equipment had been risk assessed and was being maintained according to risk. We found that the medical engineering department did not have the capacity to carry out all of the assurance and preventative maintenance

Are services effective?
(for example, treatment is effective)

that was required. The trust needs to address this issue to ensure that patients are not at risk from unsafe equipment.

Mandatory training and induction

The trust had identified that not all staff had received mandatory training. This was because it had changed the way mandatory training was organised, but the new system for booking onto the training was not working. As a result of this staff had gradually become behind in their training. To address this back log, the trust had developed a training DVD, which included subjects such as fire and health and safety. Staff could access this in various ways and could watch it independently or attend a session with staff from the training department, who would be able to answer any questions. Staff thought the DVD was an effective way of receiving their mandatory training. One member of staff told us, "The way they have done it makes you think more about what you are doing and what it means to us working on the shop floor." Significant progress had been made in relation to the numbers of staff who had undertaken the training, and the trust was ahead of their plan. Never the less there were still 40% of staff who were still to complete their mandatory training. We did not find an impact on patient care because of this, but it meant there was a risk that staff might not be properly trained or skilled to carry out their role.

We heard from a number of new staff that they had received an excellent induction to the trust. There was a corporate induction day, and we saw nurses and allied health professionals were supernumerary for, in some cases, six weeks, while they underwent a ward or department based induction. This meant that there were arrangements in place to ensure new staff were competent to carry out their roles and we considered this to be good practice.

Are services caring?

Summary of findings

The vast majority of people said that they had positive experiences of care. The trust's patient survey scores were the same as most other trusts, and the Friends and Family Test scores were above the national average.

Our findings

What people told us

We spoke with approximately 75 patients during our inspection and the vast majority of patients we talked to in the hospital told us that staff were caring and that they treated patients with dignity and respect. However, many patients or relatives commented on how busy the staff were. We observed many examples of compassionate care during our inspection. We saw good interactions between staff and patients on most of the wards we visited. Staff were offering patients who were receiving end of life care a very good standard of care. A relative of a patient who had died at the hospital told us, "The staff are so caring and compassionate. [The patient] was here for three years of his life. If we paid for it we couldn't have got better care." Data from our Intelligent Monitoring system reinforced our findings. Patients using NHS services were asked whether they would recommend a hospital or A&E department to their friends and family if they required similar care or treatment. Nottingham University Hospitals NHS trust performance was above the national average.

We held two listening events where members of the public were invited to come and talk to us about their experiences of care at the hospital. The events were attended by approximately 30 people. We heard positive and negative stories from people, but there were some themes that emerged. People were concerned about the long waiting times in some outpatient clinics, and they said that staff did not always treat them as individuals.

We also received information from member of the public via our website. Again, feedback was mixed, but comments were generally positive. Where we did receive concerns, they generally related to staff not being able to meet patient's needs, particularly patients who were elderly and or frail. However, we noted that two members of the public reported that they did not feel they had been treated with dignity and respect because of their sexuality. In one case, one person told us a consultant had introduced them to their junior staff as "a homosexual." In another case a patient in the maternity unit did not feel that their same sex partner was afforded the same visiting rights to the maternity unit as women with opposite sex partners. This meant people were not always treated without discrimination.

Staff attitude

Many staff spoke with passion about their work. They described how they loved their work, how proud they were of what they did and how working at the hospital was important to them. Staff were aware of the trust's 'We are here for you' statement and its underpinning values. Nursing staff could list the values as: caring and helpful, safe and vigilant, accountable and reliable. The trust also had a focus on the Chief Nursing Officer for England's 'six Cs', which are centred on staff providing services that offer care, compassion, competence, communication, courage and commitment. All band 5 nurses had opportunities for time-out days which were focused on the six Cs.

During our inspection, we came across a consultant's office door with this message written on it: "A patient is the most important person in our hospital. He is not an interruption to our work, he is the purpose of it. He is not an outsider in our hospital, he is part of it. We are not doing him a favour by serving him, he is doing us a favour by giving us an opportunity to do so."

Trust-wide initiatives

We were encouraged to see that the trust used Essence of Care benchmarking. This had been in use at the trust for many years, and staff actively used it to improve the care patients received. The trust also had quality priorities for 2013/2014 which had been named 'the six pack'. This title had clearly made an impact on staff, as many of them spoke spontaneously about it. The six pack pulled together six areas of quality that were important for everyone. One of these areas was attitude and behaviour.

Are services responsive to people's needs?
(for example, to feedback?)

Summary of findings

In general, the trust responded to people's needs. We found that although patients reported there were good interpreting services, only limited written information was available to patients whose first language was not English. The number of inpatients whose discharge was delayed for more than four hours was more or less as expected, and the trust was performing as expected in relation to cancelled operations when compared with national rates in other similar trusts.

Our findings

Patient feedback

The trust actively sought the views of patients and their families. The response rates for the Friends and Family Test were well above the national average, which indicated that the trust encouraged patients to give feedback. There were suggestion boxes on each of the wards we visited.

Visitors to clinical areas were able to see displays of information, including information about complaints and comments from the previous months and how the trust had taken patients' views into account when improving a service. For example, in the critical care service at Nottingham City Hospital staff told us that they had revised their visiting times in response to families' views and that they had improved identification badges and neck lanyards. This made it clearer to patients who different members of staff were.

Interpreting services

The trust provided services to an increasing number of people who did not have English as their first language. 34.6% of the population of Nottingham belong to non-white minority groups. Patient and relatives/carers said that interpreting services were generally good, but we found that written information was not readily available in languages other than English.

Discharges and access to treatment

The way in which a trust handles the discharge of patients is an indication of how it responds to patient need. We looked at the data we held about the trust, which told us that the number of inpatients whose discharge was delayed for more than four hours as would be expected.

We also looked at the performance of the trust with how long patients waited for treatment. The trust was performing as expected in relation to cancelled operations and was not considered to be at risk.

The trust's action plan for palliative care services indicated that the speciality had managed to see 100% of patients who were struggling with their end of life symptoms on the same day. This indicated a service which was committed and responsive to ensuring patients were comfortable and pain free at the end of their life.

Care of patients who have dementia

All of the medical wards used the trust's About Me document, which was completed by the patient's carer at admission and recorded information about their life, likes, dislikes and interests. It enabled health and social care professionals to see the patient as an individual and deliver person-centred care that was tailored specifically to the person's needs. It could therefore help to reduce distress for people with dementia.

On one of the respiratory wards, there were pictures on the toilet doors to help patients with dementia to find the toilet. A senior member of staff told us that they implemented one-to-one care if the patient required it. They also encouraged relatives to stay if the patient was unsettled. A member of the public contacted us to tell us that they were concerned that on one ward staff relied heavily on the patients' relatives to provide the appropriate level of care for their relative who had dementia.

We saw a patient with dementia who had been referred for cardiac investigations. The consultant and team had ensured that a mental capacity assessment and written consent was gained before treatment began.

Are services responsive to people's needs?
(for example, to feedback?)

Choice
In the maternity unit we found patients did not always get a choice of which hospital they delivered their baby in. One patient told us this had caused them some inconvenience and anxiety. Staff told us that they always asked patients which site they would like to attend, and they said that they made every effort to respect patients' wishes. Staff told us they could not always guarantee a patient's first choice of hospital. However, they communicated regularly with patients to keep them updated regarding their hospital admission.

Pain management
We talked to patients about how well they felt their pain was managed. One patient told us they had been moved from a general ward to an oncology ward to control their symptoms. They said, "I was not given adequate pain relief, but I had a contrasting experience when I moved here: they are very responsive to me. If I am in pain in the night they get the doctor to reassess me quickly." Another patient told us the staff were responsive if they complained of any pain. The patient said, "I have pain relief. The staff say I can have it every hour if I want but I prefer not to do this." Another patient told us they had "no pain, it is very well controlled".

On the surgical wards we found patients received appropriate and responsive pain relief

Emergency planning
The trust had a major incident plan which was fully compliant with the requirements of the NHS Emergency Planning Guidance 2005 and all associated guidance.

Working with the local community
The trust had a range of initiatives in place, from helping a local school give young adults with learning disabilities opportunities to gain vocational skills and employment, to supporting the Prince's Trust 'Get into Hospitals' programme, which gave 13 young people four weeks' work experience.

In 2013 City Hospital opened a new kitchen which prepares all of the meals for the trust. The kitchen uses locally sourced food and is working in partnership with Nottingham City Council to offer a 'meals at home' service to the residents of the city of Nottingham. This is good practice and demonstrates how the trust is working with other partners to provide a community service.

Empowering patients and staff
The trust ran a 'Better for You' campaign that had been in place since 2009. This programme was designed to encourage staff and patients to use their experiences to help develop services and improve care. There were over 250 ongoing projects in place across the trust. The campaign was embedded in the culture of the trust and staff in all areas we visited were able to tell us it.

'Just Do It' was part of the Better for You programme and encouraged staff to come up with new ideas for improving the staff and patient experience. There were regular awards for staff who had come up with innovative ideas. In paediatrics, one idea had been to order pillows from a new supplier who could deliver them already fitted with a protective cover. This not only saved money but also saved time, because staff no longer had to order pillows and covers from separate suppliers and put them together after they were delivered. Staff had also sourced special fitted bed sheets for cots, so that nurses could make beds more quickly.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The trust was well-led. The trust non-executive and executive directors were well established. They provided strong and stable leadership and showed a good understanding of the key issues for the trust. The executive directors were visible, and many staff commented that they could approach them if they wanted to talk with them. The medical and nursing directors worked effectively together.

Services were mostly well-led, and staff felt well supported.

Our findings

Governance and leadership

The trust had a clear organisational structure. There was also a clear governance and risk management structure.

There was a good programme for identifying and developing potential leaders in the trust. Staff told us that they felt that they had opportunities for career development at the trust. The trust also offered a Building Essential Leaderships Skills programme to all band 7 staff. This course offered an accredited qualification through the chartered management institute.

There was no clinical leadership at board level for allied health professionals (AHP's). This was historic and had come about when the two main hospitals in the trust had merged. AHP's told us they were unclear about the process for reporting their service and quality issues to the board.

The trust had a risk register in place. Risks that scored a higher rating were considered by the trust board, lower risk ratings were reviewed through the reporting lines within the directorate risk management processes. We found that the risks we identified during our inspection (such as equipment maintenance and mandatory training) had already been identified by the trust, were incorporated into its register and were being actioned. This meant the trust had systems in place to identify and escalate risks so that they could be controlled and managed but there were there were instances where the controls were not sufficient.

Each year the trust agreed corporate objectives which were linked to their six strategic priorities. For 2013 these were:

- Patient experience
- Clinical outcomes
- Staff satisfaction
- Research
- Teaching and training
- Value for money.

Not all of the objectives for 2012/13 were fully met. However, we saw that the trust had made progress with them all. For example, one objective was to have no avoidable pressure ulcers in the trust. Despite making significant improvements, pressure ulcers were not eliminated. We noted they had reduced significantly, and we did not find the trust to be complacent. We saw that pressure ulcer reduction was a high priority and steps were being taken to ensure patients at risk were identified, assessed and their care was well managed.

The Chair of the trust told us that the board undertakes a variety of activities to ensure that the improvement of patient experience is central to its work. For example, each month, the board reflects on a patient story, board members undertake planned patient safety visits to clinical areas and they support the 15-step challenge process by visiting wards as part of teams that include lay members. In addition, the Chair undertakes a regular series of visits to clinical areas alongside the Director of Nursing. Every month, the executive team dedicates one of its weekly meetings to visiting clinical areas across the trust. Staff confirmed with us that the board did undertake these visits, and we saw records confirming visits in the board minutes. This meant the trust board was taking steps to assess and monitor the quality of the care provided at the trust.

The Director of Nursing was providing mentorship to a student nurse who was undergoing nurse training at Masters level. The student nurse shadowed the director of nursing and attended the trust board with her. We saw the Director of nursing was keen to ensure less experienced staff were given every opportunity to develop. We considered this to be good practice.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Recruitment and retention of staff

The trust employed approximately 14,000 staff. Like many trusts in England, the recruitment of nursing and medical staff was an ongoing challenge for the trust. Student nurses and doctors said that they wanted to work for the trust after they had qualified, but demand for nurses was exceeding supply. The trust had just undertaken a recruitment drive in Portugal and had offered posts to nurses to help with staffing the extra winter pressures beds. The Director of Nursing told us she was concerned about the recruitment of nurses and that it would continue to be a challenge for the coming years because there were not enough new nurses qualifying to meet the demands of the services. She also acknowledged the affect this had on the rest of the health and social care community which indirectly impacted on the trust.

Our Intelligent Monitoring of the trust revealed that the total sickness absence rate was below the England average. This rate had been consistent since 2011. The pattern was replicated for medical nursing, midwife and other staffing categories. The trust spend on agency staff for the year 2011/12 was below the average for the East Midlands area. However, staff raised working extra hours as a concern in the staff survey.

The trust ran a staff awards scheme called 'NUHonours'. This scheme was supported by charitable funds and recognised individual and team contribution to patient care. Staff valued it, as it provided an opportunity to receive recognition for what they had achieved. Award schemes are known to improve staff morale, reduce sickness rates and improve staff retention.

Staff feedback

Staff were proud to work for Nottingham University Hospitals NHS Trust, and many of them told us that they loved their jobs, felt proud of what they did and would not want to leave the trust.

Most of the services we inspected were well-led. Staff reported good support from their line manager. The staff survey results reflected this, and the trust had 15 out of 28 measures that fell within the top 20% of trusts nationally. None of the survey measures were in the bottom 20% of trusts, but there were three scores that were tending towards worse than expected. These were scores for effective team working, the percentage of staff working extra hours and the percentage of staff having equality and diversity training in the last 12 months. This meant that although staff satisfaction was generally in the top 20%, the trust needed to ensure that it took action to address these potential areas of risk.

The General Medical Council National Training Scheme Survey results were more or less as expected for the majority of specialist areas. Doctors' workload was identified as better than expected across five treatment specialities. Overall satisfaction with clinical supervision was good in four areas. Handover was identified as being worse than expected across seven specialities. The trust had recognised this, and improvements were in place. This meant that the trust was using the survey results to improve the satisfaction of doctors in training.

The East Midlands Deanery report from April 2013 identified two concerns relating to emergency medicine and general internal medicine. The trust had addressed both of these concerns, and the Deanery was satisfied that improvements had been made and sustained over a period of time. This showed that the trust had responded to concerns.

We received information from staff either prior to or during our inspection. This told us some staff felt there were instances when they were not listened to. The vast majority of staff told us that they did feel listened to and that they could effect change. Nevertheless, it is important for all staff to feel they have the chance to he heard. We saw that the trust had a raising concerns policy in place and that all staff had access to a 24-hour telephone counselling service. Some of the ancillary staff told us they were concerned about the forthcoming changes to the portering services at the trust. They were worried about the impact changes would have on patient care. The trust told us that it would be monitoring this change in provider very closely to ensure that there was no negative impact on patient care.

Complaints

In 2012/13 the trust received 819 formal complaints. We were joined by member of the Patients Association on our inspection. We looked in detail at complaints handling during this inspection. We found there was a very positive commitment to the development of complaints handling in the trust, and it was evident that the trust had carried out considerable work to improve the complaints process.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The trust had been part of a project called 'Speaking Up' over the past 18 months, and there had been several peer reviews of its complaints handling. This had enabled the trust to examine its practice and target improvements where necessary. The trust was very open and honest about the further work it had to do to improve.

There was good leadership in place for complaints handling. There were clear lines of accountability and good governance processes. The trust board was aware of the value of complaints as an organisational learning tool. The trust Chair read a selection of complaints every week. The patient experience team consisted of staff from the Patient Advice and Liaison Service (PALS) and complaints team. The team was skilled in customer care and showed a real commitment to deflecting situations and being proactive. This could be further improved if more staff were trained in complaints handling and customer care.

We looked at the complaints process. On receipt of a complaint, the trust contacted the complainant and gave them a named person to contact. Staff also clarified with the complainant the areas of the complaint and the way in which they wanted the outcome communicated. The trust always sent out acknowledgement letters within three working days.

The trust had recently changed the process for investigating complaints. Matrons now undertook investigations. Although it had increased the time it was taking to investigate complaints, the new process was thought to be working better, and it would continue. We did note that some consultants felt they were not involved in the process as much as they would like to be. Having the dedicated time to investigate complaints was also an issue for staff.

We talked with some patients and relatives who had made complaints to the trust and heard mixed feedback. Some people expressed concerns that the trust had not fully answered their questions. Other people felt that the trust sided with staff. We also heard, and saw for ourselves, that some of the responses to complaints were lengthy and lacked compassion. We saw a response letter that a consultant had sent directly to a family, and it lacked compassion. There was no recognition that the family concerned had lost their very much loved relative.

We saw some good practice, and the trust offered face-to-face meetings for complainants to talk about their complaint and hear the staff's response. We thought it may be beneficial to introduce these meetings earlier in the complaints process.

Some patients did not know how to make a complaint. We did see posters and information leaflets in many areas of the trust.

We saw evidence that the trust learned from complaints and subsequently changed practice. However, it needed to further strengthen its complaints process to ensure that all of the actions identified in complaint investigations were tracked, so that the trust could ensure that they had been followed through.

Accident and emergency

Information about the service

The Accident and Emergency (A&E) department provides emergency care for over 2.5 million people in Nottingham and its surrounding communities. A&E services for this trust are located at the Queen's Medical Centre hospital only. A&E is open 24 hours a day, seven days a week. It is also the major trauma centre for the East Midlands area.

In 2011/12, there were 184,745 attendances at A&E. This was an increase from 181,433 from the previous year. The A&E department was originally built to provide care for 120,000 patients a year.

Within the A&E department, there are a number of areas. These include triage, resuscitation, minors, majors, major trauma, radiology, psychiatric assessment and the Lyn Jarrett Unit. The Lyn Jarrett Unit is a short stay observation unit located near the A&E department. Paediatric A&E is adjacent to but separate from adult A&E, and we have reported on this area in the children's care section of this report.

We inspected all areas of A&E and spoke with approximately 35 patients, 10 relatives and 50 staff, who included nurses, doctors, consultants, senior managers, therapists, security staff, support staff and ambulance staff. We observed care and treatment and looked at approximately 10 care records. We received comments from the listening events and from people who contacted us to tell us about their experiences, and we reviewed the trust's performance data.

Summary of findings

A&E had professional, caring, positive and enthusiastic staff. The department delivered innovative and effective multidisciplinary training guided by locally identified needs. Staff described an open and productive working environment with strong communication between colleagues. They had noticeable respect for one another and were clearly experienced working as a multidisciplinary team.

Patient experience was generally very positive. However, more support and attention is required to ensure that patients whose first language was not English are effectively supported within the department.

Care was good overall, but the department was unable to maintain this standard consistently under periods of increased demand, which were increasing in frequency and will increase further during the forthcoming months. This was due to pressures on the number of beds in the hospital and the limitations of the A&E environment, which was not fit for purpose.

Are accident and emergency services safe?

Patient safety

Staff identified patients who were at additional risk of falls and treated them in cubicles where they could be observed more closely. Staff also provided patients relatives/carers with a slip of paper to tell them that their relative was at risk of falls and to ask them to inform staff if they were going to leave their relative unattended at any time.

