Care Quality Commission

Nottingham University Hospitals NHS Trust

Nottingham City Hospital

Quality Report

Hucknall Rd,
Nottingham
NG5 1PB
Tel: 0115 969 1169
Website: www.nuh.nhs.uk

Date of inspection visit: 15-18 September 2015
Date of publication: 08/03/2016

This report describes our judgement of the quality of care at this hospital. 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.

Ratings

Overall rating for this hospital	Good
Medical care	Good
Surgery	Good
Critical care	Outstanding
Maternity and gynaecology	Good
Neonatal services	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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 University Hospital NHS Trust were inspected as one of 18 CQC new wave pilot inspections in November 2013 but the trust was not rated at this inspection. The purpose of this comprehensive inspection was to award a rating to the trust for the services it provided. We carried out an announced inspection to the three hospital locations between 15 and 18 September 2015. Unannounced visits were carried out on 28 September to medical wards and Haywood House.

Overall Nottingham City Hospital was rated as good with some aspects of outstanding. End of Life services however, required improvement.

Our key findings were as follows:

- Overall patients we spoke with expressed a high level of satisfaction with the care and treatment provided to them. Pain relief was given to patients in a timely manner. Staff treated patients with kindness, dignity and respect.
- There was good incident reporting culture in the trust and systems were in place to report incidents and largely there was effective learning from incidents. The exception to this was a backlog of radiology and maternity incidents where a lack of timely review may affect the ability to quickly implement any learning.
- Cleaning services were contracted out to a private provider. There had been some concerns about the standard of cleanliness and this was reflected in some ward audits. On-going monitoring and performance management of the cleaning services, delivered by the private provider was planned. During the inspection the wards appeared visibly clean.
- Hand cleansing facilities were available in all areas and mostly good practices were seen. However, we saw that some staff on Hogarth Ward did not always wash or cleanse their hands when going in and out of ward or bay areas. There were 31 cases of Clostridium Difficile (C. Diff) infections at the hospital between May 2014 and April 2015. C. Diff is an infection which causes diarrhoea. There were no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia at the hospital in the same time period. MRSA is an infection that is sometimes very difficult to treat.
- The systems for ensuring equipment was safe and fit for use was not robust. We found that some equipment was not checked or serviced as frequently as it should be.
- In most areas staffing levels were sufficient and there were escalation systems in place to identify and address shortfalls in staffing levels. At Haywood House we found that some shifts had been short of staff which had affected the care patients received.
- For end of life services we found that there was strong leadership for specialist palliative care services but this was not extended to end of life care provided on other wards.
- There was an open culture throughout the trust and staff were generally positive and proud to work there. Across different disciplines staff worked well together. The trust board members were visible and positively regarded by staff.

Summary of findings

- The trust introduced shared governance in 2012. Shared governance gave staff the opportunity to create councils for each ward or department and any level of staff could join the council. It was a 'bottom up' model of management which aimed to empower frontline staff to make decisions about patient care at the point of care delivery.

We saw several areas of outstanding practice including:

Medical care (including older people's care)

- We saw examples of innovative practice in order to reduce risks to patients. On Southwell Ward we saw patients wore a coloured wrist band when they required oxygen to ensure they received the correct rate. This ensured staff could easily identify the patient's required rate and dangerous levels of oxygen would not be administered.
- Patients receiving oxygen through a nasal cannula were at risk of developing pressure ulcers where plastic tubing went over the tops of their ears. Sponge covers were placed over the tubing to prevent this from happening. (A nasal cannula is a lightweight tube which splits into two prongs placed in the nostrils and from which a mixture of air and oxygen flows).

Surgery

- Theatres benchmarked activities against their own standards and compared their practices with external organisations. For example, they had compared some of their processes with neighbouring hospitals and as a result asked a trained band six nurse to do a specific eye procedure instead of a consultant.

Critical Care

- A critical care consultant at the trust was developing a tool to support the complex decision making process for critically ill patients. The tool was based on an ethical and balanced approach to selecting a suitable treatment plan for patients and act as a base for further clinical decisions. The tool would then be used as a tracking system so that clinicians understood previous treatment choices and clinical outcomes. This was supported by colleagues and was considered to be an innovative development in tracking the decision making process in treating critical care patients.
- The use of the trust's simulation centre had helped staff in developing advanced communication skills.
- Innovative approaches were used to gather feedback from people who used the service. One example was that patients and carers were invited to the opening of a new bed area to get their views on patient privacy.

End of life services

- A project was set up and led by a ward sister at Hayward House following a high rate of incidents related to falls. An independent falls expert was invited to look at the environment and the day to day culture of nursing practice on the ward at Hayward House. This review found a lack of focus on patients who were at high risk of falling. Steps were taken following the review to reduce the risk of falls on the ward. Two cohort bays were set up. [A cohort bay is for patients at high risk of falling to be cared for together in the same area so their needs are managed more efficiently and safely]. A cohort nurse was allocated to the cohort bay. The cohort nurse wore a brightly coloured tabard to reduce the risk of interruptions and diversions. Changes to the ward environment included a colour theme to make it easier for patients to find their way around and equipment clutter removed from corridors. A six month review in June 2015 showed these changes had led to a 43% reduction in total falls, a 38% reduction in unwitnessed falls and a 67% reduction in repeated falls.

Maternity and gynaecology services

Summary of findings

- A member of staff designed an electronic application specifically for women using the trust's services called the 'Pocket Midwife'. It was free to download and anyone could access it. It had information about each stage of pregnancy, and all of the maternity leaflets and maternity guidelines could be accessed easily. The service could add news flash information to the application for women to see, such as sending a reminder to women about flu vaccinations.

Outpatients and diagnostic imaging

- The chemotherapy department demonstrated numerous examples of improvement and development. The service had developed projects to help the service run quicker and smoother for staff and patients. For example, the service had developed a purple bags initiative. This allowed patients to access treatment quicker after having their blood tested and authorised. Another initiative improved the flow of patients through the clinic by introducing a system for staff to quickly and easily see when a chair was available for patients to start their treatment.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must ensure consultant cover in the maternity service for the labour suite meets national recommendations and guidance.
- The trust must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced nurses working in the critical care service. The Core Standards for Intensive Care Units minimum requirement is for 50% of nurses in intensive care units to have a post-registration award in critical care nursing. There were 26% of nurses with this qualification at the time of our inspection.
- Ensure that trained nurse presence on the neonatal unit meets the 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM).
- Ensure that there is sufficient neonatal consultant cover during the out of hour's period so that both hospital sites can access their own individual on call consultant. This is in line with the BAPM standards (3rd edition – section 5.1.4).
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of patients on the inpatient ward at Hayward House.

In addition the trust should:

- The trust should ensure patients' fluid and food charts are completed accurately
- The trust should ensure oxygen is prescribed in line with the trust's policy for patients who require it.
- The trust should ensure immunosuppressed patients are not nursed in the same area as those with infections.
- The trust should consider the installation of air conditioning in the Wolfson Cystic Fibrosis Unit to reduce distress for patients in warm weather.
- The trust should ensure clinical waste bins awaiting collection are secure.
- The trust must ensure City Hospital is secure at night time.
- The trust should ensure all equipment, including electrical, has been appropriately serviced and received portable appliance testing when necessary.
- The trust should ensure fire alarm break glass points have the necessary equipment so they can be activated.
- The trust should ensure the proper and safe management of medicines by staff following the correct procedures for checking and administering medication to patients.
- The trust should ensure assistance given to patients with oral hygiene is documented correctly and consistently by staff.
- The trust should ensure staff have feedback on the auditing of fluid charts.
- The trust should ensure adequate training is available for all staff using the inpatient adult risk assessment booklet NUH01873S in relation to pages 13, 14 and 15.

Summary of findings

- The trust should ensure all complaints and the outcome of the investigations are shared with the area concerned and the wider directorates.
- The trust should ensure, as good practice, that prescription charts have the name of the prescriber written in capital letters with their contact number for identification purposes.
- In the trust's Family Health division 67% of staff had not completed training in the safe use of medical equipment. The trust should ensure staff are trained and competent to use equipment safely.
- The trust should ensure that workforce requirements in the maternity service are analysed in terms of what women using the service need, rather than what midwives do.
- The trust should ensure up to date guidance is available for staff in the maternity service regarding criteria for admission to the midwifery led unit.
- The trust should ensure a home from home philosophy and environment for women giving birth in the midwifery led unit.
- The trust should ensure there are operating theatre facilities and time dedicated for planned caesarean section operations.
- The trust should ensure maternity service actively recruit user representatives.
- The trust should ensure all senior and specialist staff in maternity services are visible on the wards and participate with clinical activities.
- The trust should ensure women and their families using the maternity service have clear and accessible information about how to make a complaint.
- The trust should ensure the maternity service meets the national neonatal audit programme standards for temperature taken at birth, and mothers receiving steroid medication in the antenatal period.
- The trust should ensure confidentiality of information about women using the maternity service. Women's names and details of their treatment should not be displayed where they may be seen by visitors.
- The trust should ensure that all staff receive feedback about incidents.
- The trust should ensure that nursing assessments are fully completed and babies care plans are reviewed regularly.
- The trust should ensure that a complete record is kept for each baby, which includes appropriate information and documents the care and treatment provided.
- The trust should ensure that each staff member has an annual appraisal.
- The trust should ensure that each staff member attends mandatory training.
- The trust should ensure that medical cover in the critical care service meets the Core Standards for Intensive Care Units recommendations at all times.
- The trust should ensure all 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms are completed in line with the trust's DNACPR policy.
- The trust should have an end of life care strategy to ensure patients receive end of life care in line with national guidance and research based good practice.
- The trust should increase the number of consultants in the specialist palliative care team to reflect the recommendations of the Association for Palliative Medicine of Great Britain and Ireland and the National Council of Palliative Care.
- The trust should increase the specialist palliative care nursing team to ensure patients can access specialist palliative care services and receive a face-to-face consultation seven days a week, in line with National Institute for Health and Care Excellence (NICE) Quality Standard number 10 published in 2011 for end of life care for adults.
- The trust should ensure end of life care champions are allocated protected time each week for carrying out their role.
- The trust should consider updating their end of life care bundle to ensure staff record patients' preference for involvement of the pastoral care team.
- The trust should provide a structured programme of end of life care training for all staff to ensure patients receive appropriate care at the end of their life.