Accident and emergency

Deteriorating patients

Staff told us they undertook regular observations, directed by clinical need, in the majors and resuscitation area and that they used these to form an early warning score and detect deteriorating patients. We saw emergency department assistants informing nursing staff of patients' early warning scores as soon as they had been completed.

However, two nursing staff described difficulty maintaining regular intervals of observations during periods of increased demand, when the patient to staff ratio and availability of staff were a constraint. They also told us that regular observations were not always done when patients were waiting in the more public part of the majors area. We did not see evidence that patients were not getting observations recorded during our inspection. We did not see any evidence to demonstrate this was having an impact on patient care. We spoke with the clinical commissioning group as well as the National Trust Development Agency (NTDA) about A&E. The clinical commissioning group (CCG) have a contract with the trust and purchase care for the population of Nottingham, they are also responsible for ensuring the care they purchase is of the right quality. The NTDA are responsible for providing oversight of NHS non foundation trusts and they monitor the performance of the hospitals. Both of these agencies told us they had no concerns about the safety of the care that was being delivered in the A&E department.

Handover

Some staff told us that handover could be inconsistent if the nurse looking after a patient had to leave A&E or their shift finished before their patient was discharged or transferred to another department. We were told that the nurse would hand over to another nurse or an emergency department assistant, which could lead to a risk of inaccurate or incomplete information being handed over.

A&E staff completed a transfer proforma when transferring a patient. They retained this proforma when the transfer of a patient had been completed. It would be useful for a copy of this proforma to be left with the new department as well, to support the robust transfer of information.

Environment

When A&E became busy, patients on trolleys waited in the middle of the more public major treatment area. This area often became full with patients very close together on trolleys and wheelchairs. Staff told us that this had led to regular observations not being carried out, omissions in the provision of medication and treatment, and difficulty finding patients quickly. Staff also told us that some patients felt uncomfortable answering questions because of discomfort/embarrassment in this uncurtained public area. There was also a small waiting area nearby, and people in this area could overhear these conversations.

Patients with mental health needs

Staff told us that generally they could request quality rapid and comprehensive support from the mental health team. This service for patients needing a mental health assessment was run by a neighbouring mental health trust.

Infection control

We saw staff wearing personal protective equipment and washing their hands appropriately. However, we saw some areas of concern. Parts of A&E, such as the patient toilets in the reception area, require refurbishment to ensure they can be cleaned effectively. We saw a sharps bin that was over-filled, and clinical waste was not stored securely at all times. We also saw that some alcohol gel dispensers were empty and there were not enough dispensers to ensure that effective infection control measures were taken at all times.

Some large clinical waste bins that were in corridors were unlocked. This meant there was a risk that people had unauthorised access to contaminated waste.

Medicines Management

We saw that medicines were stored securely and that arrangements were in place to ensure that they were stored at the correct temperature and that controlled drugs were handled appropriately. Staff told us they thought it was a very secure system.

Accident and emergency

Staffing
Staffing levels seemed to be appropriate during our inspection. There were some nursing and medical vacancies, but there were plans to fill the gaps as soon as possible. Senior management told us they were looking for more staff for A&E, particularly the resuscitation area.

There was effective induction, training and supervision for most staff, and junior staff felt particularly well supported. However, some nursing staff reported that poor service provision planning often led to their training being cancelled or cut short, as they were redeployed. Work pressure was also an issue for some staff, who described significant stress and concern that current working levels were not sustainable in the long term.

Staff on the Lyn Jarrett Unit felt particularly supported by the 'Better For You' team, who had analysed their patient pathways and redesigned them to become more efficient.

Learning from incidents
Between November 2012 and September 2013 there was one serious incident reported to the Strategic Executive Information System (STEIS), which records serious incidents and never events. There were no never events in the A&E service.

Staff told us that there was good learning from incidents and that they had multidisciplinary training scenarios based on actual incidents. We saw evidence of this taking place.

Care records
We looked at approximately 10 care records and saw that staff in A&E completed records promptly. Records contained appropriate information to ensure patients received safe care.

Safeguarding
A member of staff on one ward (which was part of the emergency department) told us that A&E automatically checked patients on admission for any signs which would indicate they may have been abused or neglected, such as marks on their body or signs of dehydration. The member of staff said they always referred such issues under safeguarding procedures and said they had good liaison with local safeguarding teams. We spoke with other staff who could describe what safeguarding was and the process to refer concerns. This meant the staff were aware of their responsibilities to record, report and refer any safeguarding issues they identified, to ensure patients were safe from abuse or harm.

Are accident and emergency services effective?

Clinical management and guidelines
The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies. The department had a number of clinical pathways for care. We saw that there were protocols displayed near the initial assessment triage area for the most frequent conditions that patents present with at A&E. We also saw NICE/ Resuscitation Council guidelines clearly displayed in the resuscitation area.

We saw that emergency re-admissions following an A&E discharge were lower than the national average. However, we saw from the findings of audits carried out by the trust that patients' treatment was not always timely and effective. The College of Emergency Medicine fractured neck of femur audit stated that delivery of timely analgesia required improvement. The department had acted on these findings and had implemented changes to practice to improve outcomes for patients.

Clinic 1
Clinic 1 is an ambulatory care department which received admissions to the hospital who have been sent in by their GP. The unit opens at 8am and aims to close by midnight, but due to service demands, is often open beyond midnight. Prior to our inspection, a new pathway had recently been introduced to improve the way patients were managed. A change in procedure had also been introduced which allowed ambulance crews to divert patients who were acutely unwell directly into the A&E department. All patients that arrived in Clinic 1 have an initial assessment by a nurse within 15 minutes of arrival to assess their Early Warning Score (EWS).

Staff told us they were concerned about how the clinic ran and that it could become extremely busy and was not fit for purpose. The clinic had a number of consulting rooms but these were only equipped to a very basic standard. For example, only two of the rooms had piped oxygen and some of the rooms had no computer terminals.

Accident and emergency

However, we did note that portable oxygen cylinders were available. If patients required close observations they were placed adjacent to the 'nurses station' so they could be monitored by staff. However, this area is within the main waiting area of the clinic. We were concerned about the effect on patients' privacy and dignity because there were only curtains to pull around the trolleys. This was also a concern to staff. We were informed that the commissioners of this service were reviewing the patient pathway and the purpose of clinic 1.

Pressure care

Staff risk-assessed patients' pressure care needs, and they put in place care plans to ensure that people's skin was protected from damage on the Lyn Jarrett Unit. We did see that the care plan for one person stated that they should change their position every two hours but this had not taken place consistently.

Food and drink

Patients received appropriate food and drink on the Lyn Jarrett Unit. We saw that staff assessed nutrition and hydration needs and that they put in place and followed care plans if specific needs were identified, for example, if a patient required assistance at mealtimes.

Are accident and emergency services caring?

Patient feedback

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate NHS Friends and Family Tests for Accident & Emergency and Inpatient admissions. In August 2013, the trust scored 72 out of 100 for the A&E department, significantly above the national average of 56. The response rate was 19.2% for the department, which again was above the national average of 11.3%. In August, 1,461 people completed the test. Some 91.5% of patients were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family.

Patient Opinion is an independent non-profit feedback platform for health services. It aims to facilitate honest and meaningful conversations between patients and providers. The comments on the trust's section of the Patient Opinion website were positive regarding the quality of care provided by A&E.

Almost all patients told us that they felt they received good care. One patient said, "Staff were kind and ready to help with whatever I needed." Another patient said, "The nurses gave me all the help for my best recovery." Another patient said, "Doctors and nurses are very busy but they tried their best to assist my needs."

We saw staff providing care to patients with compassion and kindness. We observed that the end of life care provided on the Lyn Jarrett Unit was of a very high standard.

Being informed

Patients gave mixed feedback about whether they were kept fully informed about their journey through the A&E department. Some patients were aware of what would happen next and the reason behind waits (such as processing of blood tests), others were not. Two patients we spoke too wondered whether staff had forgotten them. Relatives told us that staff kept them well informed. Patients also told us that they often struggled to identify who staff were by their uniform. We did not see any posters in the department explaining how staff could be identified.

Privacy, dignity and respect

We saw that staff closed cubicle curtains and respected people's privacy when providing care. Patients told us that they were treated with dignity and respect. However, we saw that when A&E became busy, the environment did not support dignified care. Staff told us sufficient numbers of cubicles were available only 30% of the time. The rest of the time patients had to wait in areas that did not respect their privacy or dignity. The reception area was very small, and it was very difficult to preserve confidentiality when patients were waiting in line. We noted that staff did their best to adapt and work around the difficulties the unsuitable environment created. There were short term plans in place to change the department to create more space for patients.

Accident and emergency

Are accident and emergency services responsive to people's needs?

Environment

The A&E environment was not fit for purpose. The A&E department was originally built to provide care for 120,000 patients a year, however the unit was seeing approximately 50,000 more patients each year and data suggested this figure was increasing year on year.

There were long-term plans for redeveloping the whole of the floor where A&E is located to expand its capacity. However, this work will not be completed for three to five years.

The Lyn Jarrett Unit was spacious. However, there were no activities available to patients, some of who stay on the wards for a number of days. The television was not working, no radios were available and there were no windows for light or ventilation. A number of patients told us they were bored. There was also a lack of clocks, so patients were unable to orientate themselves.

The Lyn Jarrett Unit initially appeared to manage patients well when limited beds were available in the rest of the hospital. However, patients told us that there was a lack of urgency in moving them to other parts of the hospital, and we saw one patient who should have been moved in a timelier manner. We saw that the unit had good relationships with the medical team.

Speed of response

Trusts in England are tasked by the government to admit, transfer or discharge 95% of patients within four hours of their arrival in an A&E department. The data shows that the Nottingham University Hospitals NHS Trust performed consistently below the national average from April 2012 to May 2013 and that it did not meet the target of 95% for A&E admissions in less than 4 hours. However, from May to October 2013, the trust performed consistently better than the national average and frequently met the target of 95%. Between September and October 2013, the trust fell slightly below the national average to 92%.

We saw that the trust had carried out lots of work with different external providers such as the East Midlands Ambulance Service and the Clinical Commissioning Group as well as within the hospital, to improve the time in which people were treated within A&E. Commissioners told us that there had been a vast improvement in the trust's A&E performance.

The CQC analysis of Secondary Care in February 2013 rated the trust as 'low risk' for access to secondary care through A&E. It found that the trust scored 'worse than expected' in one question about waiting times in the NHS A&E survey. However, it did perform within expectations for six of the eight questions. The trust performed better than expected compared to other acute trusts for the question around 'first conversation with a doctor or nurse.'

The trust's percentage of patients whose ambulance handover time was greater than 30 minutes was worse than expected. Commissioners told us that performance had improved on this measure recently. Staff told us, and we saw, that when the department became busy patients queued on stretchers in a corridor adjacent to the ambulance handover bay. In this area, facilities were not in place to enable the administration of intravenous medicines or analgesia. Delay in receiving analgesia was identified as an issue in the department's fractured neck of femur results. A staff member told us they were considering a number of actions to address this issue and they had initiated the usage of pre-filled morphine syringes to increase the speed which patients received analgesia.

The A&E department was located close to an out-of-hours GP service run by another provider. We saw that the criteria in place for referring patients to this service were appropriate and would lead to patients receiving prompt care in line with their needs.

We saw that the department had an integrated radiology suite. This had a CT scanner to facilitate a quick response to any diagnostic requirements for patients in A&E.

The trust had a winter plan which had resulted in a small number of extra beds being opened. The trust faced challenges with the staffing of this unit, and staff told us they were concerned about this. We talked with the Director of Nursing, who confirmed that the trust had undertaken a bespoke recruitment exercise and that more staff had been employed for these areas.

Accident and emergency

Patients with diverse needs

Staff explained how they would support people with learning disabilities or autism. They told us that they had specific plans of care in place for people who regularly attended A&E and that they could access support from a specialist learning disability team when required. This meant patients with specific needs received care that was more individualised for them.

We saw staff considering a person's capacity appropriately and discussing actions that would be taken in their best interests. Staff demonstrated a good knowledge of the Mental Capacity Act 2005. This meant staff were checking that patients could use and understand information to make an informed decision.

Before our inspection, one person told us, "I was not treated with respect in A&E." This person had self-harmed and overheard a comment made by a member of staff which was disrespectful. The person went on to tell us, "The comment made my feelings of depression and suicidal ideas worse."

Accessible information

Census data shows that Nottingham had a higher than average proportion of Black, Asian and Minority Ethnic (BAME) residents. In Nottingham 34.6% of people belong to non-white minorities. Of these, Asian Pakistani constitutes the largest ethnic group with 5.5% of the population.

Information was not readily available in a format that all patients could understand. All literature and signs (including signs for emergency treatment) were only in English. Staff told us that English was the first language for most people who attended A&E, but they also said that a significant number of Polish people and other people whose first language was not English used the service. We held a focus group with people whose first language was not English. They told us that the interpreting services at the hospital were very good but that there was a lack of written information in other languages for them to take away.

Are accident and emergency services well-led?

The A&E department at Queen's Medical Centre was well-led.

Leadership

We talked with staff about leadership in the department. We found the team was motivated, and we saw evidence of excellent multidisciplinary working and good communication between all staff. Most staff felt well supported. However, some staff told us that work pressure was leading to significant stress for some of them. We saw that sickness levels for the department were lower than average. However, levels for emergency department assistants were higher than average.

We spoke with nursing staff at a focus group, and they were very positive about the teamwork and the leadership within the department and from the trust executive directors. Executive directors had worked in the department and visited regularly to offer support to staff.

Training and support

The General Medical Council National Training Scheme Survey 2013 found that the trust scored 'similar to expected' in all areas except 'local teaching' where the trust scored 'worse than expected'.

Junior nurses and doctors were positive regarding learning within the department. We also saw that good induction processes were in place for staff joining the department. One member of staff currently on their induction told us, "My induction has been fantastic. I feel so supported and have learnt so much from working in A&E already."

We had mixed feedback from senior nurses regarding their support. Some were positive about the training that was available; some told us that they were not able to participate in team learning as frequently as other team members and that they were often withdrawn from planned training to facilitate service provision.

Accident and emergency

There was 24-hour consultant cover in the department so that advice and support could be accessed when required. Between 2am and 6am a regular locum consultant provided cover. However, there were plans in place to recruit more consultants.

Governance

Our discussion with senior managers showed us that they were aware of the main risks and challenges for the department and that they had identified actions to address these areas. We saw that there had been a wide range of audits and that the trust had taken action in response to them and feedback from patients. Clear clinical governance structures were in place.

A&E was an open and honest learning environment and staff had obvious respect for each other. Learning was directed by using scenarios based on previous incidents that had occurred within the department.

Medical care (including older people's care)

Information about the service

The Acute Medical Services at the trust are provided across two hospital sites and consist of approximately 30 wards/ departments. In 2012/13 the Acute Medicine Directorate provided care and treatment to 106,295 patients and employed over 1,200 whole-time equivalent staff.

At Queen's Medical Centre, we visited:

- The Ambulatory Emergency Care Unit (AECU)
- Clinic 1
- Wards B3, B47,B48,B49,B50,C51,C52,C54,D55, D57, D58, F18,F19,F20
- The discharge lounge.

At Nottingham City Hospital, we visited:

- The Respiratory Admission Unit (RAU)
- Fleming Ward, Southwell Ward, Berman 1, Beeston Ward, Seacole Ward, Newell Ward, Specialist Receiving Unit, Toghill Ward, Fletcher Ward, Patience 1, Nightingale 2
- The Trent Cardiac Centre.

We spoke with patients, relatives and staff. We observed care and treatment and looked at care records. We received comments from the listening events and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

Services for medical care were safe and effective, because there were systems in place to identify, investigate and learn from incidents. Ward staff assessed patients' risk for falls and pressure ulcers and put plans of care in place to reduce these risks. There were processes to identify if patients were deteriorating. We found that although staff were busy, they were available to meet people's needs.

At City Hospital, we saw there was an effective stroke service which was based on evidence-based guidelines. This meant patients had the best chance of a good outcome following a stroke. We also noted the good practice being delivered on the dementia ward at Queen's medical Centre.

The wards/departments were generally well-led.

Are medical care services safe?

Managing risk

It is mandatory for NHS trusts to report all patient safety incidents. An analysis of the trusts reporting revealed that it was reporting incidents as we would expect when compared with other trusts in England. This meant staff were identifying and reporting patient safety incidents appropriately.

We saw 'safety huddles' and 'safety briefs' being used daily on the wards we visited. At Queen's Medical Centre, ward B3 used safety huddles which were consultant led and used a multidisciplinary approach. Junior doctors, a pharmacist, receptionist, nurses and sister in charge took part at 9am every day. The consultant then delivered safety messages of the day. On ward C51 the staff had safety briefs to identify patients who were at risk of falls or pressure ulcers or patients who had an increased early warning score. Staff said that they felt that safety huddles and briefs were beneficial, as they enabled them to discuss patients who were most at risk. Decisions would be made regarding patients' care and treatment. Patients at high risk of falls would be placed in a bay where they could be closely observed. Information was disseminated to staff on the shift and added to the handover sheet for staff coming on duty for the next shift.

Medical care (including older people's care)

The trust was managing patient risks such as falls, pressure ulcers, bloods clots, catheter and urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month. The trust monitored these indicators and displayed information on the ward performance boards.

The trust aimed to reduce all avoidable pressure ulcers. Although it had not achieved this, its performance was consistently improving and the numbers of pressure ulcers had significantly reduced.

An analysis of recent national patient safety alerts indicated that almost half of these notifications concerned pressure ulcers, grade 3 or above. Further analysis from the trust identified that there were twice as many patients developing pressure ulcers (grade 3 or above) at Queen's Medical Centre as at City Hospital. The trust provided a document to show how it had responded to these incidents and the steps it had taken to address this. It told us that it had introduced documents referred to as 'red skins' for patients who were most at risk of developing pressure ulcers. These were colour-coded document packs, which were graded according to risk, green being the lowest and red being the highest. This system provided all staff (including new, temporary or agency staff) with a visual sign to indicate whether the person needed extra help to prevent pressure ulcers.

There was a very robust approach towards preventing and managing pressure ulcers on all of the wards we inspected and the trust used a document for people who were at risk of developing pressure ulcers called a 'Sskinn Bundle' (surface, skin assessment, keep moving, incontinence, nutrition). The documentation had high, medium or low risk categories. We looked at the records in respect of people with pressure ulcers on all of the wards we inspected. We found them to be up to date and fully and comprehensively completed. Equipment was in place to maintain patient's skin integrity, and staff we spoke with told us this equipment was readily available on request. Senior nurses reported that the tissue viability nurse provided specialist support and advice when needed.

We spoke with a patient who had pressure ulcers. The patient was aware they had pressure ulcers and knew what steps staff had to take to treat them. The patient told us, "They have to turn me, as I have sores; they are very caring when they do it."

There was a considered approach to the use of bed rails on one ward. The ward manager told us that staff assessed the need daily in consultation with patients. They said that they would not use rails if a patient's understanding and awareness was compromised, due to the risk of them climbing over the rails and sustaining a more serious injury.

We spoke with a patient who had fallen recently. They told us they could not recall how the fall had occurred, but they were at pains to point out that staff were not at fault. The patient told us, "They really checked me over well. They asked if I wanted pain relief."

With the exception of one ward, all of the wards we inspected were clear of clutter and equipment to ensure the risk of falls was minimised. This evidence indicated the actions the trust had taken had become part of everyday practice and that staff took action where possible to reduce the risk of patients falling.