Summary of findings

- The trust should ensure effective monitoring of 'fast-track' discharges and compliance with patients' wishes regarding preferred place of care and preferred place of death. Good practice in these areas should be shared across the trust and appropriate action taken to address any issues.
- The trust should provide a structured programme of end of life care training for all staff to ensure patients receive appropriate care at the end of their life.
- The trust should ensure the system for maintaining and testing clinical equipment is timely, effective and consistent to ensure it is safe to use.
- The trust should ensure risk assessments are carried out where environmental issues may have an impact on outpatient services.
- The trust should ensure there is a sufficient and effective portering service for patients attending outpatient clinics from the wards and when required to transport deceased patients to the mortuary.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Good	Overall, we rated the medical care service at City Hospital as good, although the safety of those services required improvement. There were sufficient numbers of staff to meet patients' needs although recruitment was on-going to fill vacant posts and agency staff were used when required. Staff were encouraged to report incidents and serious incidents were thoroughly investigated. Although staff mostly demonstrated a good understanding of infection prevention and control, patients were sometimes put at risk of infection because routine hand hygiene was not always adhered to, and clinical waste was not stored securely prior to collection. Medicines were stored and administered safely. Records were stored securely, though were not always completed in a timely manner. A hospital at night and critical care outreach teams were available to support staff during night hours if patients deteriorated. Staff were aware of safeguarding adult procedures and systems were in place to minimise the harm to patients at risk of falls. The correct equipment was not always available for staff to use, and servicing of equipment was not always undertaken on time. There was a lack of security of the hospital at night time. Care pathways were in place for patients in line with the National Institute of Health and Care Excellence (NICE) guidance. Pain relief was given in a timely manner and patients were supported to receive adequate food and hydration. Staff worked across disciplines to provide joined up care to patients. Staff were competent in their role and understood the importance of gaining consent prior to treatment being given. The pharmacy department was not open after 1pm at weekends, which meant some patients' discharges were delayed. However access to medicines was available from Queen's Medical Centre. Generally we found patients were cared for by compassionate staff who showed them dignity and respect, although behaviour of some staff was

Summary of findings

variable. Patients told us staff gave them privacy when it was needed and were kind; they also involved them in decisions about their care. Members of the hospital team were available to give patients emotional support when this was necessary.
Medical services in the City Hospital were reviewed and where necessary altered to reflect the demand and needs of patients. Processes were in place to ensure access to medical services and discharge for patients was appropriate, although some discharges for older people could be delayed. Hourly documented checks were in place to ensure staff could respond to patients' individual needs. We could not be assured that learning from complaints was shared with all staff.
There was an effective governance framework in place to support the delivery of quality care with annual plans in place for each medical specialty. Wards had the ability to set up their own councils and directly influence decision-making as close to patients as possible. Senior staff were visible and staff felt supported.

Surgery

Good

Overall we rated surgical services as good, with outstanding leadership.
Surgery services at City Hospital had systems to protect patients from harm and abuse. They managed and responded to risk effectively. The specialities and theatres had reliable processes to analyse learning from mistakes. Patient areas were visibly clean. There were robust arrangements for monitoring safety and cleanliness.
Staff were conscientious about mandatory training and ward managers had good local induction processes. Although there were wards with staff vacancies, ward managers ensured that patients were safely cared for. However, some equipment checks were not up to date, and some staff were unclear about their role in a major emergency.
The services were effective because they planned and delivered patient care and treatment in line with current evidence based guidance, standards, best practice and legislation. Managers and senior

clinicians monitored this through audits and at governance meetings. Patients had comprehensive assessments of their needs. There was good multidisciplinary teamwork.
Staff were supported to deliver effective care and treatment including through meaningful and timely supervision and appraisals. Staff understood and documented arrangements for consent and understood how to apply the Mental Capacity Act.
Nurses, doctors and care assistants treated patients with dignity, respect and kindness during all interactions with staff. Patients felt supported. They were involved and encouraged to be partners in their care and in making decisions. Consultants and nurses spent time talking to patients, or those close to them. Patients received information in a way that they could understand. Staff found innovative patient orientated solutions to everyday problems.
The hospital had a new, modern admissions suite for planned surgery, did outreach work with the community and provided enough capacity to meet demand for operations. Services worked well to meet the needs of individual patients, such as people living with dementia.
However, some facilities such as the old theatres waiting area were less patient friendly.
Surgery services had a clear vision which was translated into measurable achievements by speciality action plans.
The leadership, management and governance of surgery services assured the delivery of high quality, person-centred care. Surgery leaders worked in partnership with other organisations to improve care outcomes.
Services used innovative approaches to gather feedback from people who used services and the public. Surgery services welcomed constructive challenge and feedback from the public and comparison with similar organisations.
Staff and leaders participated in continuous improvement and staff were accountable for delivering change. Innovation and achievement were celebrated and publicised.

Critical care **Outstanding** ☆

We found the adult critical care services were good for safe, effective, and responsive, and outstanding for caring and well led.

Summary of findings

There was a genuinely open and honest culture in which incidents and concerns were shared across the services and changes implemented to improve patient safety. National, trust, and local audit data was used to support service improvements.
Internal training and support for staff development was of a good standard and well established, however we did have concerns about limited access to the critical care module for registered nurses in CCD.
Care was patient centred and continually assessed on an individual basis. Emphasis was placed on the safeguarding of patients who were unable to communicate due to their clinical condition.
Patients and visitors consistently expressed satisfaction with the care and treatment they received stating that staff were very kind, caring and nothing was too much trouble.
There was a collective enthusiasm across all staff groups with a clear knowledge of the vision, values and strategic goals for the adult critical care and cardiac critical care services.
Staff told us they were proud to work in the department, felt very supported in their work and their opinions were valued.

Maternity and gynaecology

Good

Overall we rated the service as good but safety required improvement.
There were established local and divisional risk and governance arrangements. Staff felt the service had a profile on the trust board agenda. There were processes in place to share lessons learnt from incidents and investigations.
The trust promoted breastfeeding and women were supported in their chosen method of feeding.
Women were positive about the care they had received. We observed staff interacting with women and their partners in a respectful compassionate way. Women and their partners felt involved with their care and were happy with explanations given to them. Partners would have liked to have the choice to stay to support women throughout the night.
There was an effective multidisciplinary approach to care and treatment, which involved a range of

staff in order to enable services to respond to the needs of women. All staff told us that the working relationships between the professional groups were excellent.
Staff wanted to continue to develop the service and demonstrated this through implementing new ideas.
Women using the maternity service received care based on the maternity service's guidelines and national guidance. The guideline for admission of a woman to the midwifery led care unit was removed to review the admission criteria for low risk women and so there was no up to date guidance for staff to follow.
There were some displays of information for people using the service about how to make a complaint if they were dissatisfied. The majority of women and their families we spoke with did not know how to make a complaint.
The medical staffing was not in line with national guidance. The midwifery and medical vacancy rate was being acted upon but there were difficulties in recruiting staff, which meant they were unable to meet the national standards for safe staffing.
It was difficult to identify if women were high or low risk, and not all risk assessments were fully completed. Records were legible, dated and signed. However, the woman's name and hospital, or NHS number, were not documented on each page in the majority of hand held records. This posed a risk of detached pages not being returned to the correct records.
The unit did not use Neonatal Early Warning scoring charts to assist in the early recognition of deterioration of new-born babies.

Neonatal services

Good

Overall, neonatal services at City Hospital were rated as good. We found services for babies to be effective, caring, responsive and well led. However, improvements were needed for the service to be safe so that babies were protected from avoidable harm.
The Family Health Directorate recognised nurse staffing did not fully meet the 2011 British Association of Perinatal Medicine Guidelines (BAPM). This was because the ratio of one nurse to one baby in the neonatal intensive care unit was

Summary of findings

not achieved. Staffing issues had resulted in cot closures, which we were told by staff had taken place on average four to five times a month to maintain safety within the service.

The children's service workforce review document identified 25 vacancies within the neonatal service. Additional neonatal nursing staff had been and continued to be recruited following the receipt of this additional funding. However, due to staffing issues we were told that cot closures had taken place on average four to five times a month to maintain safety within the service.

There was a recognised shortfall in neonatal consultant cover during the out of hours period. Current practice meant the neonatal consultant staff covered both Queens Medical Centre and City Hospital neonatal units. This practice did not meet the BAPM standards. To mitigate the risk the service had recruited three additional consultants to help provide consultant level out of hours cover at both sites and medical cover for the transport service.

A lack of specialist radiology cover out of hours, meant babies were transferred to another hospital to receive this service.

Arrangements were in place to minimise risks to babies receiving care, and there was effective monitoring of quality and outcomes. Babies received evidenced based care and there was good multi-disciplinary working between children's services, external providers and the mental health team.

Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of openness, flexibility and commitment.

The neonatal service supports other neonatal units through its regional retrieval service and had good support from other NHS trusts when babies needed more specialist care and treatment.

Neonatal services were responsive and had mostly met babies and their parent's needs. However, due to staffing issues we were told that cot closures had taken place on average four to five times a month to maintain safety within the service. Currently 18 cots are open to admissions on the neonatal unit.

Summary of findings

Transitional care within the neonatal service was nurse led and had prepared and supported babies and their families for discharge home.
Clinical strategies and priorities were in place, against which were action plans with identified start and finish dates. The objectives were representative of the concerns identified in the service risk register.
A clear leadership structure was in place for the service. Staff said they were well supported by their clinical matron who they saw daily.
Governance processes and known clinical risks were monitored. Public and staff engagement processes captured feedback from both groups.
Following the findings from the 'Trent Perinatal Network Review' on 3 November 2014, improvements had resulted in improved consultant and nurse staffing levels but recruitment was ongoing.

End of life care

Requires improvement

End of life care at this trust required improvement because people were not always protected from avoidable harm.
Staffing levels at Hayward House were at times compromised because the staff rota did not always reflect what was happening on the ward. This did not always ensure safe and effective care could be delivered.
Care and treatment was mostly delivered in line with local and national guidance and a holistic patient-centred approach was evident.
There was good multidisciplinary working at Hayward House and throughout the ward areas at the City Hospital.
Although patient outcomes were monitored for patients who had been referred to Hayward House, patient outcomes were not monitored throughout the trust. There was no auditing of patients preferred place of care or death. The trust was therefore unable to identify whether patients' wishes were respected at the end of their life. We did however see that discussions took place around preferred place of death and care, but we were not assured these discussions took place with patients who had not been referred to the specialist palliative care team.

Summary of findings

Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were mostly made appropriately and in line with national guidance. However, we found the forms were not always endorsed by a consultant.
The leadership for specialist palliative care services was evident; however, this was not the case for end of life care throughout the hospital, even though the leads were the same people. Staff throughout the trust were aware of, and spoke highly of, the specialist palliative care team but were unaware they also took the lead for end of life care. In addition, there was no vision or strategy for end of life care although there was a specialist palliative care annual plan for 2014/15.

Outpatients and diagnostic imaging

Good

We rated the outpatients and diagnostic imaging service as good overall.
Staff reported incidents appropriately and we saw evidence of incident investigation, actions and shared learning. Clinical areas were visibly clean with effective systems to ensure cleanliness was maintained. Medicines were stored appropriately and fridges and stock were checked regularly. Records were stored securely and were available on time for clinics. There were safeguarding policies and procedures in place and staff were aware of safeguarding leads. Staff were up to date with their mandatory training. Equipment was not always checked or maintained in line with trust policies and manufacturers guidance.
Outpatient and diagnostic imaging services worked to National Institute for Health and Care Excellence (NICE) and other national guidance. There were good examples of multi-disciplinary working. All staff we spoke with had received an annual appraisal, although outpatient and diagnostic imaging services fell just below the trust target of 90%. Radiology services offered a seven day service to hospital departments. Staff understood their role concerning the Mental Capacity Act 2005 and knew what to do when patients were unable to give consent for treatment.

Summary of findings

Staff respected and maintained patients' privacy and dignity. Patients were positive about staff and the way they were cared for. Staff gave examples of when they had gone the extra mile to help patients. Staff involved patients in their care and treatment.
In some areas, the environment had an adverse impact on the planning and implementation of outpatient and diagnostic imaging services.
The trust had not met cancer waiting time targets, which meant some patients did not have timely access to treatment. There were targeted clinics for communities or groups of people who were at risk of particular conditions. Interpreters and chaperones were available for patients who required them. There was limited information available in different languages. Staff were aware of the trust's complaints policy and were able to describe what they would do in the event of a patient making a complaint.
There was a well-defined strategy for outpatient and diagnostic imaging services with clear links to the overall trust strategy. Risks were discussed at directorate meetings with clear actions and accountability to respond to them. Leaders were approachable and visible and were aware of the issues and risks affecting their service. Staff were well motivated and felt supported by their leaders. There was a patient centred and supportive staff culture. There were examples of where services sought continuous improvement and innovation.

Nottingham City Hospital

Detailed findings

Services we looked at
Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

Detailed findings

Contents

Background to Nottingham City Hospital

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.

The trust also provides specialist services to between three and four million people from neighbouring counties. 28% of the population are aged 18 to 29 and full-time university students comprise about one in eight of the population. Also 35% of the population are from ethnic minority groups.

Nottingham is ranked 20th most deprived district out of 326 in England in the 2010 Indices of Multiple Deprivation.

The health of people in Nottingham is generally worse than the England average. Deprivation is higher than average, and about 33.7% (18,600) children live in poverty. Life expectancy for both men and women is lower than the England average (approx. eight years). The rate of adults who were classed as obese was 21.7%. The rate of alcohol related harm hospital stays, self-harm hospital stays, smoking related deaths, and rates of sexually transmitted infections, and TB are all worse than average.

Nottingham University were inspected as one of 18 CQC new wave pilot inspections in November 2013, the trust was not rated at this inspection. The purpose of this comprehensive inspection was to award a rating to the trust for the services it provides. We carried out an announced inspection of the Hospital between 15 and 18 September 2015. Unannounced visits were carried out on 28 September to medical wards, children's wards and the maternity department.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

The team included CQC inspectors and a variety of specialists: A consultant surgeon, registered nurses, student nurses, allied health professionals, midwives, and junior doctors.

Detailed findings

We were also supported by three experts by experience who had personal experience of using, or caring for someone who used, the type of services we were inspecting.

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?

Before our inspection, we reviewed a wide range of information about Nottingham University Hospitals and asked other organisations to share the information they held. We sought the views of the clinical commissioning group (CCG), NHS England, the Trust Development Agency, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

The announced inspection took place between the 15 and 18 September 2015. We held focus groups with a range of staff in the hospital, including nurses, junior and middle grade doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists and occupational therapists. We also spoke with staff individually.

We carried out unannounced inspections to Queen's Medical Centre and City Hospital on 28 and 29 September 2015. The purpose of the unannounced visits was to look at the care provided in the emergency department, medical wards, maternity and children's services.

We held a listening event in Nottingham on 8 September 2015 where members of the public shared their views and experiences of the trust. We also held focus groups with members of the public. Some people also shared their experiences of the trust with us by email and telephone.

Facts and data about Nottingham City Hospital

The Nottingham University Hospitals provides integrated services to a population of 2.5 million patients. It has 1,996 beds: 1,793 general and acute; 134 maternity; and 69 adult critical care beds.

The trust employs: 11,386 whole time equivalent (WTE) staff.

The trust has a total revenue of £874,090 million and its full costs were £873,340 million. It had a surplus of £750,000.

There were 121,112 inpatient admissions, 782,702 outpatient (total attendances) and the A&E department saw 187,892 patients between December 2013 and November 2014.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Neonatal services	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Nottingham City Hospital medical care services are managed by four divisions of the Nottingham University NHS Trust. Specialities included gastroenterology, respiratory, stroke medicine, diabetes, cardiology, clinical oncology, nephrology, and infectious diseases.

There were 52,600 admissions to medical care services at Nottingham City Hospital in 2014, of which 24% were emergency admissions, 5% elective, and 72% day cases. The medical care services at Nottingham City Hospital comprises of 23 wards which includes a Specialist Receiving Unit.

During our announced inspection we visited 14 medical wards during daytime hours. We carried out an unannounced inspection visit during the night, visiting four wards. We used a variety of methods to gather evidence. We spoke with consultants, junior doctors, registered nurses, healthcare assistants, allied healthcare professionals, and other support staff. We spoke with 38 patients and five patients' relatives. We interviewed six senior doctors and the general manager for medicine. We observed care and the environment and looked at records, including nine patient care records. We looked at a range of documents, including specific plans of care for certain diseases, audit results, action plans, policies, and management information reports

Summary of findings

Overall, we rated medical care service at City Hospital as good, although the safety of those services required improvement.

There were sufficient numbers of staff to meet patients' needs although recruitment was on-going to fill vacant posts and agency staff were used when required. Staff were encouraged to report incidents and serious incidents were thoroughly investigated. Although staff mostly demonstrated a good understanding of infection prevention and control, patients were sometimes put at risk of infection because routine hand hygiene was not always adhered to, and clinical waste was not stored securely prior to collection.

Medicines were stored and administered safely and records, although stored securely, were not always completed in a timely manner. A hospital at night team and critical care outreach teams were available to support staff during night hours if patients deteriorated. Staff were aware of safeguarding adult procedures and systems were in place to minimise the harm to patients at risk of falls. The correct equipment was not always available for staff to use and servicing of equipment was not always undertaken on time. There was a lack of security of the hospital at night time.

Care pathways were in place for patients in line with the National Institute of Health and Care Excellence (NICE) guidance. Pain relief was given in a timely manner and patients were supported to receive adequate food and

Medical care (including older people's care)

hydration. Staff worked across disciplines to provide joined up care to patients. Staff were competent in their role and understood the importance of gaining consent prior to treatment being given. The pharmacy department was not open after 1pm at weekends, which meant some patients' discharges were delayed.