We raised our concerns about the clutter on one of the wards. We returned to this ward on two separate occasions, including at our out of hours unannounced visit and we found that the clutter had been removed.

Staffing levels

Staff on most of the medical wards felt that staffing levels were sufficient to allow them to provide safe care to patients. They all recognised the importance of safe staffing and the impact it had on providing care. The safe staffing tool was actively being used in areas visited and we found staffing levels were in accordance with the required levels. The trust demonstrated transparency and good practice by displaying the funded whole time equivalents on each ward/area and any vacant posts. The ratio of qualified staff to patients on duty was also on display. We saw that staff on the wards were busy but kind, caring and respectful.

One patient told us, "If I press my buzzer at night, the staff can take time to answer but it is ok in the daytime."

Medical care (including older people's care)

One member of staff told us, "It's the staffing levels that have allowed us to give a good level of care."

All new healthcare assistants received a three-week induction and attended a skills academy as part of this. This induction had been extremely well received and the feedback from it was exceptional. The trust was supporting existing healthcare assistants to undertake this as well, which we considered to be good practice.

Hospital at night

Information provided by the trust told us that the hospital at night team provided a clinically driven and patient focused acute service which used a multi-professional and multi-agency approach to care. The service was available for adult patients across the trust in the majority of acute services. Hospital at night ran from 5pm to 9am Monday to Thursday and 5pm Friday to 9am Monday for weekends. On the City Hospital site for acute medicine, the hospital at night team consisted of four junior doctors and one specialist registrar. The hospital at night team triaged referrals using the early warning score and the situation, background, assessment and recommendation tool to provide clinical advice. The service was supported by an electronic 'smart board' system called the nerve centre. It enabled the wards to make electronic non-urgent referrals directly to the doctor. This meant there was a simple system which incorporated an audit trail. This system assisted the trust with ward root cause analysis and incident reporting, because it allowed the trust to look at ward work levels and identify problem areas. We observed the hospital at night handover at the end of a night shift, and we found that all the jobs were completed and feedback was given to the individual doctors about activity overnight. Doctors and nurses expressed satisfaction with the system.

Safeguarding

Staff had an understanding of how to protect patients from abuse. The trust had undertaken a safeguarding of vulnerable patients benchmarking initiative in November and December 2012. This was an annual benchmarking process against set criteria. For the general adult benchmark, the key changes were to assess whether staff were aware of indicators of abuse and whether they were able to demonstrate how to assess a patient's mental capacity. Wards and clinics were awarded gold, green, amber or red status. Year on year analysis showed significant improvements in the scores, indicating that the trust's actions to ensure staff had the knowledge to safeguard adults appropriately were having an effect. Over 50% of wards achieved gold or green status.

The trust had analysed the reasons why some areas had achieved lower benchmarking scores, and it had discovered that scores were related to whether staff attended relevant training. The trust had set out actions to address this. Only two wards were given red status, and they received direct support from the safeguarding lead, after which they had been re-scored and achieved amber status. The use of benchmarking provided the trust with an overview of their employees' understanding of safeguarding and their roles and responsibilities in protecting vulnerable patients.

The patients we spoke with told us they felt safe at the hospital and on the wards they were on. One patient commented, "I feel in safe hands. I have no concerns about any of the staff. I would say if I did but I don't. I feel safe in every way, physically and emotionally."

Are medical care services effective?

Effective care

We saw the Hyper acute stroke unit which provided care for patients who had a suspected or confirmed stroke. It admitted patients directly from home and provided 24 hour, seven days a week thrombolysis. Calls were triaged via phone and patients were admitted directly to the ward. The out of hours thrombolysis service was co-ordinated by the band 6 nurse practitioner, who liaised with the on-call consultant via the telemedicine unit. Patients who were taken directly to the stroke unit avoided any unnecessary delays in treatment. The rehabilitation wards had an effective stroke multidisciplinary team that was patient centred. This meant patients who had suffered a stroke had the best chance of a good outcome.

The Respiratory Admission Unit (RAU) had a clear admissions protocol which included a pink card system given to patients with long term respiratory problems. The pink card enabled the patients to be seen by a healthcare professional and to be admitted direct to the RAU. This meant they could be seen by a respiratory consultant on arrival. The RAU worked closely with the community respiratory team which also saw respiratory patients and referred directly to the unit. This meant patients with long-

term respiratory conditions received effective care that was responsive to their needs.

We saw there were advanced nurse practitioners working on the Cardiac Coronary Care Unit. These nurses were competent to assess patients on their arrival, determine diagnosis and initial treatment, prescribe medication, request x-rays, blood tests and specialist scans, refer for specialist opinion, and determine whether the patient needed to be admitted to hospital.

Managing deteriorating patients

The trust used an early warning score tool which was designed to identify patients whose condition was deteriorating. The tool was designed to be more sensitive to physiological changes in the patient's condition and alerted staff by the use of a trigger score. Staff could then call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that this tool was in use and staff understood how to use it.

The trust monitored the use of this tool and reported on it every month. A nurse educator team worked with nursing and medical staff to ensure that staff understood the escalation process.

Storage and management of patient records

Patient records were kept securely and could be located promptly when needed. Most patient records we looked at were accurate and fit for purpose.

Collaborative, multidisciplinary working

The Cardiology Head of Service outlined an example of collaborative working across different specialties. This was the introduction of a renal denervation service. This was a new procedure for treating high blood pressure that is resistant to conventional therapy with multiple medications. It required collaboration with several different specialties, and the service was able to outline a well thought-out service model.

Another example of collaborative working across the different specialities was the stroke service. We observed effective and collaborative multidisciplinary working. For example, in a patient family meeting the service looked at individualised care the patient required. Staff included the patient and their relatives in complex discharge planning arrangements.

Monitoring performance

The trust had identified a problem in the system for allocating patients for coronary artery bypass graft (CABG) surgery. The multidisciplinary team (MDT) reviewed patients and allocated them to a pooled list for surgery. If the surgeon who was then assigned the patient was not at the MDT meeting and did not agree the surgery should take place, the surgeon could refuse to operate. There had been no monitoring of this, which meant that the trust was not tracking outcomes for patients. We found that the trust was fully aware of the issue and had taken action to change the process. The MDT was recording the decision-making process so that the trust could track and monitor decisions. We asked one of our professional medical advisors to review this, as we were aware there was a mortality outlier alert in place for CABG (this means that the incidence of deaths for CABG was higher than expected). On review of the evidence, we were satisfied that the cardiology service recognised the problem and was working effectively towards improvements.

The cardiac catheter laboratory was actively monitoring its performance through the use of performance matrices. For example, it monitored its call to balloon time, which is the time from when a call is received to the time procedure commences. It also monitored its door to balloon, time which is the time from the patient arriving in the emergency department to the time when the procedure commences. This meant there were systems in place to monitor the effectiveness of the treatment being provided.

Movement of patients to other wards

There are occasions in hospitals when patients have to move wards. This is usually due to pressure on beds. Nottingham City Hospital had to move patients, but it attempted to move them at reasonable times. We found that there was some confusion among staff about when patients could be moved. On one ward a member of staff told us, "We do not move patients after 11pm, and if a move is done after that time the reason will be documented. We also avoid moving patients at protected mealtimes." Another ward told us that bed moves did not happen after 9pm, but staff were unsure whether the trust had a policy for patient movement.

On the respiratory ward, three patients had been moved to another ward which was not under the speciality for their medical condition. The patients were highlighted

Medical care (including older people's care)

on a board so that the medical team could see who they needed to review on a different ward. This meant there was a system in place to ensure that patients who were moved onto another ward remained under the care of the appropriate medical team.

Winter planning

Nottingham City Hospital had plans in place to open 12 extra beds on the Specialist Receiving Unit for respiratory patients. A senior member of staff told us, "This outlying ward will be used for patients who are having antibiotics for a long period of time or for patients who have complex care needs prior to discharge." Extra medical cover for this area had also been provided. The protocol for movement of patients to this area was robust, and only patients who had all their discharge documentation or were still on intravenous antibiotics could be moved to these beds. The medical team would make the decision to move patients to this area, as the beds did not have piped oxygen.

Care plan audits

On one ward we went to we were told that the trust had carried out 'releasing time to care audits'. Ten sets of patient notes were audited on a weekly basis. The audit looked at the documentation of pressure area care, catheter care, cannula care and was checked and documented on the trust's reporting system. The results were then discussed at the monthly team meetings so that staff could learn from the results. This meant that there were processes in place to monitor the effectiveness of the care being delivered.

Are medical care services caring?

Patient feedback

The majority of patients and visitors we spoke to told us that they felt well cared for and that staff were kind and caring. One patient told us, "In the City [hospital] there are brilliant caring staff." Another patient told us, "I rang my bell for a lady opposite, and the staff came immediately." Another patient told us, "The staff are patient focused, one was kind and knelt down to talk to me and was very patient."

One patient told us that they felt that staff had not treated them with respect, as a doctor had made them feel guilty for raising a concern about not getting their procedure on two occasions, due to emergency patients taking priority.

There were feedback boards on each of the wards which encouraged patients to write about the care they received. Comments included: "Nurses wonderful, made me feel happy"; "Very impressed. Thank you"; "Excellent accommodation and staff"; "Very attentive staff with excellent bedside manners"; and "Great service. Everyone is caring".

A comment on the NHS choices website on 3 October 2013 said, "Having been admitted twice in the last two weeks I cannot stress the care and kindness shown to me both on admittance to Berman 2 and also transfer to Southwell Ward. Nothing was too much trouble and the care was unbelievable."

Interactions with patients and relatives

We heard staff talking to patients in a kind and caring manner. On one ward, we saw relatives seeking information from staff. Staff gave a clear and understandable explanation to the question asked. On another ward, we found the medical staff responded well to questions asked by a patient. They gave options for future care, for example by discussing dressing options for the district nurse and self-treatment for future infections.

On the stroke ward, we observed a consultant ward round. We found the staff were caring and compassionate.

Care planning

Staff planned and provided care in a way that took into account the wishes of the patient. We saw staff gaining verbal consent when helping a patient to change position in bed. Staff were very patient and allowed the patient time to move in their own time.

Are medical care services responsive to people's needs?

Ward environment

Ward environments were appropriate for patients. All wards had single-sex accommodation, either in bays or side rooms so that staff could care for patients with more complex needs appropriately. For example, patients who were at high risk of falls were brought together into a single-sex bay where extra staff would be on duty to maintain the safety of the patients. One ward used two bays directly opposite the nursing station, in full vision of the nursing teams, and extra staff were used if patients had a high risk of falls.

Medical care (including older people's care)

On the ward for infectious diseases, we saw that staff had kept one bay for seeing patients who required a dressing change. This meant that the risk of spreading infection was reduced.

On one of the haematology wards, the trust had built two cancer adolescent rooms with charitable funds and in liaison with the Teenage Cancer Trust.

Responding to patient feedback

We identified some best practice on Patience 1 Ward at City Hospital. Staff had encouraged patients who attended clinic regularly for dressing changes to form a user group for mutual support and transport to clinics. This had led to a request for a Saturday morning outpatients clinic, which had been established and was well attended. This significantly reduced the pressure on the ward weekday clinics. Staff indicated they were also happy with the arrangement, as it allowed more time to support and care for the outpatient attenders, and enabled them to monitor patients more closely. The ward sister told us that this had resulted in a lower number of return admissions from this group of patients.

Mealtimes

The trust had a 'Mealtimes Matter' initiative, which was a nutrition campaign that included protected mealtimes. This was a period over lunch and supper when all activities on the wards stopped, if it was safe for them to do so. This prevented unnecessary interruptions to mealtimes. Nurses, catering staff and volunteers were available to help serve food and assistance was given to those patients who needed help. We saw signs outside the ward announcing the initiative, and we observed protected mealtimes on two wards. We saw patients receive their meals in a timely manner, and staff sat by patients and engaged with them while helping them.

Care for patients with dementia

B47 is a ward for older people that demonstrated best practice. It had recruited additional staff with training in mental health and had multi-professional teams. It offered holistic care and had adopted a proactive approach to communicating with patients and carers. The ward environment was adapted to meet the needs of the patients. It had clear signs, had been decluttered and had reduced noise levels. There was an About Me document, which was completed by the patient's carer at admission and recorded information about their life, likes, dislikes and interests. This enabled health and social care professionals to see the person as an individual and deliver person-centred care that was tailored specifically to the person's needs. The trust was featured in a national newspaper in 2013 and was praised for providing excellent dementia and nursing care. It had also been nominated for a national dementia award.

Before our inspection, we received information about the care of patients with dementia. While we recognise the excellent care given on ward B47, patients with dementia are increasingly found on all wards within hospitals. We found that most wards (with the exception of B47) staff told us they were not able to give the level of care they wanted to for patients with dementia.

Patients with additional needs

The trust had set up the Learning Disability Acute Liaison Team in partnership with Nottinghamshire Healthcare NHS Trust (which is the local mental health trust). This team aimed to improve healthcare for patients with learning disabilities and to support staff treating them. Staff told us that the wards within the trust did not have learning disability champions but that safeguarding vulnerable adults champions provided necessary information.

Ward D57 used a programme called the Hospital Threshold Comprehensive Assessment for Frail Older people, which consisted of a rapid geriatric assessment on admission to an acute hospital. It was being run by the community programme with the aim of improving patient experience. We saw the Community Comprehensive Geriatric Assessment Team (CGA) on the ward. The team had a multidisciplinary approach to assessing and treating frail older people. It used an holistic assessment to set out a plan for treatment, rehabilitation and long-term support. The ward manager told us, "Having the CGA team to focus on the frail older people on the ward, help us to plan their care and assist with discharge planning is great." We considered this to be good practice.

Medical care (including older people's care)

Are medical care services well-led?

Visibility of senior management

Staff told us that senior management were visible. Most senior staff were able to tell us when the Chief Executive and Director of Nursing did a walk round the wards and what a positive experience it was. On all of the wards we visited, we saw that the matron and/or ward sister were visible. We found the ward sisters to be very approachable, and they made us feel very welcome.

Ward rounds

Every morning the board round was attended by the multidisciplinary team, with a registrar or a consultant in attendance as a senior decision-maker. This allowed clinical problems or potential delays to be highlighted and addressed promptly. One doctor told us, "Board rounds are an accepted part of our daily work."

Staff feedback

A member of staff told us, "It is a really good trust to work in. The emphasis is patient care." A student nurse told us, "This ward is well managed and I would like a job on here." On another ward a student nurse told us, "I felt part of the team, and the ward was friendly and welcoming." A member of staff on the same ward told us, "Positive changes have happened on the ward. There are better staff to patient ratios and there is good morale on the ward."

Appraisals

The trust told us that all appraisals needed to be completed by the end of December 2013. On one ward we visited we saw that 75% of staff had had appraisals. The trust had a training database to alert the ward manager when appraisals were due. One member of staff told us they felt the appraisal process was good and they received good feedback.

At a focus group with nursing staff, everyone said that issues raised in their appraisals were acted on and not passed onto the next year.

Surgery

Information about the service

The acute surgical service at Nottingham University Hospital includes 25 wards and has 48 operating theatres across both of its main hospital sites.

The trust provides a major trauma service to Nottingham and the neighbouring counties of Lincolnshire and Derbyshire, and it has a dedicated major trauma unit and ward. We inspected the acute surgical service, including operating theatres. We visited 21 wards and departments. We spoke with patients and relatives as well as staff from a range of different roles. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

The trust met all the standards. We found that services for acute surgery, including operating theatres, were safe and effective because the trust had provided good staffing levels, a strong skill mix and had encouraged proactive teamwork. There were well developed arrangements to implement good practice and learning from any untoward incidents. The trust supported staff to undertake advance training and education. Patients told us that staff were caring and supportive. Staff asked patients for their consent, and all consent forms were signed by a consultant before procedures. People's views were taken into account in improving services.

Are surgery services safe?

Staffing arrangements

Staffing levels were set to meet the needs of patients. We saw that there were few vacancies, and staff told us there were well experienced staff working in all areas we visited. On wards where some patients were frail and elderly, staff cared for them in an area designated to high levels of observation, to reduce the risk of falls. Staff in operating theatres told us that safe staffing levels were ensured prior to commencing operating lists. Theatre staff took appropriate care to prepare the anaesthetic and operating rooms with equipment required for specific operations. This meant that staff provided safe care at appropriate times. In all specialties, we asked about the senior medical cover and found that there were adequate arrangements for on-call attendance by consultants. In some cases, the cover was from the other site in the city, but this was occasional (for example with burns specialists), and medical staff were available on site. Teams undertook safety huddles on wards and in theatres at the start of shifts to discuss possible solutions to any potential safety concerns or issues.

Cleanliness

Clinical areas, including operating theatres, were in older buildings which were well maintained. Floor areas were in good condition, and staff told us that cleaning staff undertook a deep clean every week. This was important, as some patients may be at risk of infection due to their age or because they had undergone major surgery. This was also the case in operating theatres, where clinical staff and cleaning staff maintained a high level of cleanliness. Hand sanitizers were available outside the wards, bays and side rooms. All those that we used were filled and working. We found that hygiene audits completed in theatres showed 100 per cent compliance for the previous month.

Risk of harm

In patient records, we saw that staff had documented risk assessments to identify potential problems such as venous thromboembolism (VTE), falls and pressure ulcers. They had also listed care that staff needed to provide. Incidents were recorded and the trust analysed them to identify causes and trends in or across clinical areas. There was good management overview of this analysis so that lessons learnt were cascaded to all relevant teams. In particular, there were good systems for recording the risk of, and analysing the causes of, blood clots, which are a major risk for people having surgery. In one orthopaedic ward, the electronic record showed that all patients had a valid current VTE risk assessment recorded. Staff told us that this risk assessment was usually recalculated each week. We saw that the World Health Organization safer surgery checklist was adopted by each operating theatre, which meant that staff were carrying out recognised safety checks for each patient.

Surgery

There had been two never events at the trust in 2013. Never events are mistakes that are so serious they should never happen. Both of these involved surgical errors. We saw the trust had investigated these never events, identified the root cause and implemented changes to practice to prevent them happening again. We found there was good quality monitoring and learning taking place in the operating theatres.

Environment and equipment

All equipment that we examined in operating theatres was in good working order and appropriately maintained. We examined records that showed resuscitation trolleys in different areas of the operating theatres were checked regularly.

Are surgery services effective?

Teamwork

We found that multidisciplinary teams communicated and worked well together to ensure coordinated care for patients. Elderly care specialists worked alongside surgical services to undertake detailed pre-assessment of the frail elderly to ensure patients had the best preparation for any operation. Patients and families in the burns unit were supported by a multidisciplinary team that included counsellors and clinical psychologists. On the short stay surgical unit, nurses could discharge patients, following clear protocols and policies which meant they did not have to wait for medical staff to attend.

Staff in operating theatres told us they were well supported by managers. There was good analysis and learning from incidents. Senior clinical staff from City Hospital met with counterparts from Queen's Medical Centre to share experience of practice and learn lessons from each other. Displays of information throughout operating theatres reminded staff of any changes in policy and practice.

Ward teams worked well together. One ward was taking part in a project supported by external consultants to develop a strong teamwork culture to improve the service. Other wards had been recognised with an award by the trust as providing a good service due the effort of the team.