Generally we found patients were cared for by compassionate staff who showed them dignity and respect, although behaviour of some staff was variable. Patients told us staff gave them privacy when it was needed and were kind; they also involved them in decisions about their care. Members of the hospital team were available to give patients emotional support when this was necessary.

Medical services in the City Hospital were reviewed and where necessary altered to reflect the demand and needs of patients. Processes were in place to ensure access to medical services and discharge for patients was appropriate although some discharges for older people could be delayed. Hourly documented checks were in place to ensure staff could respond to patients' individual needs. We could not be assured that learning from complaints was shared with all staff.

There was an effective governance framework in place to support the delivery of quality care with annual plans in place for each medical specialty. Wards had the ability to set up their own councils and directly influence decision-making as close to patients as possible. Senior staff were visible and staff felt supported.

Are medical care services safe?

Requires improvement

Overall, the safety of medical care services required improvement.

Although staff mostly demonstrated a good understanding of infection prevention and control, patients were sometimes put at risk of infection because routine hand hygiene was not always adhered to, and clinical waste was not stored securely prior to collection. Facilities were visibly clean.

The correct equipment was not always available for staff to use and servicing of equipment was not always undertaken on time. There was a lack of security of the hospital at night time.

There were sufficient numbers of staff to meet patients' needs; although recruitment was on-going to fill vacant posts and agency staff were used when required.

Staff were encouraged to report incidents and serious incidents were thoroughly investigated.

Medicines were stored and administered safely. Records were stored securely and completed in a timely manner. A hospital at night team and critical care outreach teams were available to support staff during night hours if patients deteriorated. Staff were aware of safeguarding adult procedures and systems were in place to minimise the harm to patients at risk of falls.

Incidents

- Incidents were reported using an electronic system that enabled incident reports to be submitted from any ward or department. The staff we spoke with were aware of the requirement to report incidents, knew how to use the system, and could demonstrate its use. We saw examples of effective use of the reporting system.
- One reported incident showed that a comprehensive description of the incident was documented along with any actions needed to reduce the risk of the incident happening again. Incidents were not categorised into high, medium or low but included staffing issues, falls, and pressure ulcers.

- Staff told us about 'red flag' incidents, for example; staffing or patient safety issues. Staff raised these issues using the trust's hand held electronic devices and said senior members of staff responded quickly. A member of staff told us of a staffing issue that was resolved promptly using this system. At our unannounced inspection another member of staff told us they used the system for reporting any delays in response to a request for help from the Hospital at Night team.
- A bladder scanner on one ward was out of use because it was awaiting the fitment of a new part. This had not been raised as an incident or placed on the trust's risk register.
- In 2014, 30 serious incidents requiring investigation (SIRI) were reported in the medical services at Nottingham City Hospital. Of the 30 SIRI incidents across medical services 22 were due to slips, trips and falls. The trust had responded positively to this and put in place a system of ensuring patients identified at risk of falls were 'cohorted'. This involved ensuring those patients were placed in a specific bay(s) on each ward and had a designated member of nursing staff with them at all times, day and night, to respond quickly. Six SIRI's related to infectious diseases and infection issues.
- A root cause analysis or thorough investigation was undertaken for every SIRI. Actions were put in place to address any identified issues. We saw a root cause analysis on one ward when a patient had tripped and fractured a bone. The investigation was thorough, and actions were taken to prevent any reoccurrence.
- Morbidity and Mortality (M&M) meetings were held on a divisional basis. We saw slides from a presentation of medical care deaths at the hospital from April and May 2015. This showed the deaths were discussed, and any issues raised were actioned.
- We spoke to staff concerning their knowledge and understanding of duty of candour. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.t Most staff were aware the trust needed to be transparent and open with patients when things went wrong. The trust had audited their compliance with the regulation within the first six months of it coming into force. This showed of the 25 incidents falling into that category, all patients were notified. However, the trust had identified issues to address which included education about duty of candour for all front-line staff. This included updating of the electronic incident reporting system to assist in the auditing of compliance with the regulation and a call for another meeting of the trust's duty of candour steering group to consider the results of the audit. It did not mention one of the recommendations made in the audit relating to the timeliness of sending out follow-up letters to patients within the 45 days required.

Safety thermometer

- The medical care services at Nottingham City Hospital took part in the national safety thermometer scheme. Data for this was collected from each area on an identified day each month to indicate performance in key safety areas. This included four key areas, pressure ulcers, falls, urine and urinary catheter infections and blood clots.
- Data from the safety thermometer was clearly displayed in ward areas for staff and public to view.
- Staff were generally aware of their performance in the safety thermometer, which meant they acknowledged, understood, and took ownership of the results and their performance. Staff told us there was competitiveness amongst wards to achieve high scores.
- Safety thermometer data was used in the overall performance dashboard for each ward in the medical care directorates. We saw data for four medical care wards in the hospital produced on a weekly basis, which included infection control information, for example; screening patients for Methicillin Resistant Staphylococcus Aureus (MRSA) and staff dress code. The data was discussed at governance meetings. This showed the data was used to monitor performance, highlight themes and trends and put actions in place to reduce risks.
- We saw cleaning audits and pressure ulcer incidents on two other wards. The results showed no incidents

of pressure ulcers of grade three or four in the last two years on one ward and 90-98% compliance with cleaning, including radiators and kitchen cupboards in the other.

Cleanliness, infection control and hygiene

- There were 31 cases of Clostridium Difficile (C. Diff) infections at the hospital between May 2014 and April 2015. C. Diff is an infection which causes diarrhoea.
- There were no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia at the hospital in the same time period. MRSA is an infection that is sometimes very difficult to treat.
- Overall, we found the medical care wards at the hospital were visibly clean and uncluttered.
- Catheter acquired urinary tract infections for patients across the trust showed between two and nine patients per 100 surveyed had contracted an infection between June 2014 and June 2015.
- In most areas infection prevention and control was of a high standard. In the Wolfson Cystic Fibrosis Centre we saw staff adhering to strict protocols in order to protect the patients they cared for. For example, good hand hygiene and the use of personal protective equipment such as gloves and aprons.
- There were adequate hand washing facilities in all clinical areas and we observed staff generally washed their hands or used hand cleansing gel. The gel bottles we used during the course of our inspection were all functioning.
- The Department of Health's 'Code of Practice on the prevention and control of infections and related guidance' concerning hand hygiene was not always complied with in the medical care services in the hospital. We undertook a 40 minute observation on Hogarth Ward where we found 43 staff and visitors went in or out of ward bay areas. 21 of those were staff and 17 did not use hand gel or wash their hands. They included medical staff and senior nursing staff.
- The trust's hand hygiene audit scores across the trust were between 97% and 98% between January and April 2015 thus achieving the trust target of 95%.
- Patients with infections were generally nursed in single rooms and the necessary precautions were clearly displayed on the doors.
- On Beeston Ward there were recent concerns raised about cleaning. Staff informed us there had been a concerted effort to raise cleaning to an appropriate standard. The trust were aware of the issues and feedback had been given to ward staff.
- Staff we spoke with were aware of cleaning audit figures as they were emailed to them by senior nursing staff in their areas and directed as to how to improve them. This meant cleaning standards were audited and the results monitored.
- In two wards the most recent cleaning audits were 67% and 85% respectively, so below the trust's expected level of 95%. Staff in both areas informed us the issues had been rectified and expected a higher figure at the next audit within two weeks. During the inspection the wards appeared visibly clean.
- There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff used them appropriately.
- We visited the specialist receiving unit (SRU) and found patients who were immunosuppressed because of their treatment were sometimes nursed alongside patients with infections. Immunosuppression means that those patients have almost no immunity to infections. It Whilst patients with infections were sometimes nursed in side rooms this was not always possible. We were informed that in the two months prior to our inspection a patient with an infection was nursed in a bay with another patient who was immunosuppressed. This was because a side room was not available. Staff had raised this as an on-going issue to a senior member of nursing staff but were not aware of any action being taken.
- Equipment shared between patients, such as blood pressure monitors and commodes, were usually identified as ready for use by a standard green label although most clinical equipment was single use only.

- On two wards staff told us they had cleaned clinical trollies and a stand for holding intravenous fluids, but no green clean stickers had been applied. Staff told us they knew they were clean although we were not assured this was the case.
- Staff in the endoscopy unit followed appropriate decontamination procedures for cleaning endoscopes after use.
- To reach the clean part of the sterilisation room in the endoscopy unit staff had to walk through the procedure room and the fire escape route; this was not mentioned in the Joint Advisory Group (JAG) accreditation report for the unit in January 2015.
- Clinical and domestic waste was appropriately separated and arrangements were in place for the separation of high risk linen, for example linen used for patients with infections or linen that was soiled.
- The management of sharps for example used needles, complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps containers were used appropriately and were dated and signed when they were assembled and when they were closed.
- Procedures were in place for staff receiving accidental needle-stick injuries. Staff were aware of them and processes were in place for staff to receive post-exposure treatment.
- Infection Prevention and Control training formed part of the trust mandatory training for all staff; this was updated on an annual basis.
- During our unannounced visit we saw ten large clinical waste bins stored outside the hospital. We were able to lift two of the lids of the four we tested where clinical waste bags were easily accessible; all should have been locked. This meant clinical waste was not being appropriately stored correctly prior to collection.