Performance information

Wards displayed information for patients and visitors showing staff levels and the incidence of any falls or pressure ulcers in the last month. Pressure ulcers and falls are an indicator of the quality of care. We saw that in all areas of surgery there was a low incidence, showing that patient care was effective in reducing falls and protecting patient's skin. This was the case even in areas where frail elderly people were being cared for, such as in the orthopaedic wards.

Are surgery services caring?

What patients told us

We saw that patients were well cared for in surgical wards. We spoke with nine patients and three relatives on seven wards. Patients and relatives told us they were very satisfied with the service. In many clinical areas we saw display boards with patient feedback. In two areas, nobody had raised a complaint in the past 12 months. One patient told us, "The nurses are very caring and supportive. They are busy." One family told us that they were extremely appreciative of the care for their relative, which they said had accommodated specific cultural needs.

Patients on surgical wards told us that they had been given a clear explanation of their surgical procedure. They said that before they had signed their consent form, staff had explained their treatment and care. In the records we examined, we saw that staff had clearly documented discussions about consent. We saw that consent was checked during different treatment stages.

We saw that staff made patients preparing for their surgery in the operating theatres comfortable, and they reassured them and explained procedures to them. Staff in theatres spoke with children kindly as they checked their comfort and condition.

Before our inspection, we received many positive comments about the surgical services from patients. One person said, "I was impressed by the bedside manner of all of the staff (doctors and nurses). I was well informed about my operation and I felt comfortable asking questions."

Surgery

Are surgery services responsive to people's needs?

Pre-operative assessment

We visited three pre-assessment clinics at the Nottingham City Hospital site. They were staffed with experienced nurses who knew the specialty that they were supporting. Medical and allied health professional staff also formed part of the team completing the pre-assessment of patients. Some patients came to the clinic directly from outpatients department, which meant they had their decision about surgery, and the advice support and checks they needed prior to surgery all on the same visit to the hospital. Patients were advised about this possibility in letters inviting them to their outpatient appointment. Staff in these clinics were able to take blood and complete other tests to provide a comprehensive check prior to surgery. The pre-assessment clinics were in older buildings, but staff had helped design patient areas to promote dignity, privacy and comfort during what could be a few hours of assessment. There were partitions in open areas, and double sized bays were used so that patients were not too close together.

Elderly patients for orthopaedic, cardiac or spinal surgery who were particularly frail or at risk were referred to a specialist clinic. At this clinic, staff could assess their complex needs during the weeks that they were waiting for their operation. This meant that frail elderly people were given additional guidance and rehabilitation to prepare for their operation. Staff told us that one patient who was immobile benefited so much from their preparation that they decided they did not require the surgery on their limbs.

Care of people with dementia

We found that the trust had supported staff in developing skills for caring for people with dementia who may be admitted to surgical services. All staff were able to explain the implications of the Mental Capacity Act and how they would make decisions in the best interests of a patient. Ward and department teams had dementia link nurses to provide guidance to other staff and communicate between teams about new developments. Staff had developed a video training tool to explain to staff how to support people who may be confused.

Elective orthopaedic surgery

The trust had invested in the move of all elective surgery to the Nottingham City Hospital site in February 2013. This move was supported by a trust project within the 'Better For You' programme. This meant that staff and patients were involved in the planning to promote a smooth transition and an effective service. We asked three patients in ward areas about this, they told us they had a pre-assessment which helped them understand and prepare for surgery. One patient said that staff were "knowledgeable and [they] explained everything." We saw that in one ward there were patients who were 'medical outliers'. This means they were being treated by staff from another speciality. This means they were cared for on a ward which was a different speciality. One of these patients told us that they were being looked after by their medical team and that their doctors had visited every day.

Interpreting services

One person told us they had experienced difficulties getting timely access to a British Sign Language Interpreter. The person told us, "Sometimes the doctors would come when the interpreter had not arrived and would try and communicate with me without an interpreter. Can you imagine trying to communicate with a person and not being able to hear or understand what they are saying?"

Patients who needed language interpreters told us the service was good.

Are surgery services well-led?

Surgical services were well-led.

Management arrangements

Surgical services had good arrangements to recognise problems and make improvements to protect patient's health and welfare. Staff told us they audited the quality of clinical records. We examined patient records in ward and theatre areas. Risk assessments were completed and plans included records of patient consent to treatment and agreement with other decisions about care. This meant that management arrangements were directed at promoting good quality of care.

Surgery

Clinical teams

Teams in operating theatres worked well together and with other departments. There was good organisation and arrangements to deal with unforeseen emergencies. Anaesthetic staff were available to provide support across operating theatres. Performance information was displayed throughout operating theatres.

Improving efficiency and safety

There was effective learning from incidents. The operating theatre teams at Nottingham City hospital worked with the team at Queens Medical Centre to improve quality and effectiveness of care. There were screens displaying safety information and learning from incidents in operating theatres across both hospital sites of the trust. Staff told us that communication was good in operating theatres and that issues and improvements in safety were shared across all teams. There were regular meetings to enable monitoring and the discussion of safety improvements. This effective governance system across both sites meant that the care of people in the perioperative period was safer and more efficient.

Intensive/critical care

Information about the service

We inspected intensive and critical care services across the trust. We visited the adult intensive care and cardiac intensive care departments. We spoke with patients and relatives as well as staff from a range of different roles. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed performance data for the trust.

Summary of findings

The provider met all standards. We found that the effective systems of management and clinical improvement we saw at the Queens Medical Centre were in also place or shared at the City Hospital site. There were robust systems of incident analysis and learning to improve care. Staff provided safe and effective care, as they worked well as teams and made appropriate risk assessments to support care planning. Patients told us care was good, and the trust had taken into account patient and relative viewpoints in improving the service.

Are intensive/critical services safe?

Learning from incidents

We saw that there were robust systems in place to learn from incidents. We saw that staff and departments were open about discussing and learning from incidents. There were clear arrangements for recording and reporting untoward incidents. The trust included staff in root cause analysis of the reports, and staff took ownership of the process by developing plans to reduce the possibility of recurrence. We saw that departments had changed practice in the management of arterial lines following learning from an incident in another department. This meant that safety was continually being improved.

Facilities

Patients had the benefit of overhead hoist systems, which meant that if they were immobile or weak staff could lift and move them safely and efficiently. The hoist also allowed staff to monitor the weight of patients, which is important for accurate drug administration and nutrition monitoring. We saw that in some areas controlled drugs were held in ward storage that was electronically monitored. The storage had personal identification security systems and daily automatic checking. This meant that drugs were stored safely and securely.

Capacity

There were a total of 77 critical care beds across the trust. The bed occupancy rate for the trust was 95.1% between April and June 2013; this was higher than the national average of 83%. This meant that critical care beds were in use most of the time.

Staffing

We spoke with staff in critical and intensive care departments. One of the departments was newly opened, and we found that the trust had recruited staff with appropriate skills and that experienced staff were managing the unit. Staff told us that they rotated with intensive care to gain experience in caring for critically ill patients. They showed us their accountability handover sheet, which they used alongside clinical records to communicate the needs of patients. This meant that staff were aware of their patients' needs. In most departments there were staff available as 'runners' to support those staff who were providing one-to-one care to critically ill patients. There were certain staff with specific responsibilities or interests, such as infection control or end of life care.

Services were staffed appropriately to ensure safe care for critically ill people. Staff told us that they had closed a bed temporarily on one unit because they had a patient who required very intensive support and the staff would not be able to provide safe care for any further patients. This meant that safety was the priority for the unit. There was one trained nurse for every patient who was assessed to be at level 3 and one trained nurse for two patients for those assessed at level 2. This meant patients were being cared for in accordance with national guidelines for critical care.

Intensive/critical care

We saw that there were systems to ensure that senior intensive care medical expertise was available to the critical care areas at all times. This is important because patients' conditions can deteriorate very rapidly. We saw that physiotherapy specialist support was available to patients seven days a week, which meant that patients received the optimal support to make progress.

Critical care outreach

The Intensive Care Unit was the base for a critical care outreach team which was able to provide expert advice to help ward staff manage patients whose conditions had deteriorated in the ward areas. This team provided support to 8,000 patients every year. The team was able to educate other staff in managing critically ill patients and also monitor trends in problems. It had identified that fluid management was often a contributing factor in patients becoming ill. The team was multi-professional and had specialist critical care skills. The team worked seven days a week from 8am until 10pm. Overnight deteriorating patients were managed by the hospital at night team. A ward nurse told us, "It's good to have the critical care outreach team. They support us if we have someone going off and deteriorating. I have learnt from them, and it makes me feel safer when they arrive."

Specialist training

Nursing staff had education and training to undertake additional roles, which allowed prompt action or more efficient working. In cardiac intensive care, some nursing staff were trained and were competent to undo patients' chest closures after surgery. They carried out this procedure if access to a patient's open chest was required in an emergency.

There was a good induction package for new nurses to the departments. Nurses told us they felt extremely well supported and had lots of opportunities for ongoing professional development and supervision.

The service ensured that it was clear which medical staff were accountable for the care of specific patients who had major trauma with complex patterns of injury.

Infection prevention and control

The trust's rates for healthcare acquired infections such as MRSA and Clostridium difficile were within an acceptable range, suggesting that infection control policies were in place and followed in practice. The trust provided evidence of the systems it had in place to reduce the infections. These included weekly clinical case reviews by the infection prevention and control doctor, checks to see if cross infection was a factor and a rigorous approach to hand hygiene. These steps had resulted in a significant reduction in healthcare acquired infections over a five-year period.

Are intensive/critical services effective?

Specialist staff

There were common management and clinical leadership arrangements across the trust's two main sites. Staffing levels and systems to maintain staff competency meant that effective care was provided on both sites. At City Hospital, we found that staff in the specialist intensive and critical care units were very experienced and were supported to develop their skills to provide high level support to very ill patients. Advanced nurse practitioners were able to undertake routine and emergency procedures as part of the multidisciplinary team to ensure patients received timely treatment and care.

Teamwork

We saw that staff had improved their handover paperwork and processes between shifts to ensure that relevant information about patients was passed on. There were systems to ensure senior intensive care medical expertise was available to the critical care areas at all times. Staff were well trained, and there were clear systems in place for contacting specialist surgeons or anaesthetists, including out of hours. For patients who needed emergency airway management, advanced nurse practitioners had specialist skills to manage people's airways until an anaesthetist could support them.

Nursing staff had education and training to undertake additional roles, which allowed prompt action when required and more efficient working. In cardiac intensive care, advanced nurse practitioners were able to undo chest closures after surgery, if access to the heart was required in an emergency.

Audit data

The trust contributed data to the Intensive Care National Audit and Research Centre (ICNARC) audit, which aims to improve critical care across the UK. The trust's results from

Intensive/critical care

this audit were outstanding and revealed that standardised mortality rates were much better than expected. The trust had between 82 and 94 more patients survive than expected. Graphical comparison with other similar critical care units shows good comparative performance. The standardised mortality rate for the critical care units across the trust was 83 for the year June 2011 to July 2012. A score of 100 is average mortality and a score less than 100 is better than average. This meant that the critical care units were providing effective care.

There had been significant improvement in the management of patients who had or were at risk of getting a serious infection because of their critical condition. The trust agreed with commissioners of the services targets for improvement of quality and clinical outcomes developed through research and clinical audit. Over a period of seven years, the clinical staff had carefully audited practice and outcomes and were able to predict infection complications and treat patients earlier and in a more effective way. The specific treatment protocols for infection and the methods of this quality improvement were being cascaded to other patient services in the trust. The service had other monitoring processes and projects such as the management of ventilated patients and review of emergency cases. There was a culture of learning from incidents that was supported by clear accountability and processes to record and cascade learning. This meant there was effective planning of service improvement.

Are intensive/critical services caring?

We had no concerns about the care being provided in the critical care units.

Patient care

Patients in intensive care departments told us that care was good. We saw that critical care areas were clean and well organised and that patients looked comfortable. We received no negative comments about the care received on the critical care units.

Support for patients

We examined patient's records and saw that they carried risk assessments that included dietary needs, pain control, pressure sores and the patient's pre-assessment, if they had had surgery. We saw that critical care staff used a booklet specifically designed to prompt appropriate risk assessment for the type of very ill patients they cared for. This meant that staff assessed patients' needs and managed major risks. We saw that patients received good nutritional support, including when they could not eat normally because of their condition.

Are intensive/critical services responsive to people's needs?

Patient views

Clinical areas had displays of information that included complaints and comments from the previous month and explanations of how the trust had taken into account patient views when improving the service. Staff told us they had revised visiting times in response to family's views and had improved their identification badge and neck lanyards so that it was clear to patients and visitors who the different members of staff were.

Capacity

The trust had invested in a larger high-dependency unit with 20 beds. It told us that more beds were planned. There had also been investment in the major trauma ward, which allowed for more effective care of people with multiple injuries. Staff told us that medical specialties worked well together to ensure rapid and appropriate care for people with major trauma. This meant that the trust had developed facilities and was continuing to plan improvements in capacity so that people could receive appropriate trauma and critical care.

Intensive/critical care

Are intensive/critical services well-led?

Clinical leadership

Critical care services were well-led by managers and senior clinical staff working together. Services had a strong focus on continuous quality improvement. There was strong leadership and clear management to improve and develop a range of services that included critical care departments, trauma services and pain management. Managers told us that the trust board provided strong support for the development and improvement of these specialist care services.

There had been significant improvement in the management of patients who had or were at risk of getting a serious infection because of their critical condition. Targets for improvement of quality and clinical outcomes developed through research and clinical audit were agreed with commissioners of the services. Over seven years, the clinical staff had carefully audited practice and outcomes and were able to predict infection complications and treat patients earlier and in a more effective way. The specific treatment protocols for infection, and the methods of this quality improvement, were being cascaded to other patient services in the trust. The service had other monitoring processes and projects such as the management of ventilated patients and review of emergency cases. There was a culture of learning from incidents that was supported by clear accountability and processes to record and cascade the learning. This meant there was effective planning of service improvement. There was a clear visual display on the unit of safety information and performance against improvement targets. Senior clinicians were using innovative ways to communicate with staff, such as the use of a blog.

Senior medical staff told us that they were well informed by staff and systems in critical care units about the performance of the teams and patient condition and outcomes. They were proud of the improvements in the management of infection risk. They considered the sepsis care pathways they had developed to be clear, and they believed that the pathways were responsible for improving the effectiveness of care. They told us that discussions about current and previous cases (including critical care and emergency surgery cases) provided feedback to help the teams improve the service.

Clinical teams

Staff in clinical areas took responsibility for improving the quality of service. Staff told us that every two weeks they checked that the documentation of risk assessments for pressure ulcers, blood clots and infections were being completed. They said that they reviewed research findings to improve quality, and one team said they had improved their awareness of respecting critical care patients' dignity and independence. In critical care areas, staff had monthly meetings to review the effectiveness of care. They reviewed past cases and checked patient outcomes and survival rates. Where patients had died as a result of their condition, another doctor reviewed their case to check that care was appropriate and identify lessons to be learned. This meant the service used audits and reviews of clinical practice to improve the quality of patient care.

Maternity and family planning

Information about the service

The trust had a single maternity service with maternity units located on both hospital campuses. In addition, the trust also provided community midwifery services. Both sites had labour suites, operating theatres, antenatal, intrapartum and postnatal care wards. Both sites also had a neonatal unit. There were more than 10,000 deliveries a year across the trust.

During our inspection we visited the labour suites, antenatal clinic, antenatal and postnatal wards, the fetal maternal care unit and the neonatal units. We spoke with patients and relatives as well as staff from a range of different roles. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

Maternity care was generally safe and effective. Feedback from patients and relatives was mostly positive, but a recent national maternity survey suggested that in some areas care was worse than expected.

The service delivered care to patients in line with their needs and had responded to identified areas of improvement related to the delivery of care and treatment. The service provided a multidisciplinary approach to the provision of professional, supportive and sensitive care to patients.

However, staff had not always appropriately followed and managed procedures for management of medicines and the prevention and control of infection.

Are maternity and family planning services safe?

Patient safety

Staff were aware of the trust's incident reporting system and used the online system to report incidents. Maternity clinical governance staff told us that nominated individuals investigated and reviewed reported incidents. The department acknowledged that it had not fully completed the review and investigation process for many incidents. We were told that the maternity clinical governance team had recently recruited more staff and was taking action to address the backlog of reported incidents on the incident reporting system. This meant the trust had responded to difficulties with the system but the back log in the review and investigation of incidents meant there was a risk that staff were not learning from what had happened to prevent it reoccurring. We saw an example of a change that the service had made following an investigation into a patient safety incident.

Staffing establishment and skill mix

The maternity service used a dashboard to monitor and review key performance indicators within the service. The dashboard showed that City Hospital had a ratio of midwives to patients of 1:29.5, which was slightly above the standard rate of 1:28. We also noted that the ratio of supervisors to midwives was 1:14, which was within the national standard ratio. This meant there were slightly more midwives to patients than the national standard. At Queen's Medical Centre the ratio of midwives to patients was 1:29.5. This was slightly above the standard rate of 1:28. This meant there were slightly fewer midwives to patients compared to national standards. We also noted that the ratio of supervisors of midwives to midwives was 1:14, which was within the national standard ratio.

The maternity service senior management team confirmed that it had recruited 20 new midwives across both City Hospital and Queen's Medical Centre, and these midwives were due to start work soon. This meant that the trust had taken action to address the midwife to patient ratio for the trust's maternity services across both sites.

However, staff we spoke with raised concerns with us that the staffing skill mix and levels might not be appropriate. This was because the recruitment of new midwives was for Band 5 roles, which they felt might not provide adequate skills coverage.

We looked at medical cover arrangements for the neonatal Units at both City hospital and Queen's Medical Centre. The units were both covered by a separate consultant out of hours, but there were occasions when there was one consultant to cover both units. We spoke with senior staff about this, and they told us that each unit had a ward-

based team of doctors that included a senior registrar. On rare occasions, one consultant would indeed cover both units out of hours. If this happened, the registrar could get support from the paediatric consultants based at Queen's Medical Centre. Staff were not concerned about the out of hours cover arrangements. We were also reassured that there had never been an incident where safety had been compromised.

Infection prevention and control

Procedures and practice for the prevention and control of infection were not always effective. We found dust on low and high surfaces in patient bays, and there was dust on equipment in the labour suite. This meant that patients could not be certain that they were receiving care in premises which were clean and suitably maintained for the delivery of care and treatment.

We checked procedures for the safe storage and disposal of specimens and waste materials. We found cases at both hospital sites where specimens had not been stored in accordance with the trusts policy.

Medicines management

We looked at the management of medicines, including the procedures for storing, recording and administering controlled drugs to patients at both hospitals.

At City Hospital we found that staff had left ampoules of medicines in labour rooms instead of locking them away. We discussed this with staff, and they were aware of issues related to medicines storage. They told us that staff were regularly reminded to store medicines appropriately in the lockable facilities.

Staff had not appropriately recorded information related to medicines management. We checked the controlled drugs books. Controlled drugs are a group of medicines that have the potential to be abused. For this reason, the handling of these drugs is subject to certain controls set out in law. We saw that information on the administration of controlled drugs to individual patients had not always been recorded accurately.

We also found some calculation errors in the controlled drugs books, and we noted that staff had crossed out and amended several entries without signing the changes to confirm who had made them. Many entries in the controlled drugs books were signed by two members of staff, which indicated that the staff members had completed appropriate checks before the medicines were administered. However, this practice was not evident for all entries.