Environment and equipment

- We were informed by nursing staff the specialist receiving unit (SRU) was moving to a different area within the hospital as patients with respiratory conditions were more likely to be admitted during the winter period, and the respiratory ward required additional beds. Some staff voiced their concerns to us because they were concerned about the lack of visibility of their patients. However, a meeting was planned to discuss their concerns. This meant managers had listened to staff's concerns.
- We spoke with a patient who regularly attended the in-patient area of the Wolfson Cystic Fibrosis Centre. The building was modern and spacious with en-suite and drinks facilities in every room. However, because of the large glass windows the patients told us it became unbearably hot in the summer and they found it difficult to breathe. This meant patients who were already experiencing respiratory problems were cared for in rooms that may create further problems for them. We spoke to a respiratory consultant about this who told us there were inadequate funds to place air-conditioning in the building. This was not identified on the risk register. The trust informed us the unit was based on a business case and in some areas the design was revised with the agreement of the consultant in order to make the case viable.
- The younger peoples' unit on Hogarth Ward offered a quiet space with an activities and treatment area where patients could meet and chat whilst undergoing their chemotherapy treatment.
- We found each clinical area had resuscitation equipment readily accessible. There were audit systems in place and recorded checks were performed on a daily or weekly basis to ensure it was complete and ready for use. In one ward we saw the expiry dates on individual items were ringed to make them more identifiable. The equipment was mostly checked regularly; we only found a few examples of a day being missed in the last few months.
- Staff told us the trust had an equipment library which was available and access to all equipment was done through the library. They told us it was unusual for them not to be able to access equipment quickly when it was needed.
- Portable Appliance Testing (PAT) labels were attached to electrical systems to show they had been inspected and were safe to use. We found not all PAT testing was up to date, for example weighing scales in one area should have been retested on 7 August 2015.

- Servicing for some pieces of equipment was also out of date. For example a bladder scanner should have been serviced on 14 October 2014 and a pair of scales on another ward had been due for servicing on 27 July 2015.
- In another ward we saw no weight limits on a hoist that was being used: it was due for replacement. This meant staff were unaware of the safe working load for the hoist and it could be a danger to patients.
- Blood glucose monitoring equipment should receive daily quality checks to ensure any readings taken are correct. On one ward we saw there were a number of gaps for those checks for August 2015.
- When we visited the medical wards at night we found one entrance where access to the site was not secure and we were able to enter unchallenged. In addition, an external door at the base of a staircase was open even though the door could be accessed via a keypad locking system. Wards were locked at night but we were able to gain entry onto one ward without anybody checking our identity.
- We looked at fire-fighting equipment and noted the majority of equipment was maintained and tested. During our inspection we found a fire alarm with a break glass tube; there was no hammer with the alarm to break the glass. This could cause a delay in alerting the trust to an outbreak of fire.

Medicines

- Medicines were stored securely in locked trolleys, cupboards and rooms. Intravenous fluids were arranged appropriately and stored off the floor. Keys to drug cupboards were held by an appropriate member of staff in each clinical area.
- Medicines requiring refrigeration were stored in dedicated medicines fridges. Clinical areas varied on use of documentation for the recording of fridge temperatures; there did not appear to be a standardised form in use and we observed three different forms being used. One ward had created their own form which did not record the maximum or minimum temperature the fridge had reached each day. Staff were unclear about the action that should be taken if the temperatures were out of the acceptable range. For example on one ward staff told us they would telephone the estates department and on another ward staff told us they would telephone pharmacy. On one ward we saw the fridge had a maximum temperature of 10 degrees centigrade for a number of days and no action had been taken. This meant that patients could be at risk because the medicines may have developed harmful bacteria. The trust's medicine policy did not specify the action for staff to take if this occurred.
- The management of controlled drugs (CD) met legal requirements. Controlled drugs are specific We checked one ward's CDs and found stock balances were correct. CD registers were completed appropriately and legibly.
- Oxygen is a prescription only medicine, unless given in an emergency, but was not always prescribed for patients who were receiving it. However, on a respiratory ward we saw this happened for all patients requiring it.
- The prescription charts we saw were legible and complete and patients 'allergies were noted. We spoke with a patient who had experienced an anaphylactic reaction to a particular penicillin antibiotic. Anaphylactic shock is a serious and profound state of shock brought about by hypersensitivity to an allergen such as a drug, foreign protein, or toxin. Staff had reacted promptly and appropriately to the incident.
- We saw a prescription chart where the prescriber had not written their name in capital letters and had not supplied a contact number. This meant the prescriber could not be identified or contacted if there was a problem or query with the prescription.
- We observed that medicines were administered by appropriately trained staff following the Nursing and Midwifery Council's 'Standards for Medicines Management' Patients we spoke with informed us nurses waited for them to take their medicines before they left their bedside.
- New nursing staff had their competency for drug administration checked within the first month as part of their preceptorship programme. All nurses had to pass a calculation test before commencing work and were initially supervised when administering medication until they were considered competent.

There was no on-going training for staff regarding medicines after their initial induction, although annual training for parenteral administration was undertaken. Parenteral

- The majority of prescription charts we saw had evidence of a thorough clinical pharmacy review including medication histories and medicines reconciliation. The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. At the time of our visit the reconciliation rate was almost 85% and there were steps in place to increase this further. Any administration advice was clear and written in green ink for quick recognition.
- There was a ward based pharmacy service in place and visits were undertaken daily. Patients' prescriptions were checked by a pharmacist to ensure their medicines treatment were safe, effective and met current guidance. Clinical staff could access a pharmacist for advice when needed. We observed pharmacy technicians on the wards during our visit.
- A new antimicrobial stewardship group had been set up in the trust. Antimicrobial stewardship refers to coordinated interventions designed to improve and measure the appropriate use of antibiotics. This is done by promoting the selection of the best antibiotic regime, the dose of the antibiotic, how long it should be taken for, and what route of administration should be used.
- The pharmacy department closed at 5pm during the week and at 1pm at weekends. This caused difficulty for some patients who required medicines to take home. Staff informed us taxis were required to go between City Hospital and Queen's Medical Centre in order to obtain medicines outside of pharmacy working hours.

Records

- In all the clinical areas we visited we saw patients' records were stored securely when not in use.
- Information governance training was included in the trust's mandatory training. Rates across the staff groups varied between 77% and 100% for different staff groups: the trust target figure was 90%.
- Medical and nursing records were filed separately. We looked at nine sets of medical and nursing records and found these were compliant with guidance issued by the General Medical Council and the Nursing and Midwifery Council's guidelines, the professional regulatory bodies for doctors and nurses. The records we viewed were and reflected the care and treatment patients received.
- Because of a complaint raised by a relative we looked at the recording of mouth care undertaken for patients not able to eat or drink. During our night visit we found records were not always maintained relating to assistance with oral hygiene. When we spoke with staff about this we were informed there was nowhere to document this and it should be undertaken when a patient's position was changed. Some staff put it on the fluid balance charts whilst others did not. It was therefore difficult to determine when and if assistance with oral hygiene was given to patients requiring it.
- Patient records were readily accessible to those who needed them.
- A new document 'NUH Inpatient Adult Risk Assessment Booklet' had recently been introduced in the trust for use across all areas except critical care. It included risk assessments for pressure ulcers using the Braden score, manual handling and falls. The majority of records were legible and up to date.
- Records we requested in ward areas, such as duty rotas that were relevant to the running of the service could usually be produced without delay.
- On one ward that provided neurological rehabilitation, 'intentional rounding' (where staff attended patients at set intervals to check a range of patient-centred issues) was not documented but staff informed us they gave care around the clock. This meant we could not be assured patients were being monitored at regular intervals.
- World Health Organisation (WHO) surgical checklists were in use for patients undergoing invasive procedures in the cardiac catheterisation laboratory. We saw these in use although we were informed the forms were not audited. This means senior managers could not assure themselves correct procedures for the completion of the forms was undertaken.

- Fluid balance is important for patients being treated for renal (kidney) diseases. On the renal unit staff were not aware of audits being undertaken on the correct completion of fluid charts. This means that no data was available to check if those forms were completed accurately to ensure patient safety.

Safeguarding

- Safeguarding training was delivered as part of mandatory training. Rates across the staff groups varied between 77% and 100% for different staff groups: the trust target figure was 90%.
- The trust had provided all staff with information relating to safeguarding adults. The information could be kept in their identification badges so was readily available to them. It explained the types of abuse that could occur and contact numbers for key personnel in the trust to seek advice if needed both in and out of normal working hours.
- Staff we spoke with were able to identify the different types of abuse and knew how to respond to safeguarding concerns and allegations of abuse. They felt confident in identifying potential abuse.
- The trust had a safeguarding lead in place. Staff told us they knew the lead's contact details and could approach them if they needed advice or support.
- Staff told us the safeguarding team were accessible and responsive to concerns and issues. They also told us the safeguarding team undertook teaching on safeguarding, mental capacity legislation and deprivation of liberty safeguards as part of the trust's mandatory training programme.
- During our visit we were advised by a member of our inspection team about the possibility of a safeguarding incident. We raised this with senior managers in the trust who responded immediately.

Mandatory training

- There were arrangements in place to provide annual mandatory training to all members of staff. Mandatory training is
- Staff we spoke with were aware of the mandatory training they were required to undertake.
- In the medical care services at City Hospital the completion percentages as at 31 August 2015 varied between 77% and 100% for different staff groups: the trust target figure was 90%.
- We saw a list of mandatory training for nursing staff on one ward and saw it was up to date.
- The trust used staff's birthday month as a reminder to them that their mandatory training was due for completion: this was linked to their annual appraisals.
- Mandatory training included two and a half hours of face to face teaching, plus the viewing of a digital visual disc (DVD) with discussions. The modules covered included; infection prevention and control, fire safety, and patient confidentiality. Nursing staff who were required to move or handle patients had to complete a practical session with the area's moving and handling link nurse to ensure they were competent.