There were gaps in the daily recording of fridge temperatures, and staff told us that room temperatures were not checked. This meant staff did not take appropriate action to check that room and fridge temperatures were appropriate to ensure the efficacy of medicines was not affected.

Are maternity and family planning services effective?

Delivery

We looked at data for the rates of the different types of delivery methods at the hospital. Between April 2012 and March 2013, there had been 10,017 deliveries across the trust. Of those deliveries, 22.2% were performed by caesarean section. This rate is lower than the national average. The trust's rate of emergency caesarean sections is almost 3% lower than the national figure, which indicates there is good practice within the maternity service.

Guidance from the National Institute for Health and Clinical Excellence (NICE) states that women should be offered an induction of labour if their pregnancy goes beyond 42 weeks. However, it allows women who want to avoid intervention to continue with their pregnancy with increased monitoring. There were 85 deliveries in a 14-month period that went beyond 42 weeks. We had not concerns about this rate.

Handover

We observed a doctors' handover during our inspection and saw that doctors were able to discuss individual patient care pathways and to plan the delivery of care to patients for the shift. This meant doctors received information to help them plan care that met patients' needs.

Equipment and resources

Staff had access to required equipment, including single-use items of stock. We found that stock items and equipment were stored in an organised manner and were available to staff when needed. We also checked

Maternity and family planning

the emergency equipment trolleys in the labour suite and found they were well stocked. We saw evidence that these trolleys were checked regularly. This meant staff had access to emergency equipment which was routinely checked and maintained.

In the neonatal unit, we saw that equipment was cleaned and regularly serviced. This meant the unit had equipment available for use which had been maintained and serviced.

Are maternity and family planning services caring?

Provision of care

The majority of patients and their relatives said they were happy with care at the hospital. Patients were extremely positive. One said, "I'd recommend the service to my family and friends." One patient in the neonatal unit said, "I've been very well cared for. The service has been excellent."

Other patients told us that the care they had received had been "brilliant – I've been well looked after and even the food's been good" and "I've had such good care and the staff have been fantastic". A relative we spoke with said, "The staff were great. They really supported my relative, and we couldn't have asked for anything more. It was marvellous care." However, one relative expressed concerns about the standard of care their relative had received on a postnatal ward.

Staff in all the areas we visited were welcoming towards patients and supported them in a professional and sensitive manner. We noted that there were good working relationships between different professional groups, and there was an apparent mutual respect between staff.

Parents whose babies were being cared for in the neonatal unit said that they felt supported and staff were keeping them very well informed. One patient told us, "Staff have been very responsive to my needs in neonatal." Another person said, "It is fantastic here, the staff are so kind all of the time."

One person at our listening events said that they felt that they had not always received the care they needed.

Patients and their relatives were positive about the City Hospital Maternity hotel. They told us the hotel offered additional facilities which they could use while they or their baby were cared for in hospital.

Privacy, dignity and respect

Staff treated patients with dignity and respect. They were respectful of patients' needs, ensured that patients were not disturbed and interacted with them courteously to maintain their dignity.

Maternity Survey

Following our inspection to the trust, the results of a national maternity survey were published. The trust scored about the same as other trusts in two of the three main areas. They scored worse than expected on questions that asked them if they felt they were given information and explanations after the birth and if they felt they were treated with kindness and understanding by staff after the birth.

Are maternity and family planning services responsive to people's needs?

Equality and diversity

We spoke with staff about the needs of patients whose first language was not English, and we asked how staff communicated with them and provided them with information about their care. Staff told us that the service used the trust's telephone translation services to arrange for translators to attend appointments with patients. They said that these systems worked well to ensure that patients were able to understand and staff could communicate effectively with women. We held a focus group with women whose first language was not always English. They told us that the trust had good interpreting services but there was a lack of printed information. We saw that all information leaflets had information in other languages and large print about how to request the leaflet in an alternative format.

Maternity and family planning

Before our inspection, we received a comment from a woman who had used the maternity service. She told us that her same sex partner had not been given the same rights to visit the maternity ward as male partners. This meant this person felt that she was not treated with respect.

Ward improvements and relocations

The department was being refurbished to provide a main reception desk at the entrance to the labour suite and delivery theatres. We were told that the reception desk would be staffed at all times and would provide a single contact and entry point for all patients and relatives coming to the labour suite and delivery theatres.

Bereavement facilities

The labour suite at City Hospital had a delivery room dedicated to supporting bereaved patients and their relatives. There were facilities and arrangements in place for staff to support recently bereaved patients and their families. These includes memory boxes. The labour suite had a quiet room, which patients and relatives were able to use to discuss concerns with staff. This meant that the labour suite at City Hospital had effective systems and practices in place to help support bereaved patients and their relatives.

Queen's medical Centre did not have the same facilities to support bereaved patients. The labour suite did not have a dedicated bereavement room where patients could be offered support and care in a suitable environment. Staff told us they tried to accommodate the needs of bereaved parents and relatives by using the generic facilities within the suite. We discussed this with the maternity service senior management team, who acknowledged this issue. They told us that they did not have any specific action plans to address this issue, but the service was hoping to get charity funding to improve bereavement facilities at the hospital. However, we did note that the trust employed bereavement nurses and a specialist bereavement midwife who could refer parents whose babies had died for counselling services. We also saw that the trust did offer a service and either a cremation or woodland burial to women who miscarried their baby before 24 weeks. Women who miscarried after 24 weeks were offered a multi-faith funeral service, if required. This was an exceptionally compassionate and caring approach towards grieving parents.

Are maternity and family planning services well-led?

Leadership and governance

The trust had a single maternity service with maternity units located on both hospital campuses. Staff worked together to provide obstetrics and gynaecology care across the trust. Key roles within the maternity service (for example matrons and midwifery clinical educators) worked across both City Hospital and QMC campuses. Staff told us that senior managers (including ward and directorate managers) were accessible and visible to staff at City Hospital.

The maternity service had clear management and governance structures. There were monthly clinical governance meetings, and key staff attended trust committee meetings on behalf of the service. We saw minutes of the clinical governance meetings and saw that information from local and directorate level was considered. For example, meetings had discussed incidents, investigations and subsequent action plans and major risks.

We looked at the major risks identified in the service and noted that risks were monitored and reported to the trust's clinical risk committee.

Culture, communication and cross site working

The trust provided antenatal care within the community and at both QMC and City Hospital campuses. The community midwifery service had transferred to the acute trust three years ago. There were still ongoing issues with the compatibility of IT systems between the antenatal community midwifery teams and those based at the hospital. Although we found no evidence that this had impacted on patient care, it meant there was a possibility that the different teams might not be able to deliver care in an effective manner.

Staff told us that communication continued to be an issue between community midwives and those based at the hospital. They said that the working culture and communication had improved but work was still in progress.

Staff also told us that there was a difference in the working cultures between QMC and City Hospital

maternity services. The maternity service senior management team acknowledged these issues and confirmed that key managers and staff in identified roles had fostered closer working relationships more recently by working across both sites.

We noted that staff in the Maternity service at QMC and City Hospital campuses received email updates which provided information, including changes to guidelines. The maternity service also regularly published communication magazines which provided information and updates on best practice, risk management and governance topics within the service. Two members of staff told us that they felt that their managers listened to them but that directorate level managers and those above them did not always appreciate their opinions. Some staff also told us they did not always receive feedback from local and senior management teams. This meant staff did not always feel that their views were fully respected.

Many staff told us that they provided care using a multi-disciplinary team approach, which meant that staff with specific roles were able to support patients appropriately. We noted there were good working relationships between different professional groups, and there was an apparent mutual respect between staff. One doctor told us, "The consultants are very supportive and there's always someone I can contact if I need to."

Staff support and involvement

Most staff we spoke to, including doctors in training, felt well supported by their managers. Staff also told us that the trust had encouraged them to develop professionally. The matrons told us that midwifery staff at all levels contributed to local and directorate maternity services meetings and groups. However, we also spoke with some staff who felt that management had not always sought or listened to their opinions. In particular, staff expressed their concerns about the plan to move patient inductions away from Lawrence Ward, a postnatal ward, to the City Hospital hotel on the top floor. Staff felt that patients and staff would not have adequate support if the trust implemented this plan, and they were worried that the trust had not fully considered potential safety issues. Staff said that they felt that the trust had not taken their views into account or adequately addressed their concerns.

Some staff also said that appraisals had not always been completed, which meant that staff were not always able to discuss their personal development with their manager or highlight issues of concern formally.

Training, learning and development

The maternity service senior management team told us that it held divisional learning days for staff on a monthly basis. These learning days provided learning and governance updates to staff. They also said that they held weekly dedicated training sessions as part of the training programme for doctors. This meant staff were provided with opportunities to attend learning days and training sessions to help them provide appropriate and adequate care.

Staff survey

We discussed the staff survey results for obstetrics. The last staff survey results had been published two months before our inspection. The maternity services senior management team acknowledged that staff had reported concerns about staff bullying, staff being unable to take breaks and staff who felt they were working under pressure. The senior management team confirmed that it was working on the issues which had been raised and that it was reviewing the process for capturing staff opinions on an ongoing basis.

Future of the service

The trust's maternity services had 12 unit diversions and three unit closures during September 2013 and October 2013. We were informed that a unit diversion resulted in the closure of one of the trust's two maternity services and patients were diverted to the second service, which remained open. A unit closure resulted in closures of both of the trust's maternity services. Some of the staff we spoke with, including midwifery and medical staff, told us of their concerns about the future of maternity service provision within the trust. Staff told us they were not fully aware of the trust's future plans for maternity and neonatal services on both Queen's Medical Centre and City Hospital campuses.

Children's care

Information about the service

Paediatric services at Nottingham University Hospitals NHS Trust are known as the Nottingham Children's Hospital and are based at Queen's Medical Centre. This is a regional centre for children's care in the wider East Midlands area, and it cares for up to 40,000 children each year. Services include:

- 24-hour accident and emergency (A&E)
- outpatients
- oncology
- haematology
- intensive care and high dependency units
- neonatal care
- dialysis
- burns services.

The Nottingham Children's Hospital also offers a complementary therapy service as part of its programme of care.

We visited and observed care in 16 ward areas, and we spoke with over 70 staff and 36 patients and their parents or carers over the course of a three-day inspection. We also used information provided by the trust and information that we requested, which included feedback from people using the service.

Summary of findings

Paediatric services were safe although some improvements were required. The trust was not always ensuring that learning from incidents and best practice were fully implemented. Staff were placed under pressure at times when nursing numbers fell below recommended ratios and patients with challenging behaviour were being cared for on the wards. Facilities and equipment were not well managed to ensure that they were always clean and properly maintained.

Services were good and caring. This was confirmed via feedback from people using the service, surveys and our observations of care, which revealed some examples of excellent care.

The trust's ability to respond to people's needs required improvement. Information was not available in formats suitable for people with learning disabilities or whose first language was not English. There were limited facilities to help parents and carers who wanted to stay in the hospital with their child. However, children's education arrangements and the play therapy programme were excellent.

Leadership required improvement. We saw good examples of team leadership at local level, but there was no consistent approach to sharing messages with senior management. Executive staff were not as visible on the wards as they could be to better connect with frontline staff. Services also needed a more proactive approach to addressing corporate risk.

Children's care

Are children's care services safe?

Patients were very complimentary about how safe they considered the service to be. They told us that they were comfortable in raising any issues with staff. According to feedback in the trust's regular customer survey, patients and their families said they felt safe on the wards.

Incident reporting and learning

Staff told us that there was an open culture at the trust and that they were encouraged to report incidents and 'near misses'. There had been a total of 861 incidents reported via the National Reporting and Learning System (NRLS) between November 2012 and October 2013. This showed a healthy reporting culture. However, we found that the highest number of medication errors in the trust between 01 July 2012 and 30 June 2013 had occurred in paediatrics.

The flow of communication from 'board to ward' was inconsistent in paediatrics, and this meant that there was a lack of assurance that key messages and learning were being disseminated to frontline staff. Some wards were more proactive than others in sharing information. For example, information-sharing was good in the paediatric intensive care unit and paediatric outpatients, where there were regular team meetings. The clinical lead for paediatrics told us that team meetings for ward staff were not compulsory, and this was confirmed by staff in some of the ward areas we visited. On the children's assessment unit, nurses did not get any feedback following completion of an incident form. But on wards D33 and E39 nurses outlined how they received feedback and how changes had taken place as a result of incidents.

Therefore, there was a lack of assurance that learning and key messages were being fully communicated. A further example was the inconsistent performance in relation to nursing indicator targets. For example, wards D33 and E37 and the neonatal intensive care unit scored 'red' or 'amber' for these targets in most months since April 2013. This indicated inadequate performance. In the small number of cases where performance had reached the required threshold to score 'green', this improvement had not been sustained the following month. This meant that the department was not implementing learning consistently to ensure patient safety.

Staffing

Children's A&E was open 24 hours a day and had good medical staffing arrangements in place. In general medical staffing was good. The department produced weekly rotas that included good assistance from consultants. Consultants were on call at night and over the weekend on the general wards.

In the Children's Assessment Unit Ward E38, the nursing to patient ratio was given as one nurse to four children during daytime and one nurse for six patients during the night. Although the day time levels did meet national standards, the night time levels did not meet the 2013 Royal College of Nursing's standards. These standards state that there should be one registered children's nurse for every three children under the age of two and one registered children's nurse for every four children over the age of two. The trust did not routinely adjust its staff numbers when caring for children under two, and there was no dependency tool in place to help with staff planning. However, the trust told us that they did adjust staffing numbers according to the needs of children in all ward areas. This was based on the judgement of the site matron. The clinical lead for nursing said that the trust was not yet using the Association of UK University Hospital staffing dependency tool to calculate minimum staff numbers. However, the trust was currently evaluating the use of a recognised children's dependency tool, and aimed to implement this within six months.

We visited a number of the children's wards during our unannounced visit to the hospital. We saw that ward E37 had two registered nurses for the night shift. The ward had eight babies under the age of two plus two older children to care for. They expected more admissions overnight as the children's A&E unit was very busy. The children under the age of two and all had breathing problems. We saw a baby who did not have any parents/guardians with them. This baby was crying and was very distressed. The crying of this baby was distressing, not only for the child, but for the other parents and children on the ward. While this child did not require one to one care all of the time, they did require care when they were distressed. The trust told us they did not rely on children's parents or carers to be present at all times. One parent told us, "I feel so bad for the child. They do what they can, but they are busy. He needs someone with (them)." A parent of a child also told

Children's care

us they thought the staff were very good but said, "They rely a lot on the parents to do a lot." The trust promoted "negotiated care," which was to ensure families and carers were involved in their child's care.

We were unable to talk with any of the nursing staff on ward E38 because they were too busy delivering patient care. Again, there were two registered nurses for the night shift on this ward. We saw a young baby who had been admitted from A&E with breathing problems. The baby had an oxygen mask to its face. The parents of the baby told us they had been on the ward for about half an hour but they had not seen any of the nurses or doctors as yet. We were concerned that staff were not actively monitoring this young baby. Young babies with breathing difficulties require careful monitoring, as they can deteriorate quickly.

We visited the oncology ward during our unannounced visit and found there were two registered nurses on duty for the night shift. The staff told us they could meet the needs of the patients with that level of staff. We did not find evidence to suggest this was not the case, but the staffing levels did not meet with Royal College of Nursing standards

During our unannounced out of hours visit we did not find any concerns about the levels of medical staff cover for the paediatric wards or department.

On wards E37 and D33 that there was a lack of response to equipment alarms.

Infection, prevention and control

We found some areas in the children's services were not clean. For example, parts of the Neonatal Intensive Care Unit (NICU) were dusty, and we found medical equipment, such as monitors and cable junctions that were also dirty. We found some of the toys in Ward E37's playroom appeared dirty, although they were being wiped with antiseptic wipes.

Equipment

Staff had not always completed daily temperature checks on drugs fridges. In NICU and the Children's Assessment Unity, we saw paediatric resuscitation trolleys that had not been checked.

Children's accident and emergency

Children's accident and emergency was open 24 hours a day. It was properly staffed and good arrangements were in place to ensure that appropriate medical cover was available overnight. The doctors providing this cover had the appropriate paediatric training to ensure that the service was safe. The A&E environment was set up well and was comfortable and stimulating for children. Each child received an initial triage from an advanced paediatric life-support-trained nurse at the entrance of the children's A&E. They carried out initial checks on the child, gave pain relief if required and flagged up very ill patients. Although this was good practice, there were no signs in the waiting area to remind parents to notify staff if they felt their child was deteriorating. In addition, staff could not see part of the waiting area from the reception desk, so it was difficult for them to observe people who were waiting there. There was very helpful information on the wall to explain the stages of triage and consultation and where people might go for onward referral.

Safeguarding

The trust's safeguarding children team was proactive in visiting each ward daily, regardless of whether staff had raised concerns or made referrals. This helped to focus staff on safeguarding matters. We saw an incident report that showed that a patient with a mental health problem had displayed disruptive behaviour and had been physically restrained by staff. We were concerned that the restraint had been conducted by ward staff who had received no training in control and restraint.

We looked at some patient records and saw one patient had been discharged without the safeguarding process being fully followed. The patient had not been reviewed by a consultant and there was no documentation or alert from the safeguarding children's team. We spoke with a nurse who was not fully aware of the process they should follow when they discharged patients where there were safeguarding concerns. We also found not all staff were up to date with safeguarding children mandatory training.

Are children's care services effective?

Collaborative working

We found that there was generally good collaborative working across the paediatric areas. Our interviews with matrons and staff in the community nursing team showed good joint working with the community paediatricians and physiotherapists to keep children with complex needs out of hospital and facilitate early discharge of children

requiring dressings, intravenous drugs or suture removal. However, the community team said it did not have access to the local authority's system to check on safeguarding issues, which it felt stopped them achieving the best outcomes for patients. . The team had raised this with senior management who had been unable to resolve the concern because it was a national data sharing issue.

Staff training and welfare

Induction processes were in place, and staff we spoke with spoke highly of them. This was also the case for the preceptorship programme, in which newly qualified staff received valuable support for six months. Once staff came out of preceptorship they were able to access clinical supervision, but this was optional and meant that they did not have to receive on-going professional support and development.

Staff said that the trust was a good and caring employer. We found examples where staff had been supported in their role following illness and where they had had a period of support to go back to work, which included working in a supernumerary capacity until they felt able to return to full-time work.

Care of patients with special needs

The trust had a policy of caring for child and adolescent mental health service (CAMHS) patients who required acute care on its general wards. Nursing staff described how they managed care for these patients without disrupting care for other children. We found that one patient was not receiving care in the most appropriate place due to a shortage of specialist CAMHS beds in England.

Are children's care services caring?

Patient views of care

People's views of the care they and their child had received were mainly very positive.

We observed some good doctor/parent interaction about care and discharge planning and saw that staff sought the parent's views before taking any decisions. When the doctor had left, the parent of the patient told us that the care they had received had been "fantastic".

On the oncology ward, we spoke with the parents of a young child who had come to the hospital from out of town. They said that all the staff they had dealt with at the hospital had been "amazing". They said that at their local hospital that they had received little information from consultants, but at Queen's Medical Centre nursing staff and the consultant came into the room, sat down and spent a considerable amount of time discussing care and treatment with them and making sure they were involved and well informed.