Assessing and responding to patient risk

- Patients were monitored in line with National Institute for Health and Care Excellence (NICE) guidance 'Acutely Ill-Patients in Hospital.'
- The trust had introduced a system of e-observations in almost all of the medical care services at City Hospital to enable clinicians to monitor patient observations including blood pressure, temperature and pulse via mobile devices. We watched observations of pulse and temperature being taken and noted the technique used would ensure an accurate result. E-observations are a system for clinicians to record observations on a handheld device at the bedside, which then calculates a score and saves it electronically. It also provides clinical staff with the option to review observations remotely and automatically alerts them to the patient's state of health.
- The Wolfson Cystic Fibrosis Unit did not use the e-observation system; they were reliant on using a paper version of the National Early Warning Score (NEWS).
- Both the e-observation and NEWS depended upon observing certain physiological signs on a regular basis. The NEWS grading system was designed to

enable clinical staff to recognise and respond to acute illness and/or acute clinical deterioration and to trigger different levels of clinical response, which is proportionate to the severity of their illness.

- All qualified staff received acute illness management training (AIM) the basis of which was reacting to suspected sepsis in patients. On the specialist receiving unit we saw sepsis posters on display as a reminder to staff the importance of acting promptly to any signs of sepsis. Sepsis is a common and potentially life-threatening condition which is triggered by an infection.
- During night hours a "Hospital at Night" team was accessible at the City Hospital. If a patient's e-observations raised cause for concern, the senior nurse on the Hospital at Night team was automatically alerted on their mobile device and usually a member of the team went to the ward concerned or rang them for further information.
- There were arrangements for staff to access a critical care outreach team to support and advise on the care of very sick or deteriorating patients. The night staff felt the support the teams provided was valuable and helped in the provision of safe care.
- In all the wards we visited we saw a newly implemented system of 'cohorting' patients who were at risk of falling. In practice this meant those patients were placed in one or two particular bays with a member of nursing staff in place permanently in the bay and responsible for observing all the patients on an on-going basis. Some of those staff wore tabards to signify they were undertaking the role and should not be used for other duties; others did not. Early indications were that this had reduced the number of falls on the medical wards.
- Patients were risk assessed in key safety areas using nationally validated tools. For example we saw the risk of pressure damage was assessed using the Braden score. We observed that when risks had been identified the relevant care plans were generated. Risk assessments were reviewed and repeated in appropriate and recommended timescales.
- On Southwell Ward, where patients with respiratory diseases were cared for, we saw a system in place to ensure patients were not given high concentrations of oxygen when this could be dangerous, for example those with chronic obstructive pulmonary disease (COPD). Patients wore different coloured bands on their wrists to alert staff to the oxygen saturation level the patient should have. We saw these being used for patients.

Nursing staffing

- Average sickness rates for nursing staff working in medical care at the hospital was between 1% and 4% in the period from January to July 2015. This compared to a national average of between 4.2% and 4.8% in the same period.
- In the same period vacancy rates for nursing staff across the medical care services at City Hospital varied between 3% and 49 %. Turnover for nursing staff across the medical care services between April and June 2015 varied from 2% to 6%
- Nursing staffing was acknowledged as a significant risk area in common with other NHS trusts. The trust had stated there was a potential hazard to patient safety and experience from insufficient nurse capacity and capability. Despite being able to recruit newly qualified staff from the local university, the trust was pro-active in recruiting overseas staff and we met with a number of them during our visit. They told us they felt well supported.
- Data received from the trust indicated there were 44 registered nurse vacancies across all the medical assessment areas in the trust although 22 had already been recruited to.
- The National Institute of Health and Care Excellence (NICE) had recommended minimum registered nurse patient ratios in its guidance 'Safe staffing for nursing in adult inpatient wards in acute hospitals' giving a ratio of 1:8 registered nurse to patients during the day and a 1:10 ratio at night. We were informed that data on dependency levels of patients was collected from each ward twice a year to determine whether staffing levels were correct. Staff acknowledged the trust responded appropriately to individual patient demand and where possible increased staffing levels.
- Nursing shift patterns varied but generally nurses undertook 12 hour shifts, commencing at either 7 am or 7 pm. This meant when night staff commenced

duties, patients had not necessarily settled for the night and visitors were still on the wards. This meant the wards were still very busy and staffing numbers had reduced.

- When we visited the wards at night we spoke to staff who felt there were generally sufficient registered nurses to meet patients' needs at night. On Southwell Ward (respiratory) at 3:10am staff informed us they had been extremely busy but it had then quietened. We saw there were three registered nurses and two healthcare assistants for 28 patients. All the patients were settled and comfortable with their needs met.
- If wards required registered nurses because of sickness or absence, senior nursing staff made a decision about whether it was necessary to use bank or agency staff, or if staff could be deployed from other areas where the need was less.
- Staff working in the hospital were available on a flexible basis and were used when there were staffing shortfalls.
- Staff on one ward were worried there was to be an increase of five in-patient numbers on the ward as part of the trust's contingency plans for winter pressures commencing in November 2015. Staff were informed there would be no additional staffing on night duty, and patient dependency needs on the ward were generally very high. This would mean the ratio would go up to one registered nurse for 11 patients which is above the recommended 1:10 ratio. Staff had raised this as an issue with managers although no response had been given. The trust informed us the staffing had increased in line with the business case but it had subsequently been identified the increase was insufficient for 16 beds.
- Staffing on Berman Ward – which was the hyper acute stroke unit – was one registered nurse to every four patients on day duty and one registered nurse to five patients on night duty. A senior member of staff told us they thought that was a 'safe minimum'. Staffing on Hogarth Ward – oncology – was 1:4 or 1:5 during the day and 1:7 at night. Patients told us their needs were met during day and night hours.
- We found the Wolfson Cystic Fibrosis Unit was staffed with registered nurses with a ratio of 1:5. We were informed additional help could be obtained if they were caring for a very sick patient.
- Advanced nurse practitioners were available in cardiac intensive care and the acute cardiac unit. When we interviewed a number of clinical directors for acute medicine they hoped those nurses would be developed into nurse consultants in the near future. Nurse consultants spend a minimum of 50% of their time working directly with patients. In addition, they are responsible for developing personal practice, being involved in research and contributing to the education, training and development of other nurses.
- The number of patients in the acute cardiac unit was increasing from eight to 16 because of an additional need for the service. However staffing had not increased to reflect demand.
- Accountability handovers were undertaken on all wards at 7am and 7pm and involved incoming and outgoing staff. Those discussions were confidential and took place away from the patient. However, the majority of information sharing took place discreetly at the patients' bedside.
- Newly employed staff received a formal trust induction as well as a local induction to the ward they were working on.
- Agency staff received orientation and induction on the wards.
- Information from the trust indicated that 6% of the total pay spend was on agency usage.

Medical staffing

- There were adequate numbers of doctors at appropriate grades to meet the needs of patients. Junior doctors reported that rotas were covered and worked well and they received the supervision that was necessary.
- There were fewer consultants and middle grade doctors employed in medical care services than the England average. The number of registrars and junior

doctors was higher than the England average. This meant the service was more dependent on junior doctors and registrars to provide care and treatment for patients.

- Information from the trust revealed there were five substantive acute medical consultant physicians in post. Work was on-going to fill the vacant consultant posts within medical care services..
- Data provided by the trust showed medical wards had an average of 5.6% locum usage from January 2014 to June 2015. General medicine as a service had the highest locum usage over the time period with 36%. Locum doctors were provided with an induction leaflet when they commenced working in the trust. This included items such as behavioural standards, health and safety and major incident planning.
- Overall, the acute medicine doctor vacancy rate was 24%, although nursing staff informed us they could always access a doctor of the right grade to provide direction and support when caring for sick patients.
- Patients who had experienced a stroke and required rehabilitation could have three different consultants caring for them during their treatment in the hospital because of the way the patients' pathway was managed. Nursing staff informed us this did not deliver continuity of care and patients sometimes became quite confused about whose care they were under.
- The specialist receiving unit was staffed by a junior doctor at night supported by experienced nursing staff and an on-call registrar. A consultant was available and would see the patient if requested to do so.
- On Hogarth Ward an F1 or F2 junior doctor were available all day on the ward for patients. There was support from up to 10 chemotherapy or radiological oncologists and an additional five medical oncologists. F1 and F2 doctors are those who have completed their medical school training and are undertaking further foundation training in either their first or second year.
- On the Wolfson Cystic Fibrosis Unit consultants undertook two ward rounds per week. Any out of hours support was provided by the Hospital at Night team with support from the respiratory consultants. Staff told us they felt well supported.
- Junior doctors we spoke with told us they found their consultants were contactable and supportive. They also told us that although weekend cover was reduced, there were sufficient doctors to meet patients' needs and they were well supported by the registrars at weekends

Major incident awareness and training

- Major incident plans and the trust's business continuity policy were available on the trust intranet. Some staff knew about the policy whilst others did not.
- We saw hard copies of the trusts' major incident policy in two ward areas. On Hogarth Ward we were informed they were part of a storage area for specialist equipment used in major incidents.
- The trust had planned for seasonal bed pressures in the winter of 2015/2016 arranging additional bed capacity where this was appropriate to be able to increase the demand for patients. One ward was moving to another location in order to increase the number of beds for respiratory patients.