We spoke with another young patient on the oncology ward who said they were looking for the receptionist, as they wanted to play with them. We later saw the receptionist playing with the patient. They had clearly built up a good relationship, and this demonstrated how all staff on the ward created a caring atmosphere.

We observed a very good interaction between a consultant and a patient and their parents. On the morning ward round, the consultant went to talk to the parents of a baby who had been in hospital for between 36 and 48 hours. The consultant approached the cot, washed their hands, introduced themselves to the parents by name and role and explained what they wanted to do at that time. The consultant then started by asking the parents what had happened over the weekend and listened to their account, asking relevant questions and prompting them for information to help inform a judgement. Permission was asked to examine the baby in a caring and gentle manner. The consultant responded to parental questions, gave the parents information and set out a plan of care. The consultant also told the parents that they would be on duty all week.

One parent in A&E, whose child was being transferred to a ward, asked the inspectors if they could give feedback. They told us that the care had been "'excellent."

Before our inspection, we received a comment from the mother of a child who had used the inpatient services at the hospital. They told us, "My son presents as challenging due to lack of understanding. The doctors and nurses went out of their way to make him feel safe."

There was some negative feedback provided about care, however. We spoke with one parent whose child was on the paediatric high dependency unit and who had come to the hospital from out of town. This was their second

Children's care

stay in the hospital in the last six months. Their child required 24-hour care, and they were very positive about the care and support the child and family had received in the Paediatric Intensive Care Unit and the Paediatric High Dependency Unit. However, they said they were "relieved" about being transferred back to their local hospital rather than being moved to a general paediatric ward at Queen's Medical Centre, as had happened during their child's previous admission. They felt that the general ward and nursing staff were not set up to care properly for children with special needs. They said that staff were happy to have the parent give the child medication and see to their care needs, tasks which they felt should have been done by the nurses. They said that at one point a nurse had woken them up to ask them to give their child their medication and food.

Ward activities

Play specialists told us about their work on the wards. We observed them setting up activities for children and providing care at the bedside.

We saw that play specialists made a point to visit all the patients before they did anything else to see if any of the children were alone. This was good prioritisation of care, as they recognised that those children without any parents/visitors would require most support or might be worried. Play specialists also talked about spending time with adolescents with mental health needs. A housekeeper on one ward had bought white tiles and, along with play specialists, had spent time with the children, helping them to paint the tiles. They had the tiles fired with a view to placing them on a new design board in the playroom. This was a very good initiative.

Staff treated older children on the same wards as younger children and babies, and there were often fewer activities available for teenagers than there was for younger children. However, on some wards there was a dedicated teenagers' relaxation room with a television, music and books. We saw confirmed plans for the refurbishment of the oncology ward that would incorporate a five-bedded teenage cancer unit, which showed that the trust had considered patients' comfort, dignity and respect when care was planned.

Are children's care services responsive to people's needs?

Working with stakeholders

There was a good community planning system to co-ordinate discharges, people with long-term health conditions and those receiving end of life care. We found good collaborative working between matrons and the community teams to keep children with complex needs out of the hospital and facilitate early discharge. This complemented the trust's Winter Plan, which had been agreed. Matrons told us that capacity to increase the number of children's beds had been built into the plan. The community teams were confident that admissions would be well managed over the coming winter.

Information in special formats

There was a lack of information in languages other than English. Staff in all areas were aware of the availability of telephone translation services (Language Line), and they also told us about internet translation services. There was a learning disabilities resource pack for staff to use when caring for patients with a learning disability. However, there were no signs to let people know that information was available in special formats for people with special educational needs or who did not have English as a first language.

Responding to the specific needs of children

Due to space limitation, the trust had a policy of treating all children, regardless of their age, on the same wards. There were no separate, specific areas for babies, pre-teens or teenagers. We saw that staff tried to manage bays in a way that kept children of a similar age together, but this was not always possible. This meant that facilities for older children were not as plentiful as for younger children. We saw that separate space had been made for teenagers, where possible, and this contained a television, music systems and age-appropriate books and DVDs. The trust had agreed plans to refurbish the oncology ward in April 2014. This would create a dedicated teenage cancer unit and also introduce a separate area for younger children. This showed that the trust was being responsive to the needs of patients and families.

Children's care

Education and stimulation

The trust was proactive in the use of play specialists on the wards, and this was a system that was working well. Separate play facilities and rooms were available, and activities also took place at the children's bedsides. Play facilities were also used in clinics for distraction therapy, if a child was undergoing a procedure or having bloods taken.

The trust had good links with the local education authority and had an established and effective school programme for inpatients. This service had been rated as 'outstanding' at the last Ofsted inspection. Facilities included the use of classrooms, but lessons were provided on a one-to-one basis for patients who were susceptible to infections, such as those children with cystic fibrosis. The service had an overview of the national curriculum and teaching staff had training to inform them of any changes. There was internet access at the children's bedsides to facilitate learning.

Facilities for parents and relatives

As a regional centre for specialist children's services, the trust treated a number of children from outside of the Nottingham area. In an attempt to reduce travel pressures on parents a pre-assessment service was offered by telephone, where feasible. Facilities for parents staying overnight were cramped, and nurses on wards D33 and CAU said it is not always possible to provide single sex sleeping arrangements for parents staying with their child. Those families that were from out of town spoke highly of the care their child received and of the staff. However, they said that they were unhappy that the hospital restaurant closed at 2.30pm on weekdays and that it was not open at all at weekends. This prevented them from obtaining freshly cooked food. One father said that he did not want to eat in front of his child if his child was not allowed to eat before undergoing a procedure. There was an alternative café in the hospital that served hot food, such as jacket potatoes, soup and toasted sandwiches. This was open until 11pm.

Patient feedback and information

The trust actively sought the views of patients and their families. We saw data for April 2013 to October 2013 that had been obtained from the regular inpatient survey. Results were good for questions about whether people felt they were included in decisions about care and treatment; whether they felt they had received the right amount of emotional support and whether staff were friendly, caring and polite.

There were suggestion boxes on each of the wards we visited. However, there was a lack of information for children, and the trust did not publicise the fact that it wanted to hear children's views. Feedback forms were not available in a child-friendly format. In the children's outpatients department, suggestion boxes were high up on the wall, which meant that small children would find it difficult to give feedback. Also, there was a lack of information in languages other than English.

Some feedback was displayed on dedicated message boards in each clinical area. These all contained positive comments. When we asked staff how they would respond if someone gave negative feedback, they said that the ward manager would discuss the person's concerns with them and act on them.

Are children's care services well-led?

Senior leadership and governance

Governance arrangements within paediatrics were not applied consistently. Some wards did not have team meetings to ensure that key messages, best practice and the learning from incidents were disseminated to staff and their implementation tracked. Other ward areas were far more proactive and held governance days and team meetings. Staff we spoke with said they did not see much of the senior management team on the wards, and there was an accepted and shared view among many of the frontline staff that the executive team was too senior to visit the wards. Furthermore, staff in the Neonatal Intensive Care Unity and Children's Assessment Unit said they did not see many staff above matron level in their respective areas. This indicated disconnect between the executive team and frontline staff.

Some risks on the trust's risk register had been raised by staff, which indicated an 'open' culture of reporting, but not all risks had been reviewed by the required stated date. The clinical lead for nursing admitted that this was an area that could be improved. We found that the person who raised the risk was allocated the work to address the risk. However, oversight of the register was lacking, as some risks were assigned to staff who no longer worked for the trust.

Children's care

The nursing dashboard was in place on the wards but, as discussed previously, monthly performance was inconsistent. Good performance in one area in one month was not sustained the following month. This was a particular issue on those wards that did not have regular team meetings. This increased the risk of adverse outcomes for patients.

End of life care

Information about the service

End of Life services are provided throughout the trust. The City Hospital campus has 20 dedicated palliative care beds as well as outpatient and day care services, which are provided at Hayward House on the hospital campus.

The oncology department currently sees around 4,000 new patients every year. It provides a comprehensive range of chemotherapy and radiotherapy treatments as well as an acute oncology service. These services are provided 24 hours a day across the trust, and a consultant and specialist registrar are available and on call to see patients urgently. Between the hours of 8am and 5pm Monday to Friday there is an acute oncology team of specialist nurses that provides emergency triage and assessment of acutely ill patients at both hospitals.

Outpatient services for oncology are provided in a specialist oncology outpatient department, which has a total of seven clinic suites across the trust. Outreach oncology outpatient and chemotherapy treatment is also undertaken at Sherwood Forest Hospitals NHS Foundation Trust. Annually, outpatient clinics see approximately 4,000 new patients and have 22,000 patients attending for follow-up appointments or treatment.

Queen's Medical Centre does not have any wards which are specifically established to provide end of life care. However, there is the potential for many of the wards to provide care and treatment for people receiving palliative care. Patients receiving end of life care are identified and supported by the palliative care team. It offers support, advice and guidance as well as tracking the care and treatment patients receive. Where necessary (and subject to beds being available), the team can arrange for patients to be transferred to an oncology ward or to Hayward House based at the City Hospital site. This is usually done to ensure that patients' symptoms can be stabilised properly or to meet patients' expressed wishes to receive end of life care on a particular ward.

We also inspected a number of end of life support services, including the multi-faith centre, chaplaincy service, the bereavement centre, the mortuary and chapels of rest. We spoke with patients, relatives and staff and observed the care being provided. We also looked at patient records.

Summary of findings

Overall, patients received safe end of life care, and patients and relatives we spoke with reported high levels of satisfaction.

Patients received effective care and treatment on most of the wards we inspected, and we saw some outstanding practice and support services for people nearing the end of their life.

All of the patients and relatives we spoke with told us that staff were caring, informative and compassionate. We observed and were told about some outstanding practice, in particular from the bereavement service, the Lyn Jarrett Unit and the multi-faith and chaplain services.

The response to patients' end of life care wishes was very positive. The staff and the trust were responsive to suggestions about improvements which would enable patients to die in comfort, in their preferred place and in a dignified manner.

There was evidence of an open and honest appraisal of the quality of the end of life services being provided across the trust. There were robust audits taking place with clear feedback to governance leads indicating what improvements needed to be made.

Are end of life care services safe?

Prevention of pressure ulcers

A senior nurse told us that Hayward House had quite a number of patients who developed pressure ulcers when they were in the last days of life, and told us some did not want to be moved as it caused them so much pain. The nurse told us in such situations they discussed the patient's wishes with the multidisciplinary team, and the consultant would discuss the risks and benefits of receiving treatment with the patient. The nurse told us that staff kept clear records of decisions in such situations and that the wishes and comfort of the patient remained paramount.

End of life care

Do not attempt Cardio-Pulmonary Resuscitation orders

We looked at Do Not Attempt Cardio-pulmonary Resuscitation (DNACPRs) orders on all of the wards we inspected. In all cases, staff had completed these in line with guidance published by the General Medical Council (GMC).

Consultants and staff on the wards confirmed that the trust had systems in place to audit all DNACPR forms. The resuscitation team undertook this on behalf of the resuscitation department, and it recorded any issues of concern and fed back to the relevant consultant in writing. The consultant was invited to reflect on the DNACPR form they had completed and review the order to make sure it met the standards expected.

We spoke with four patients who were receiving palliative care. With the exception of one patient (who told us, "I know what is happening but I am not ready to have it said out loud yet"), they all understood their diagnosis and their prognosis. The relatives of two of the patients said that they were fully aware that the patient was at the end of their life.

This indicated that the consultants were following the GMC guidelines and were making sure patients knew they would not receive CPR in an emergency situation and why this had been decided.

Staffing levels and supporting workers

The staff on the wards we spoke with told us that staffing levels were higher on the oncology and palliative care wards to give patients the care and support they needed when they were at the end of their life. A ward manager told us the benefit of having extra staff was that "it enables added extras and better communication with patients and their family".

Several of the patients we spoke with commented positively on the staffing levels on the wards we inspected. One patient commented, "There are plenty of staff around, and they are so intuitive. They know I don't want them to do anything, just be there for me when I am panicking. I find their calm presence reassuring. They are always there." Another patient told us, "This ward is better staffed than the [general] ward I was on. The staff have time for you." This showed there were staff available to offer support and reassurance to patients nearing the end of their life and that the care they offered was centred on the patient rather than being task focussed.

Safety and suitability of equipment

The palliative care ward had its own syringe drivers for people needing continuous pain relief. There was a process whereby the consultant could send syringe drivers out into the community with the patient on discharge, and there was a system for ensuring they were returned. Equally, staff made sure syringe drivers were returned to community nursing services if patients came in with them. This system ensured that people were discharged home with the correct equipment for controlling their pain and there was no interruption or delay in treatment.

Are end of life care services effective?

Mortality rates

The trust's Oncology and Radiotherapy Action Plan 2011–16 indicated that mortality rates were below average national rates and that they were broadly similar to rates for other local trusts. This meant that the rates were not raising concerns in terms of being either excessive or very low. These figures suggested the service performed as expected in relation to the effectiveness of oncology and radiotherapy treatment.

28-day readmission and rapid discharge

We considered the data on the 28-day readmission rate for patients receiving radiotherapy or chemotherapy, as this can indicate that patients were discharged too soon, without adequate support structures or before they were medically ready and stabilised. We found that the readmission rate was above average compared with other local hospitals. However, the trust is a specialist centre for patients with complex conditions and, as such, accepts referrals from other local hospitals for these services. This may mean that local trusts' readmission figures were much lower because they were not treating patients with complex conditions.

The trust had a lower length of stay than the national average for oncology patients, but its figures were broadly similar to those of other local trusts. This may be because the trust had a lower bed to population ratio than the

End of life care

national recommendations for palliative care (having 20 beds as opposed to 32), or it may be because it worked more effectively with community-based services to effect an earlier discharge in order to meet patients' end of life wishes.

We spoke with a specialist palliative care nurse and the head of palliative care about these issues. They both reinforced their commitment to ensuring that patients' symptoms could be stabilised and patients could be discharged quickly to ensure that they were able to end their life in a place they had identified in their end of life plan.

All of the staff we spoke with were highly motivated and committed to meeting patients' preferences about where they ended their life, often going to some lengths to enable this to happen. A consultant on the palliative care ward gave an example of a patient with a very complex condition whose pain was not under control and who wished to return home to die. The team researched and were able to obtain a new medication for the patient which enabled their pain to be managed and their end of life preferences to be met. This was an example of outstanding end of life practice.

All of the staff reported excellent links with community based teams such as the Macmillan Nurses, district nurses, GPs, the palliative care team, adult social care services and community-based physiotherapists and occupational therapists. Ward managers informed us that hospital and community-based services worked together to enable the rapid discharge of a patient if they wished to end their life at home.

Some of the patients we spoke with wanted to return home to end their life; others wished to stay in the hospital. Three of the six patients we spoke with at Hayward House wished to remain at the unit to die. One patient told us, "I have talked with staff and my doctor, and I have said I want to die here. I don't want to go home. The staff are so attentive." Another patient commented, "Before I came here I felt out of control, panicked. I feel safe here, reassured. I can't begin to think of leaving."

Staff satisfaction and commitment

We looked at the staff survey results and saw that the levels of staff satisfaction for the end of life speciality were very high. The service was ranked sixth out of 31 specialities in terms of job satisfaction. All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed to end their life with dignity and without pain. We heard of many instances of exemplary practice, and the patient feedback about the service and the staff who worked on all of the wards we inspected was very positive.

Implementing national guidelines

The National Institute for Health and Clinical Excellence (NICE) was rewriting guidance to remove reference to the Liverpool Care Pathway (LCP) following a recent independent review of the pathway. Senior clinicians and nurses were aware of this change.

NICE guidance indicates that physical symptoms such as pain, breathlessness, nausea and fatigue must be properly managed by collaborative multidisciplinary working. The trust end of life team had developed a formula for prescribing to manage these symptoms regardless of whether the patient was under the care of a specialist or generalist consultant. The specialist palliative care nurse told us that they would on occasion arrange for a patient to be transferred from a general ward at Queen's Medical Centre to an oncology or the palliative care unit to ensure effective symptom control. This was because they had access to medication which would control symptoms but needed careful monitoring by the palliative care specialists. The palliative care consultants were also involved in a number of clinical trials which offered patients (who consented to taking part) the opportunity to try new and (as yet) unlicensed medication which may afford better control of their symptoms.

Two patients we spoke with on the palliative care unit at City Hospital told us how staff had controlled their symptoms effectively since their arrival. One patient told us, "I was so breathless when I came in, I couldn't breathe but I am calm now and off oxygen." Another told us, "I have no pain now. My breathlessness is much better. I

End of life care

panic and that does not help, but the staff are supporting me." We were assured that patients were monitored to ensure effective symptom control when they were nearing the end of their life.

One patient we spoke with told us they had been at home on weekend leave for three days but their pain was not well controlled during this time. The patient rang staff on the ward, who immediately offered readmission, but the patient chose to stay at home for the period of leave and the patient told us the consultant respected this decision. This demonstrated a considered approach to balancing the need for admission with the patient's expressed wishes.

The specialist palliative care nurse did not express any concerns about the end of life care on general wards, but they told us that if there were any concerns they would provide feedback to the matron on the ward. They said they would on occasion arrange for the patient to be transferred from a general ward at Queen's Medical Centre to an oncology or the palliative care unit at City Hospital to ensure effective symptom control. This was because services at City Hospital had access to medication which would control symptoms but needed careful monitoring by the palliative care specialists. We were assured that patients were monitored to ensure effective symptom control when they were nearing the end of their life.

Nutrition and hydration

The end of life team had a clear end of life care plan, which was to be used across all sites and wards. This indicated that the aim should be for people to eat and drink normally for as long as possible, acknowledging that the need for hydration and nutrition may reduce as people approached the end of their life. The document made it clear that in such circumstances oral care was to be provided to ensure the patient was comfortable.

The patients we spoke with were not receiving artificial nutrition or hydration. Some patients told us their appetite was not good, but they said the staff tried to tempt them with various foods. We observed that all patients had access to drinks which were within their reach, and patients and relatives on this unit told us the food was "very good."

Two patients on oncology wards told us about staff going out of their way to get them food and drinks they would enjoy. One patient told us they had significant difficulties with swallowing but said the staff had never provided any food they could not eat. Another patient told us they wanted a McDonald's milkshake, and staff made sure they got the ingredients and made a milkshake for the patient. Staff working at Hayward House said they would go to the shops for bacon sandwiches if patients requested this, to try and encourage their food intake.

We saw on one ward at the Queen's Medical Centre that there was a clear plan in place for a patient to receive oral care. Staff said they were happy to teach relatives how to do this if they wished to be involved in making the patient comfortable. The relatives of the patient told us they were very happy with the quality of care their relative had experienced.

However, we were concerned about a patient on another ward who had just been placed on an end of life care pathway. When we spoke with the patient they told us their mouth was "so dry I cannot speak." We made sure that staff gave the patient a drink.

Staff handovers

Staff handovers were very effective. All of the wards we inspected had visible leaders and clear handovers. At Hayward House all staff received a written handover for each patient, which contained important information about them, their current needs and any treatment and their diagnosis. We saw staff referring to these documents throughout the day.

The provision of religious support for patients at the end of their life and their relatives

Queen's Medical Centre had a purpose-built facility that provided multi-faith and bereavement services in one place. This made it very easy for relatives to access different support services.

Support services comprised the bereavement centre, the multi-faith centre (which provided specific areas for prayer and reflection for people following the faiths of Islam, Judaism, Hinduism, Sikhism and Christianity) the

End of life care

chaplaincy service and a chapel of rest. There were strong links with other community-based faith leaders, if other additional support was needed. All of the support services were run by combination of paid staff and volunteers.

Staff we spoke with on two wards were aware of the multi-faith centre and the spiritual and emotional support it could provide to grieving relatives or to patients who were nearing the end of their life. Many staff had a clear understanding of the need to make sure religious rituals were observed when people died. A member of staff from A&E told us of instances where they had liaised with the police to ensure the family of a patient could observe their religious rites of passage by washing their relative after they had passed away.

City Hospital had a multi-faith room available and a chaplaincy service. The service was located some distance from the oncology wards, and the department had submitted a business case for it to be located more centrally. The service was available 24 hours a day. The chaplain said they had established close links with a number of wards, including Hayward House. The staff were very caring and compassionate, despite being busy. The staff from the service were involved in training on cultural awareness.

There was a bereavement centre which was linked with the mortuary service and these were located close to each other. This made it very easy for relatives to access different support services with ease.

Hayward House also had a day and outpatient service available for patients. A range of complementary therapies were provided in a purpose built section of the service. These included aromatherapy, reflexology, Indian head and neck massage, relaxation techniques, hypnotherapy and simple massage. The therapies were available to patients (both in patient and community based), their families and staff free of charge.

The purpose of the therapies was to help patients relax and to assist with symptom control. Several therapies were provided by staff who had funded their therapy training and had completed it in their own time, as they believed these therapies helped patients cope with their illness and diagnosis.

People using the service were encouraged to give their feedback, and the trust had been collating it since August 2013. Some 23 people had provided feedback, and this was overwhelmingly positive, with some patients commenting on the positive impact a complementary therapy had had on them. Comments included "I felt much more relaxed", "Very relaxing, I was able to talk openly and get stressful thoughts and guilty feelings away", "It helped me sleep" and "The reflexology helps tremendously with my physical and psychological wellbeing."

The commitment and dedication of the staff providing this service was an outstanding aspect of the end of life service.

Are end of life care services caring?

Patient satisfaction and complaints

The trust action plan for palliative care services indicated that the speciality had the highest levels of patient satisfaction in the patient experience surveys. When we looked at the complaints data collected by the trust over the past year, it confirmed that there were very few complaints about oncology services and wards, which also indicated patients were generally happy with the service.

Patients' and relative's views

All of the patients and relatives we spoke with expressed very high levels of satisfaction with their end of life care. Patients commented "I am cared for with respect and dignity", "The care is exemplary", "The staff have spoken with my relatives and we could not ask for more. The staff are exceptionally kind" and "The care is wonderful, very caring staff".

One patient told us the staff at the unit had helped them break bad news to their children, and they had been very grateful to have the support. The patient said the staff had shown care and compassion for them and had been supportive throughout without being intrusive. The patient felt the staff were very intuitive and understood what patients needed. They told us, "I honestly do not know what I would have done without the care, compassion and support I have received." Staff on the palliative care unit told us that they signposted

End of life care

and referred children who were bereaved to a specialist counselling service. They also had books available for children of different age groups to help them understand and come to terms with their loss.

All of the staff we spoke with demonstrated a real commitment to enabling patients at the very end of their life in hospital to die in a calm environment and in a private and dignified manner. Staff told us that side wards were allocated to patients who were at the end of their life wherever possible, to allow them and their relatives privacy.

All of the relatives we spoke with were very happy with the quality of the care their loved ones had received they all told us they felt well supported by the staff. One relative commented, "I have been kept informed, I am aware of [my relative's] condition and the plans in place to keep him comfortable."

One relative told us about the care their loved one had received at the end of their life. They described the conversation the consultant had with the patient and the family about the DNACPR order and said that the patient's wife was able to stay the night with him. The relatives told us, "The staff are so caring and compassionate. He was here for three years of his life. If we paid for it we couldn't have got better care."

A senior nurse on a ward attached to the emergency department at QMC told us that one of the main motivations in opening the ward was to enable patients at the very end of their life to die in a calm environment and in a private and dignified manner. Patients would be transferred to a single room on the ward if they needed end of life care. However, they were able to remain on the ward until they passed away, if they so wished. This demonstrated a compassionate and responsive approach towards patients.

All of the relatives we spoke with were very happy with the quality of the care their loved ones had received on the wards we inspected at Queen's Medical Centre. One relative commented, "We are very pleased with the care, it is very good. We have been kept well informed and we are aware of the prognosis."

Support services at the end of life

Queen's Medical Centre had a bereavement centre on site and we spoke with two staff and a volunteer from the service. We also spoke with a bereavement nurse who worked in the emergency department to identify what support patients received at the end of their life and what support their relatives received following their death.

The bereavement staff told us they worked with patients as they were nearing the end of their life when asked to do so. They also offered support to families at any time. The faith leaders and chaplain staff demonstrated a caring and compassionate approach towards relatives and also to staff who may be distressed.

All of the staff we spoke with told us there were specialist bereavement nursing staff who focussed on providing support to children and young people who were either nearing the end of their lives or who had lost their parent. The bereavement nurse and social work staff would assist families or take the lead in breaking bad news to children in a compassionate manner. Several staff we spoke with were highly complimentary about this specialist support. Bereavement staff told us that there were age appropriate information packs, books and memory boxes available for children who had been bereaved and these could be filled with (for example) handprints, locks of hair, key rings or candles as well as personal items selected by children themselves. The staff would also refer children or adults who were struggling to cope with their loss to counselling services. This service was also available for parents whose babies had died.

We saw some good practice. For example, the trust offered women who miscarried before 24 weeks a service and either a cremation or a woodland burial. Women who miscarried after 24 weeks were offered a multi-faith funeral service, if required. This was a compassionate and caring approach to supporting grieving parents.

Staff told us that six weeks after every death in the emergency department, bereavement nurses sent a handwritten letter to relatives. This letter offered condolences and invited recipients to speak with a bereavement nurse or senior doctor, who would be able to answer any questions they may have. This was an area of outstanding and compassionate practice.

End of life care

Arrangements following a patient's death

Staff continued to treat patients with dignity and respect following their death. Staff who worked in the mortuary referred to people as "the patient" or "the deceased" at all times. We saw that personal items were kept with the patient, if relatives had requested this or it formed part of the patient's end of life care plan.

Staff showed considerable compassion towards relatives who wished to see their loved one following their death and were responsive to relatives who wanted the patient to be released quickly. There were a range of viewing rooms and two chapels of rest available so that relatives could say goodbye to their loved ones. Viewings were by appointment but could be arranged as many times as people felt necessary. Computer systems flagged whether any organs had been removed during a post-mortem, and the flag remained on the system organs were returned. This meant relatives could be assured that their loved ones were returned to the undertakers intact, unless organs had been donated.

Are end of life care services responsive to people's needs?

The trust action plan for palliative care services indicated that the speciality had seen 100% of patients who were struggling with their end of life symptoms on the same day. This indicated a service which was committed and responsive to ensuring patients were comfortable and pain free at the end of their life.

Where patients needed to be admitted to specialist oncology or palliative care beds for symptom control, staff arranged this with minimal delays. The trust gave us information from a data sample of 100 patients at the end of their life between February 2012 and May 2012. It showed that patients waited an average of 1.5 days for a palliative bed if they were a trust in patient on a general ward and an average of 2.7 days if they were admitted from the community. This indicated the service responded quickly when patients were in crisis or when they were inappropriately placed and needed specialised support.

One patient told us they had been moved from a general ward to an oncology ward to control their symptoms: "I was not given adequate pain relief, but I had a contrasting experience when I moved here. They are very responsive to me. If I am in pain in the night they get the doctor to reassess me quickly."

Another patient told us that staff were responsive if they complained of any pain. The patient said, "I have pain relief, the staff say I can have it every hour if I want, but I prefer not to do this." Another patient told us they had "no pain, it is very well controlled".

Hayward House took part in a wide range of clinical trials and was able to offer patients receiving palliative care the chance to be involved in clinical trials if they wished. It was recognised as a major centre in the East Midlands for palliative care research.

Rapid discharge

End of life discharge planning documentation supported the rapid discharge of patients who wanted to end their lives in their own home.

All of the staff we spoke with reported excellent relationships and liaison with other agencies, such as the ambulance service, adult social care services in the community, district nurses and Macmillan nurses. In addition, the palliative care team would contact the patient in the community once they had left to ensure that they received the care, treatment and support they needed at the end of their life and to try and prevent further unplanned admissions to hospital, where possible. One patient told us, "My oncologist is very supportive and informative and co-ordinates my care and tests in a timely way."

We spoke with a physiotherapist who received referrals from wards so that people could be assessed before being discharged home to receive end of life care. They told us that the most common referrals were for fall risk assessments, mobility assessments and the provision of mobility aids before discharge. They said that there was a real multidisciplinary approach to discharge planning, involving hospital and community-based staff to facilitate quick but safe discharge. The hospital and community-based staff would also follow the patient up once they were back in the community to make sure they had the support and equipment they needed.

One ward manager told us they always achieved a rapid discharge to comply with patient's end of life wishes.

End of life care

Responsive care to meet the needs of patients

One of the wards we inspected had a specialised unit for young people aged between 18 and 24 to provide a service more tailored to the needs of this age group (as opposed to these patients being supported on either children's or adult wards.) There were no young people on the ward when we did our inspection, but the facility was available for up to four patients if needed.

We spoke with two patients who had been admitted to general wards before being transferred to specialist oncology wards. One of the patients told us, "It [the general ward] felt crowded, like a battle-zone. It was too busy and noisy, especially at night. I was not given adequate pain relief. I have had a very contrasting experience here [on the oncology ward]. The care is very good, staff have time and they are responsive to my needs for example if I am in pain at night." The other patient had received good care, but their symptoms were not controlled or managed until they were admitted to the palliative care unit. The patient told us, "I made the decision not to have any further treatment, and then panicked about what that meant. The staff have been so kind and reassuring."

A senior nurse told us that the trust had established one of the wards we visited to try and afford patients who were admitted to the emergency department at the very end of their life with a more dignified and private death. We saw that there were clear criteria for patients being admitted to the ward, and staff checked these before offering patients a bed.

The service on this ward was highly responsive to patients' needs and wishes. Patients were often admitted to the ward from the resuscitation room in the emergency department, and sometimes they had already formed a strong relationship with the resuscitation staff. In such cases, staff would 'flex' their work between the two units, so that the patient had continuity of care from staff they already knew and liked. This was very good, compassionate and responsive care.

Planning for the needs of the local population

The trust had carried out an in-depth analysis of all of its end of life care, to determine whether it was meeting expected standards and the needs of the patient population. Its report included an analysis of potential future needs, demands and competition from other providers, as well as an assessment of whether the trust was able to provide the end of life care services that clinical commissioning groups said they needed. This report demonstrated the trust's ongoing commitment to providing a service that evolved in response to the needs of the population it served.

Spiritual support

The National Bereavement Survey 2011 indicated that patients did not feel they received the spiritual support they needed in the last two days of their life. We saw that the trust had taken robust action to address this, and staff we spoke with in all areas of Queen's Medical Centre told us about the availability of spiritual support for people of many different faiths. This was further evidence that the trust had improved services based on feedback from patients.

Staff on a ward which was part of the emergency department showed us a checklist which was used after a patient died. This included checking whether the patient or their relative had a religious affiliation, whether the chaplain or multi-faith centre had been contacted and whether patients' relatives needed support from the bereavement centre. They told us that the chaplaincy service and multi-faith centre were always very responsive and had hospital and community-based volunteers available to support patients and their relatives. Staff could contact them at any time during the day and night. We looked at some completed checklists and saw that staff had given consideration to each area.

The staff we spoke with in the chaplaincy and multi-faith services told us they had introduced a DVD for staff to explain and publicise their service. They said that the DVD had significantly increased awareness among staff. They told us that they were involved in training doctors, administrative staff and student nurses on end of life care, managing difficult conversations and breaking bad news. The staff in these services provided support for a very wide range of patients, from children to older people. They also provided support for staff who were in need of spiritual guidance. Staff were kind, calm, dedicated and compassionate.

Concerns and complaints

We heard two examples at Queen's Medical Centre of how the trust had changed services to reflect the needs of patients following feedback from staff.

End of life care

One consultant told us of an incident in which staff had created a DNACPR order without any consultation with the patient's relatives. As a result, the consultant had changed their practice to make sure there was proper consultation with both the patient and their relatives before putting an order in place.

The trust had established the Lyn Jarrett Unit to prevent patients at the end of their life having to die in busy and noisy areas of the emergency department, without dignity or privacy for them and their relatives. The ward offered single en-suite rooms with chairs for patients' relatives. The ward was calm, quiet and well organised, and it enabled staff to give patients and their relatives a more appropriate environment for people at the end of their life.

These two examples demonstrated a responsive approach to patient and staff comments.

Are end of life care services well-led?

Are wards well-led?

All of the wards we inspected were very well-led by managers and consultants who had a clear philosophy of care and a commitment to ensuring patients received high quality, compassionate and responsive care and treatment. They all spoke of their commitment to ensuring patients ended their life in a dignified way in the place they preferred.

The leaders on wards had a very visible presence, and staff and patients commented that the consultants were available on the wards. This had had a very positive impact on patient care. Staff gave examples of ward managers challenging junior doctors when paperwork and practice were not completed to acceptable standards, or when patients and relatives remained uncertain and had questions. The staff we spoke with across the wards were very dedicated and committed, often working extra hours rather than asking for agency staff to cover shifts.

Patients said the wards were well managed. Comments included "This ward is so lovely, well run, well managed. I honestly could not say a bad thing about it" and "The commitment to patients and what they want is outstanding. Care is really focussed on the individual".

Clinical governance

The trust had an integrated action plan for end of life care, which covered radiotherapy, chemotherapy and palliative care services. It included clinical outcomes, patient and staff satisfaction and financial effectiveness. This document provided an overview of current performance of end of life services and analysed future demand and market needs.

There were trust-wide and speciality-specific risk registers which identified areas of high, medium and low risk to patients and staff. The trust had used data from national patient safety alerts to identify risks, as falls and pressure ulcers featured on the end of life risk register. We saw evidence that actions the trust had taken had been understood and embedded in practice on most of the wards we inspected. This had had a positive impact on patient safety.

The resuscitation team audited DNACPR forms, and there were systems for informing individual clinicians when forms did not meet the required standards. This was resulting in more reflective practice, and staff and clinicians confirmed that they were looking again at forms that had not been completed to a satisfactory standard. This meant that decisions about DNACPR forms were more likely to be made in consultation with patients and their relatives when they were receiving end of life care.

The trust had acknowledged that it needed to improve its training. In particular, it needed to ensure that all staff had completed their mandatory training to ensure the workforce was suitably skilled and could competently meet the needs of the patients in its care. Staff on the wards we inspected commented positively on the 'Dying to communicate' training run by the head of palliative care. They said they found the training helpful and informative. All of the staff had a clear and consistent approach to providing good quality end of life care. The very positive comments we received from patients showed that the training had become part of everyday practice.

End of life care

There was clear evidence that, when determining where services needed to be improved, the end of life governance leads considered data such as:

- Mortality rates
- 28-day readmission rates
- How quickly symptomatic patients were seen
- How quickly transfers to specialist services were undertaken
- Patient satisfaction
- Complaints
- Staff survey results.

The Essence of Care Steering Group had undertaken benchmarking scoring of end of life care services. This exercise scored services against best practice clinical standards and an examination of the numbers of patient deaths, observed practice and patient/carer feedback. Wards were rated gold, green, amber or red. The benchmarking results were independently verified. No wards received a gold award in 2013, although three were awarded green status and had only minor changes to make. Two wards went from gold to red, but the group noted that these were not wards which specialised in delivering end of life care. The group made a number of recommendations and emphasised the need for benchmarking to be linked to training and education, especially for wards which did not perform well or those which did not specialise in delivering palliative care. This demonstrated there was a strong commitment to assessing and monitoring the quality of the end of life services across the trust and to service improvement.

Outpatients

Information about the service

Nottingham University Hospitals NHS trust provides outpatient services from three separate sites: Queen's Medical Centre, City Hospital and the Ropewalk House. In total, there are 17 distinct outpatient clinics listed for adults at City Hospital in addition to other outpatient clinics run by specialities such as burns. At Queen's Medical Centre there are eight distinct outpatient clinics for adults.

This is the first time we have inspected the outpatient service for this trust. We inspected eight of the outpatient clinics at City Hospital over two days, and we spoke with 21 patients, seven relatives and 26 staff.

We received comments from our listening events and from people who contacted us about their experiences. We also reviewed the trust's performance data.

Summary of findings

Overall, patients received a safe service. They were protected as far as possible against the risk of falls and infections, and they were protected from harm or abuse.

Treatment was generally effective. We identified pockets of excellent practice where some clinics had used reminder calls and texts to get their DNA rates down from 30% to 5%. The trust had not identified this good practice or shared it with other clinics which were not achieving good rates of appointment attendance.

A number of clinics had highly effective multidisciplinary teams to ensure patients' holistic needs could be met. However there were significant concerns about the effectiveness of the patient transport scheme and the consequent impact of transport arriving late on the patient and the outpatient services. This needed to be addressed.

Patients said that staff were caring, kind and compassionate. Most of the patients we spoke with who had a diagnosis of cancer said that staff had given them the news sensitively and in a way they understood. They said that staff had answered their questions fully.

We found some excellent responsive practice in the clinics we inspected. Some clinic staff had taken on board patient comments and had changed their practice as a result. Most of the patients we spoke with felt that they were seen quite promptly and felt well informed if the clinic was running late.

Although we identified some very well managed clinics, we were concerned that no one person at the trust had overall responsibility for assessing and monitoring the quality and consistency of the service across the trust. This resulted in a lack of shared learning and consistency across clinics and across the trust. This needed to be addressed.

Outpatients

Are outpatients services safe?

Preventing falls

An analysis of recent national patient safety alerts indicated that patient falls accounted for a significant number of notifications. The trust had highlighted this on its risk register as an area needing improvement. It told us that it had introduced falls risk assessments and care plans, had improved liaison with the falls prevention team and had had a closer trust-wide monitoring of falls to try and improve performance in this area.

When we analysed data for reported outpatient incidents between May 2013 and October 2013 we saw that there had been five falls in outpatient clinics during this period. Many of the falls occurred in specific clinics, and in some instances the incidence was likely to be linked to the reasons the patient was attending the clinic.

The outpatient areas we inspected displayed information about the number of falls which had occurred in the clinic during the month. This provided a visual reminder to staff to be vigilant and indicated to patients that the trust was focusing on keeping people safe.

Staffing levels and supporting workers

The outpatient risk register identified the risk to patients from difficulties recruiting and retaining cardiology staff. This recruitment difficulty resulted in an increased pressure on existing staff to provide on-call services. The trust was trying to address this by continuing to try and recruit to its vacant posts.

Data on reported outpatient incidents for May 2013 to October 2013 showed that there were no specific incidents recorded which would indicate a difficulty covering the cardiac outpatient clinics. There were three incidents reported across all of the clinics at City Hospital in this period which were linked to staffing levels. Two of these related to a consultant failing to cover a clinic, which resulted in patients having to book another appointment. Overall, across the site and the outpatient clinics, this was a low number of incidents.