Are medical care services effective?

Good

Overall, the effectiveness of medical care services at City Hospital was good.

Care pathways were in place for patients which followed the National Institute of Health and Care Excellence (NICE) guidance. Pain relief was given in a timely manner and patients were supported to receive adequate food and hydration. Staff worked across disciplines to provide joined up care to patients. Staff were competent and understood the importance of gaining consent prior to treatment being given.

Evidence-based care and treatment

Medical care (including older people's care)

- Staff were aware of National Institute of Health and Care Excellence (NICE) guidance relevant to their work. We observed practice was broadly compliant with guidance from NICE. We specifically looked at the requirements of guidance relating to myocardial infarction (heart attack), stroke and acutely ill patients in hospital.
- NHS England interventional guidelines were met and practices were reviewed regularly. For example, there was a recent alert concerning the use of chlorhexidine and so staff practice was reviewed by senior members of staff to ensure it was used appropriately and safely. Chlorhexidine is an antibacterial liquid commonly used as an antiseptic.
- Clinical policies and guidance were available on the trust intranet system and we saw staff using the system to locate policies when required.
- A specific care pathway was put in place for patients with respiratory diseases. The hospital had its own respiratory admission unit, which was increasing bed capacity to accommodate additional patients over the winter months. 60% of respiratory admissions were admitted directly to the respiratory admissions unit with only 40% going through the emergency department at Queen's Medical Centre. This had resulted in 90% of patients with respiratory conditions being cared for in specialist respiratory beds. Specialist respiratory nurses were also available for those patients.
- We viewed data for patients who had experienced a stroke and required thrombolysis. Thrombolysis is commonly called 'clot busting' and to be effective must take place within 4.5 hours of the beginning of a stroke. On Beeston ward, which was a hyper-acute stroke ward, we saw the 'door to needle' time for thrombolysis from January to March 2015 was 50 minutes. From April to July 2015 this was 56 minutes. This meant patients requiring thrombolysis experienced treatment within the recommended guidelines.
- On Nightingale Ward, a ward caring for patients with infections, there were negative pressure rooms to prevent cross contamination. Staff on the ward were trained in caring for people who had contracted diseases such as Ebola or Severe Acute Respiratory Syndrome **(**SARS). These staff provided relevant training for other staff when appropriate.
- The endoscopy department was awarded Joint Advisory Group (JAG) accreditation. They were re-certificated in January 2015 for the year, dependent upon the unit continuing to maintain the standards laid down and submit the appropriate evidence to JAG when requested to do so. The accreditation process assessed the unit to ensure they met best practice guidelines. A report of the most recent visit was available and recommendations were made, some of which the trust had already addressed. This meant the endoscopy department was operating within this guidance.

Pain relief

- Patients told us their pain was managed well and during our day and night time inspection we saw no patient in pain. We observed staff pro-actively managing patients' pain control and providing appropriate medicines when they were required.
- On one occasion we observed a patient request pain-relief and this was given immediately.
- We saw an assessment of patients' pain was included in all routine sets of observations. As part of the 'intentional rounding' process (where staff attended patients at set intervals to check a range of patient-centred issues) staff checked to ensure patients were comfortable.
- Staff used a Pain Assessment in Advanced Dementia (PAINAD) tool to aid the assessment of patients with a cognitive impairment. The PAINAD tool was developed to assess pain in older adults who were living with dementia and were unable to communicate their pain in a reliable way.

Facilities

- On Nightingale Ward a staff toilet had been out of order for two weeks prior to our visit. Staff had reported this to the estates department who were waiting for spare parts to be delivered. As a result of

this, staff had to leave the ward in order to use another toilet. We were not informed when the situation would be resolved. Following our inspection the trust informed us the staff toilet had been repaired.

- On Newell Ward we saw there was a wasp nest located on the outside of the building. A private provider for pest control had treated the nest. Staff had been advised to keep windows closed and turn off lights in unused areas. It was noted that wasps were feeding off the sap of nearby trees and staff stated wasps had been found in the staff room on the ward. We were informed if anybody had an allergic reaction to a wasp sting, medication was available on the ward to deal with the emergency.

Nutrition and hydration

- Patients and relatives we spoke with were generally satisfied with the quality, range and choice of food provided. However, some patients told us the quality of food wasn't good although there was a varied menu. Food that met people's special cultural and religious needs was available.
- Meal service times were generally calm and well managed. From our observations, staff were on-hand to assist patients at mealtimes if required and volunteers were available to chat with patients
- Patients who needed special diets were identified by staff writing on a white board at the head of the bed. This meant the information was easily accessible but not confidential.
- For patients living with dementia, blue plates and glasses were used to help staff identify those who may need more observation and assistance.
- During our announced and unannounced visits we observed that patients had drinks left within reach so they could access them when they wanted to. Water jugs were placed on patients' lockers and were replenished during the day.
- Where necessary adaptive utensils and equipment such as plate guards, beakers, and special cutlery was available. This showed there was equipment to support patients to be independent with food and drink.
- Patient's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. Staff recorded scores and included appropriate action in the patient's care plan in response to any identified risks, for example the completion of food and fluid charts. Referral to a dietician was made when patients were at high risk of malnutrition.
- Food and fluid charts were not always kept up to date and volumes of fluid taken were not always documented.
- On Beeston Ward arrangements were in place to ensure all patients who had experienced a stroke were assessed promptly to ensure they were able to safely swallow and were not denied food or fluid unnecessarily.
- Nurses on Beeston Ward were trained in initial simple swallow tests. If a patient failed three of these, a referral to the Speech and Language Therapist (SALT team) was made for further assessment.
- Appropriate documentation was in place and completed for patients who had received initial swallow screening by nurses and a full swallow assessment by members of the speech and language team. A full swallow assessment for a patient requiring it was undertaken within 24 hours of admission or when appropriate.
- Members of the SALT team were available at weekends and regularly attended ward rounds to discuss the needs of patients.
- For some patients requiring Percutaneous Endoscopic Gastrostomy (PEG) or a Radiologically Inserted Gastrostomy (RIG) this could be undertaken at the hospital. A PEG and RIG are ways of placing thin tubing into a patient's stomach through the wall of their abdomen when they are unable to take anything by mouth, for example, if they do not have a strong swallow reflex because of a stroke.
- When nasogastric nutrition was required for patients and dieticians were not available, for example; at weekends and bank holidays, starter feeding regimes

were available for staff to follow. A nasogastric (NG) tube is a narrow bore tube passed into the stomach via the nose. It is used for short or medium-term nutritional support.

- Daily entries from the medical and SALT team were in place for patients requiring a nasogastric tube. Documentation showed checking of the NG tube to ensure it was correctly situated before feeding commenced.
- Concerns were raised by a ward manager that the feeding of yogurt, as advised by the SALT team, to patients unable to take liquids, may not be nutritionally adequate for patients' needs. A multidisciplinary workgroup was set up to consider whether the use of a PEG or RIG earlier in the patients' pathway than the National Institute for Health and Care Excellence guidance recommends would be beneficial. This showed that staff were proactive in their approach to outcomes for patients with regard to food and nutrition.
- The SALT team had developed swallow boards to highlight consistency of patients' diets. The team were involved in research using electrical stimulation to aid swallowing for patients without a fully formed swallow reflex.
- We talked with staff about a patient with renal impairment who had complex needs. The patient's care had included the involvement of a renal dietician and referral to a psychologist for a possible mental capacity assessment with regard to the insertion of a PEG) tube.
- Patients who had undergone a renal transplant were able to telephone the ward after they were discharged if they needed any assistance with regard to food or fluids. Patients were given a pink card with telephone numbers and had direct access to the ward if necessary.
- Patients with cystic fibrosis had access to nutritional supplements when necessary and snacks 24 hours a day. A patient we spoke with told us the snacks included pasties, chips, pizza and pot noodles. They had received a welcome tray on arrival on the Wolfson Cystic Fibrosis Unit. The unit provided its own chefs who discussed individual requirements of patients on a daily basis.
- A volunteer on one ward informed us they worked six hours a day four days per week. Their role included distribution of drinks and meal orders.

Patient outcomes

- The Standardised Relative Risk (SRR) of re-admission for elective admissions at trust level was 128, above the benchmark value of 100. It was worse than the benchmark for emergency admissions standing at 109. For respiratory medicine the relative risk of re-admission was 132 and clinical oncology at 140.
- The Sentinel National Stroke Audit Programme (SSNAP) for 2014 showed the hospital achieved an overall rating of band D for both patient–centred and team-centred key performance indicators (where band A is the highest and band E the lowest). The rating for the hospital had remained at band D since January 2014.
- In the last national Heart Failure Audit reported in 2013, the hospital scored above the England average in all four in-patient care measures. In three of the seven discharge measures the hospital scored above the England average and in the remaining four it scored below.
- In the last National Diabetes Inpatient Audit (NaDIA) reported in September 2013, the trust performed worse than the England average in 14 out of 20 measures. The trust were aware of the data and were putting actions in place to address the underperformance.
- In the Myocardial Ischaemia National Audit Project 2013 - 2014 we found there was no data available for the hospital.
- On Berman Ward we found Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and the use of end of life care bundles were used appropriately to ensure appropriate outcomes for patients.
- When required, physiotherapists and occupation therapists were involved in the treatment of stroke patients within 24 hours of admission.
- A care pathway was in place for the acute ambulance trust to take patients directly to the cardiac unit if their electrocardiograph (ECG) reading indicated the

patient was having a heart attack. Staff at the Queen's Medical Centre (QMC) could also transfer patients straight to the cardiac unit if this was required. This meant patients who had a heart attack received an effective service.