We analysed the number and type of formal complaints received about outpatient services at City Hospital. We saw that there were three relating to cancellation of clinics and one relating to delays in the clinic. These are low numbers, suggesting again that staffing levels were satisfactory and enabled clinics to go ahead as planned.

Safety and suitability of equipment

The resuscitation equipment we inspected was clean, single-use items were sealed and in date, and emergency equipment had been serviced. This meant the equipment was safe for use in an emergency.

Are outpatients services effective?

Outpatient Survey 2011

The trust performed well in the 2011 Outpatient Survey for the effectiveness of its treatment of problems that had led to patients' referral to hospital. Overall satisfaction with outpatient treatment was almost better than expected.

Follow-up appointments

At the Queens Medical Centre, we were told that the ophthalmology department had not allocated a significant number of follow-up appointments. This meant people who had undergone ophthalmic surgery may not have been checked to make sure the surgery had been successful and there were no complications. Patients with macular changes could experience a significant deterioration in their sight whilst waiting to be seen by a specialist consultant. The trust had a risk assessment and action plan in place to address this and progress against the plan was monitored monthly. We spoke with a person at one of our listening events who raised concerns about the process for ophthalmic follow up appointments.

Concerns about the transport service

Data on reported outpatient incidents for the trust between May 2013 and October 2013 revealed that the second highest number of incidents at City Hospital arose due to difficulties with the transport arrangements to and from outpatient appointments. The incidents reported concerned patients being brought too late for their appointments and having to re-book. A number of incidents concerned patients waiting excessive amounts of time to be transported home following their appointment.

Outpatients

The trust used a patient transport service to get patients to and from hospital if they were unable to travel themselves. It told us that there was an escalation procedure if there were significant delays in transport to or from hospital. Analysis of the outpatient incidents indicated this was not always successful at resolving the issues.

Patients and staff consistently told us that the delays in transport were a significant issue on patient satisfaction and service efficiency. One patient said, "I hate the transport arrangements. They tell me I have to be ready for 7.30am but I am never collected until 9am. I am often waiting around to go home for up to an hour. I have cancer, I'm tired and it spoils an otherwise brilliant day." Another said, "[My relative] was taken to the wrong hospital in spite of them knowing which clinic I attended."

Staff also raised concerns and did not think the patient transport service was satisfactory. They told us this affected the running of the clinics, as patients arrived late and missed appointments. This meant they had to be fitted in, causing delays to other patients, or they had to rearrange their appointment, causing inconvenience and, in some cases, risks of delays in diagnosis and treatment for the patient. Some staff also raised concerns about delays in collecting patients, as those needing hospital transport were more likely to be frail, vulnerable and at risk of falls or ill health. This meant nurses had to be available to make sure the patients were safe until they were collected, which took them away from their outpatient clinic responsibilities. One member of staff told us that a patient's transport was delayed for so long recently that they had to be admitted into the patient hotel overnight.

Our evidence demonstrated that the patient transport systems were not always providing an effective service and this had a potential knock on effect on the effectiveness of outpatient services.

Consent to treatment

Most of the patients we spoke with told us the consultant and nursing staff had explained in depth any diagnostic tests and treatment which were needed, including the risks and benefits of any proposed treatment. All of the patients we asked said they had signed a consent form before they had any tests or treatment.

One patient commented, "The consultant went through the treatment being suggested in a lot of detail. I had the chance to ask any questions I had, but to be honest I didn't want to dwell on what would happen. It needs doing, that's fine. I signed a consent form before the treatment and the anaesthetist also went through the risks of having an anaesthetic." Another said, "The clinic sent me a letter telling me exactly what would happen today, what I had to bring. The staff have gone through this again with me and the doctor has also told me about my treatment and I have signed my form agreeing to surgery."

A patient we spoke with had received their treatment and said they had been "scared and embarrassed" beforehand. However, they said, "It was pain free and I was reassured throughout." We saw that staff gave the patient very clear post-treatment advice about possible symptoms and who they should contact if they occurred. Staff gave this information both verbally and in writing.

Patients who had attended the breast unit told us that the consultant had been very thorough. One said, "They went through, in detail, the possible causes of the lump and the possible treatment options. [They] were really reassuring, I never felt rushed and all of my questions were answered."

Our evidence demonstrated that staff were giving patients the information they needed to make informed decisions about treatment.

Multidisciplinary team working

We observed some exemplary multidisciplinary working in the clinics we inspected. We attended a multidisciplinary meeting in the breast clinic which was extremely well organised. We saw each patient's diagnostic tests were discussed in depth, and patient notes about diagnosis and treatment were updated contemporaneously to ensure they were accurate. We saw that at the meeting staff had discussions about situations which were complex, and they agreed on treatment and how to communicate results to the patient.

One clinic was managed by a physiotherapist, who received input from many others to ensure positive outcomes. Another was nurse led and provided education for patients about managing and living with their condition as well as offering treatment. One patient told us, "This clinic is wonderful."

Outpatients

The Hayward House clinic was on the same site as the inpatient, day service and complementary therapy services. Here, there was real multidisciplinary team input to provide patients with the care they needed to effectively manage their symptoms at the end of their life. A consultant was present on the day we inspected the service, and they were administering nerve blocks to patients to help control their pain. A range of complementary therapies were provided in a purpose built section of the service. These included aromatherapy, reflexology, Indian head and neck massage, relaxation techniques, hypnotherapy and simple massage.

The purpose of the therapies was to help patients relax and to assist with symptom control. Several therapies were provided by staff who had funded their therapy training and completed it in their own time, as they believed that the therapy helped patients cope with their illness and diagnosis.

The trust encouraged service user to give feedback, and it had been collating this feedback since August 2013. Some 23 people had provided feedback, and it was overwhelmingly positive. Some patients commented on the positive impact the therapy had on them. Comments included "I felt much more relaxed", "Very relaxing, I was able to talk openly and get stressful thoughts and guilty feelings away", "It helped me sleep" and "The reflexology helps tremendously with my physical and psychological wellbeing."

Are outpatients services caring?

Outpatient Survey 2011

In the 2011 outpatient survey, the trust got good results for the way clinicians explained to patients why they needed diagnostic tests and how they would be carried out. Patients also felt that doctors and nurses were good at explaining the risks and benefits of the proposed treatment. Patients were not dissatisfied, but felt less confident, in their understanding of the results of diagnostic tests. Most patients felt they had the time they needed to discuss their health with the doctor and that doctors had listened to their views. As a consequence, most patients felt confident with the doctor who was treating them.

The trust performed less well when it came to treating patients with dignity. Many patients reported that doctors or nurses spoke in front of them as if they were not there, and they said that they were not always afforded privacy when discussing their condition or treatment. One patient said, "The stroke consultant did not speak directly to patients, and the staff did not understand my diabetes." However, during our inspection all of the patients we spoke with who needed to be examined told us that this was conducted in private. One patient commented, "I was examined in private, and I felt really comfortable throughout."

Patient and relative feedback

Most of the patients and relatives we spoke with were very happy with the quality of the care and treatment they were receiving and with the approach of the clinic staff.

A patient at the women's unit told us the staff had been "reassuring and held my hand throughout my treatment". We looked at the patient comments book on the unit. The following were recent comments about the service:

- "A caring and professional service, thank you."
- "I was made to feel comfortable and relaxed from the minute I arrived. Thanks to all."
- "Thank you for being so kind and helpful."

We saw that the consultant and nursing staff on this unit were approachable, welcoming, compassionate and helpful.

Patients attending Dundee House told us that staff were "wonderful" and "excellent". The clinic manager told us one of their aims was to increase and improve patient empowerment through education and awareness.

Patients and relatives gave us very positive feedback about staff working at the breast unit. Patients commented:

- "The staff are all very kind, I feel reassured."
- "The staff are very kind and caring. They go the extra mile to make you feel comfortable, they really do."
- "We have found everyone here wonderful, from the reception staff to doctors, kind and caring."
- "As the doctor was a male [my relative] was automatically provided with a chaperone while being examined. It was done with real sensitivity."

Outpatients

We saw staff offering patients drinks, and we saw their approach towards patients was gentle and supportive.

All of the patients we spoke with at the urology service commented on how kind the staff were. One patient said, "I cannot say a bad thing about the service, the staff are fantastic, very kind, professional and informative." Another patient said, "The staff have reassured me throughout my treatment. I always felt I would get better. They were supportive to my family too. They explained everything and answered all of our questions." We saw that the staff in the urology centre responded to patients with warmth and respect. We saw them telling patients when there was a delay and letting them know how soon they would be seen.

Patients' experience of general outpatients varied. Most were positive about the staff working in the clinic. One patient said they found their experience stressful because of waiting, parking and booking problems. They did not feel staff had given them clear information about their diagnosis.

Others reported a more positive experience. One patient said, "The staff are good, I have had a lot of tests and these have all been good experiences," and another said, "I have had excellent care throughout." We saw that general outpatients had a calm and organised environment.

We received mixed feedback about the care people received in outpatients at Queen's Medical Centre. Many patients were frustrated with the waiting times. Some patients thought that, despite the wait, they received good care from the staff. Other patients felt less satisfied, and the term 'conveyor belt' was used a number of times to describe how services were run. One person told us, "You go knowing you're going to have to sit and wait, but when you do get seen the doctors are great." Another person said, "My consultant is fantastic. He has done so much for me and treats me very well."

Patient Cancer Survey 2013

The trust as a whole was in the bottom 20% of trusts in the cancer patient experience survey for six questions that asked whether patients:

- Felt they were told sensitively that they had cancer.
- Were given clear information.
- Were given the right amount of information about their condition.
- Were given the right amount of information about treatment.
- Felt that they were treated as a set of cancer symptoms.
- Had got enough emotional support from the hospital.

We spoke with a number of patients who had a diagnosis of cancer during our inspection. We asked them about their experience of being told they had cancer. The majority of patients we spoke with were positive about their experience. One patient told us, "I was told very, very kindly. There was nothing they could do to help by the time I was diagnosed, I understood that. They offered me a lot of information and support but I knew it was cancer really. I asked the questions I needed to and they answered every one." Another patient told us, "I was told with [my relative] in a very sensitive way. We both had lots of questions and they answered them all. I felt well informed."

Only one of the patients we spoke with was unhappy with the way in which staff had communicated their diagnosis. They said, "I was given a poor explanation of my condition, and I didn't understand it. On the first appointment I was told I had abnormal cells, one the next appointment I was told it was "cancer cells." This patient did not feel they were informed of their diagnosis in a supportive way. There had been one complaint about the oncology department about the failure to provide written information. This evidence indicated that although most patients were informed of their diagnosis in a compassionate way and in a way that helped them understand their diagnosis, the trust needed to take steps to ensure this was consistently done well.

Are outpatients services responsive to people's needs?

Appointment times and delays

The trust performed well in the 2011 Outpatient Survey in terms of how quickly it offered patients an appointment, its choice of appointment times and how it explained to patients what would happen at their appointment. The trust results were tending towards worse than expected

Outpatients

in respect of patients being informed of delays and how long they would have to wait to be seen in the outpatient department.

Data on reported outpatient incidents for the trust between May 2013 and October 2013 showed that there were four incidents about patients being unhappy with delays in being seen at City Hospital. There were also two incidents reported where clinicians were not present to cover clinics at the hospital. When seen in context of the number of outpatient appointments which took place at City Hospital in this period, this was not a significant number, indicating this was not a systemic problem for patients.

Trust data on reported outpatient incidents for May 2013 to October 2013 showed that there were twice as many incidents about patients being unhappy with delays at Queen's Medical Centre as City Hospital. Queen's Medical Centre also had a greater number of incidents in which clinicians were not present to cover clinics.

There was a national patient charter standard indicating patients should be informed if their appointments are delayed by more than thirty minutes. Our interviews with senior managers from the trust provided evidence that this was not consistently monitored across the trust and was not seen as a key performance indicator for outpatient services or for patient experience in general. This meant that not all outpatient clinics kept patients informed of delays and the reasons delay.

We analysed the number and type of formal complaints received about outpatient services at Queen's Medical Centre and identified the eye clinic (5 complaints) and the spinal outpatient clinics (11 complaints) received the most complaints over the year. Most of the complaints about the eye clinic were to do with the standard of medical assessment or treatment We also noted that the eye clinic received a number of negative comments from patients in feedback we received before our inspection. This clinic was also raised as an issue at one of our listening events. Two patients told us that they felt they got inconsistent care and advice from this clinic, and they complained that staff did not always treat them as individuals. Most of the complaints about the spinal outpatients department were about waiting times for an appointment and cancellations of outpatient clinics. This was also reflected in comments we received before our inspection.

Patients who miss appointments

Data on the number of patients who did not attend (DNA) their booked appointments show that rates were very high in some clinics.

We identified pockets of excellent practice where some clinics had used reminder calls and texts to get their DNA rates down from 30% to 5%. The trust had not identified this good practice or shared it with other clinics which were not achieving good rates of appointment attendance.

We visited two of the clinics at City Hospital with high recorded rates of patients who did not attend their appointments. In both cases we identified there may be errors in recording the data, as the clinic managers attributed most non-attendance to patients not being able to attend (cannot attend) as a result of ongoing complications with their illness, condition or with problems with allocated transport. These figures should not be recorded in the DNA rates.

Neither of the managers was aware that their service had high DNA, rates and they told us the DNA rates were not routinely fed back to them at clinic level to enable them to manage the situation proactively. They talked us through the work they did to try to make sure patients attended their appointments as planned.

Are outpatients services well-led?

Records

Three members of staff told us that they felt the clinic preparation rooms at Queen's Medical Centre were inadequate environments with insufficient computer access for staff. They raised concerns that patient files being transported through the hospital were at risk of being lost.

We analysed the trust's data for reported outpatient incidents between May 2013 and October 2013. Queen's Medical Centre had over twice as many reported incidents of missing or inaccurate records as City Hospital. Some of these issues were raised and reported following internal audits and others were reported by consultants who felt ill-prepared when seeing patients without full access to their records. In at least one case, a patient had had to rearrange their appointment. There were also a number of incidents of information about patients being located in

the wrong file. This meant there was a risk of important information going missing, which could affect diagnosis and treatment. It also highlighted concerns about the confidentiality of patients' medical information. There was evidence to show that the trust had responded in each instance, but this had not stopped further incidents taking place. This led us to question the efficacy of the systems for ensuring that patient records are stored securely and are easily retrievable.

Organisational and service delivery risk

There were trust-wide and speciality-specific risk registers which identified areas of high, medium and low risk to patients and staff. The trust had highlighted that many staff working in outpatient departments were not up to date with their manual handling training. It had tried to address this by increasing the number of places on training courses but had identified that staff were not attending this training. This presented a risk to staff and patients, especially when patients needed support with moving or after falling.

Management and clinical leadership

We spoke with clinic staff and managers, and they were not sure who was ultimately responsible for the quality and oversight of outpatient services across the trust.

We interviewed senior managers from the trust and were informed there no one person assumed overall responsibility for assessing and monitoring the quality and consistency of the service provided across the trust. The result of this was that they were able to identify pockets of excellent practice, where consultants led the clinics with a great commitment to ensuring the best possible outcomes for patients (the examples we were given were general surgery and gynaecology). However, the senior managers told us that this practice was not consistent. Nor was good practice shared and replicated in clinics which were not performing as well, to ensure a consistently good quality service across the trust.

Some of the specialities at Queen's Medical Centre were highlighted as not performing as well. They were failing to reflect on whether they were meeting their targets and to plan ahead to ensure capacity could meet the demand for the services. Staff said that this had led to the setting up of ad hoc clinics with very little notice for patients, which had resulted in high numbers of patients not attending their appointment. This area required improvement to ensure there was a standardised approach to capacity planning across the trust.

A senior manager told us that the trust had appointed new personal assistants, who were monitoring the number of clinic cancellations and ensuring that they wrote to patients if clinics had to be cancelled. This ensured patients were kept informed about any changes to their appointments. The manager told us that consultants "broadly stuck" to the rule about giving six weeks' notice of their absence and any impact on their clinic so that patients could be notified accordingly.

Concerns about the accuracy and availability of records

Data for reported outpatient incidents at the trust between May 2013 and October 2013 showed that most of the issues reported at City Hospital concerned missing or inaccurate patient records.

Some of these issues were raised and reported by consultants or nursing staff who felt ill prepared when seeing patients without full access to their records. In at least one case this had led to the patient having to attend the clinic again for their consultation. There were also a number of incidents highlighted where patient information was located in the wrong file. This meant that there was a risk of important information going missing, which could affect diagnosis and treatment but also compromise the confidentiality of individual patient's medical information. There was evidence that the trust had responded in each instance, but this had not prevented further incidents from taking place. This led us to question the efficacy of the systems for appropriately storing records so that they are easily retrieved and secure.

Good practice and areas for improvement

Areas of good practice

- The bereavement nurse on the Lyn Jarett Unit sending a hand-written letter to relatives of deceased patients. The letter was sent six weeks after a patient's death. It offered condolences and invited the family to speak with a bereavement nurse or senior doctor and ask any questions they had.
- The Hospital Threshold Comprehensive Geriatric Assessment for Frail Older People which was providing an improved experience for people who were older, frail and vulnerable.
- The QMC trauma centre providing effective care delivered by a strong multi-disciplinary team. This had improved outcomes for patients sustaining major trauma.
- The effective care being provided by the critical care unit. Outcomes for patients were better than the national average, with the mortality rate for the department being significantly better than the national average.
- The care being provided to patients on the dementia ward was person centred and based on evidence based practice.
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work and felt proud of the trust and what they did. They understood the hospitals values.
- The bereavement care that was offered in the trust by the multi faith centre and the compassion shown by the mortuary staff towards relatives/friends of deceased patients.
- The medical staffing levels within the trust and the support given to doctors in training by senior medical staff.
- The quality of the senior leadership was good, particularly that shown by the executive directors.
- The care and range of services offered at Hayward House.

Areas for improvement

Action the hospital MUST take to improve

- Ensure preventative maintenance is carried out on clinical equipment.
- Ensure all staff receive mandatory training.

Other areas where the trust could improve

- Review the process for the recording of controlled drugs in the maternity and gynaecology departments so records are accurately maintained.
- Review the staffing requirements for the paediatric wards and departments.
- Ensure there is management oversight of the whole outpatient service and processes to ensure shared learning and consistent practice.
- Ensure action is taken to address the outpatient follow up appointments for ophthalmology.
- Address the privacy and dignity issues that patients may face when the A&E department has reached capacity and patients have to be cared for in corridor areas.
- Ensure all areas of the trust are free from dust and hand gel is always available in all dispensers.
- Review the length of time patients are waiting for outpatient appointments and ensure people are given information about how long they will have to wait.
- Review the facilities for visitors to have access to a hot meal after 2pm, particularly for those visitors who are further away from home and need to stay for long periods at the hospital to be with their relative.
- Review the availability of information so that it is accessible for people who find it difficult to access.
- Ensure children are given opportunities to give feedback on their experiences of care.

This section is primarily information for the provider.

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury.	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010: Safety, availability and suitability of equipment. Regulation 16 (1) (a). How the regulation was not being met: People who use services were not protected against the risks associated with unsafe or unsuitable equipment because of inadequate maintenance.

Regulated activity	Regulation
Treatment of disease, disorder or injury.	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010: Requirements relating to workers. Regulation 23 (1) (a). How the regulation was not being met: People who use services were at risk of not receiving care and treatment by appropriately trained staff.