- Monitoring by the CQC had not identified any areas where medical care services at City Hospital would be considered a statistical outlier when compared with other hospitals.
- Patients who were referred to the specialist neuro-rehabilitation ward had to wait for a bed to become available. Staff told us this could take weeks. This meant that patients may not be receiving the on-going specialist treatment they required in a timely manner.

Competent staff

- All new staff attended a corporate induction programme, supplemented by a local induction to their ward or department. Staff we spoke with confirmed they had received an adequate induction.
- There was a system in place for supporting new nursing staff, especially those that were newly qualified. There was a comprehensive competency based programme for newly qualified staff to work through with the support of a preceptor. We saw examples of these and spoke with staff who were undertaking the programme. This meant staff were assessed as competent and their managers and patients could be confident they had the skills to carry out their role. Information provided by the trust showed 177 newly qualified nurses starting employment in acute medicine had undertaken the training since it started in 2013.
- Staff told us they received annual appraisals which included discussions about corporate objectives as well as their own learning and development needs. Data received showed appraisal rates for staff across the trust was 89%. The trust's target rate was 90%.
- Medical and nursing staff stated they received sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely and is a process that is new to the nursing profession. On Hogarth Ward the ward sister told us they were planning a continual professional development day for staff. This would include a session about the revalidation process as well as fire training, professional boundaries, social media and chemotherapy care.
- One junior doctor told us they felt well supported by their consultant who was also their clinical supervisor.
- Ward staff were supported to develop skills and experience specific to their role. Some health care assistants we spoke with had undertaken specific training, for example to become end of life care champions.
- Staff received training to care for people living with dementia but some told us they thought it was insufficient to care for those patients. Staff told us they had not received any training in dealing with challenging behaviour. We asked the trust for information about this sort of training but we did not receive it.
- Consultants and physiotherapists provided training to staff on the Wolfson Cystic Fibrosis Unit to ensure they remained up-to-date in their practice.
- Staff told us about the newly implemented falls risk assessment document. They said they had not received any training about how to complete the mini mental state examination and the abbreviated 10 point mental test score. They told us they felt confused and ill-prepared to undertake these, which were needed as part of the falls risk assessment. This meant staff may not have completed the assessments adequately to protect patients.

Multidisciplinary working

- Wards teams had access to a range of allied health professionals including physiotherapists, occupational therapists and dieticians. Ward staff described the relationship with the different teams as being good.
- Medical and nursing staff worked well together to provide co-ordinated care to patients.
- Medical and nursing notes were filed separately but members of teams were aware of the input of others and care was well co-ordinated for patients and their relatives.

- The Wolfson Cystic Fibrosis Unit held regular meetings between the unit's outpatient department and the respiratory wards in the hospital to ensure care was co-ordinated for their patients.
- Because the average length of stay on Beeston Ward was between 26 and 30 days, senior staff on the ward members of the local clinical commissioning group (CCG), ward staff and social services met to facilitate safe and effective discharges for patients.
- Multidisciplinary team working was well established throughout the specialist medical wards at the hospital with daily communication between members of the team and daily board rounds taking place in most of the areas.
- On the acute cardiac unit multi-disciplinary meetings were held for patients with complex needs to ensure appropriate actions were taken by specialist staff.

Seven-day services

- Physiotherapy services were delivered seven days a week. The dietician service offered a five day a week service, although discussions were underway to extend to seven day working.
- There was seven day availability of all diagnostic services including imaging and laboratory facilities. Staff told us they did not encounter any problems with accessing diagnostic services out of normal working hours.
- If the cardiac catheter laboratory was required out of hours, staff were on call and responded quickly.
- Computerised tomography () staff were on call overnight and at weekends to provide urgent CT scans when required. Radiographers were also on-call out of hours.
- Some consultants provided a 24 hour, seven day a week service, for example on Berman Ward.

Access to information

- All clinical staff told us they had access to current medical records and test results such as blood tests and x-rays, to support them to care for patients safely. Nursing records were kept in each bay on wards so they were easily accessible for staff to use
- Information about policies, pathways and support services was available on the trust's intranet.
- There were systems in place to ensure the transfer of information was safe and complete when patients moved between wards or sites.
- Senior managers had information relating to the flow of patients around the hospital supplied by the wards. Information about patients in the wrong specialty beds (outliers) was collected and shared as appropriate. We requested this data during our inspection and received it promptly.
- Ward doctors communicated with patient's doctors in the community and produced an electronic summary of the patient's treatment and care on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff gained their consent before giving care or treatment. We observed this in the areas we inspected.
- Patients consent was sought appropriately and correctly when people were able to give their consent to care and treatment.
- We observed appropriately signed consent forms for specific procedures, for example cardiac catheterisation and clinical photography.
- The trust had a Mental Capacity Act 2005 (MCA) policy which incorporated the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to plan ahead in case they are unable to make important decisions in the future and includes such things as advanced decisions or 'living wills'. Ward staff referred applications for DoLS to the trust safeguarding team who carried out the appropriate assessments to ensure the deprivation was in the patient's best interests.
- The medical and nursing staff we spoke to were aware of their responsibilities under the MCA.
- We saw two DoLS applications authorised for patients on Beeston Ward; a two stage capacity test was undertaken for each patient.

- MCA and DoLS training were included in the mandatory training programmes for frontline staff. The percentages of staff completing this training as at 31 August 2015 varied between 77% and 100% for different staff groups. The trust target figure was 90%.

- On Hogarth Ward we talked with a member of staff about gaining consent from a patient whose first language was not English. They told us they would ensure an interpreter from the trust's designated provider of such services would be booked for that specific purpose.

Are medical care services caring?

Good

The care provided to patients by medical services was good.

Generally we found patients were cared for by compassionate staff who showed them dignity and respect although the behaviour of some staff was variable. Patients told us staff gave them privacy when it was needed and were kind; they also involved them in decisions about their care. Members of the hospital team were available to give patients emotional support when this was necessary.

Compassionate care

- Overall patients we spoke with expressed a high level of satisfaction with the care and treatment provided to them. The quality of care was described as good throughout medical care services at the City Hospital.

- Throughout our inspection we saw patients were treated with kindness and respect. Their privacy and dignity was maintained; for example we saw all care interventions were carried out behind curtains or closed doors and staff asked before they entered when this was appropriate.

- Men and women were nursed in separate bays on the wards.

- The Friends and Family Test (FFT) response rate for medical care services overall was 49% which was above the overall trust level figure and above the national average of 36%. Individual wards response rates were between 35% and 83%.

- We looked at the latest FFT scores available to us for twelve medical wards for the period March 2014 until February 2015. The percentages recommending the medical wards had improved across the year and in February 2015 seven of the wards had a figure of 100% of people who had said they would recommend them. The lowest score was 81%.

- On one ward, a staff recognition book was in place for patients and relatives to make their comments. All the comments were positive.

- A patient we spoke with on one ward told us they would have preferred if the lights were switched off at 10pm but stated, "The care is very good, genuinely so. They're trying to help me – they don't want me walking on my own."

- The in-patient survey conducted by CQC in May 2015 showed the trust scored about the same as other English trusts in the patients experience relating to their care, including doctors, nurses, care and treatment and leaving hospital. We did not have a breakdown between hospitals or wards. The highest score related to doctors (eight out of ten). The lowest score (seven out of ten) related to their experience of leaving hospital.

- In 2014, 95% of patients receiving cancer treatment in the trust stated they were always given enough privacy when being examined or treated. We were not able to separate the data for City Hospital from the trust wide data.

- A volunteer on one ward informed us they worked six hours a day four days per week. They told us how they talked to patients and sang to them and were appreciated by ward staff

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- The majority of patients told us they were kept informed of their plans of care and were involved in them. Where appropriate, they told us they were given choices about the care and treatment options available.
- A patient on the Wolfson Cystic Fibrosis Unit told us how they had built up good relationships between nurses and doctors on the unit and was not at all worried about discussing any concerns they had.
- A patient on the cardiac unit told us how a doctor had informed them about the stents they had put in their coronary arteries.
- One patient told us they had not seen their consultant with whom they had a good relationship. A junior doctor had told the patient they could go home and then admitted they had told the wrong patient; this incident had upset the patient.
- Another patient told us communication from staff was sometimes lacking so the patient and their relatives were not aware of what was happening.
- On Hogarth Ward a relative told us how the patient had received sensitive communication about their disease and how the family was involved in those discussions. On the same ward, a patient told us about the poor communication with regard to appointment times and dates and how they had found this very stressful.
- We were informed about a 'password' system for ensuring the relatives of patients living a distance away could ring up and receive detailed information about the patient's condition and care. This was used after a password was set up to ensure patient confidentiality was maintained.

Emotional support

- Patients and their relatives/carers told us that generally, the clinical staff were approachable and they could talk to staff about their fears and anxieties.
- We found patients could access a range of specialist nurses, for example, in palliative care, stroke and diabetes care. The specialist nurses offered appropriate support to patients and their families/ carers in relation to their psychological needs.
- A hospital chaplaincy service was available and staff were aware of how this could be used to meet the spiritual needs of patients and their families.
- In the 2014 National Cancer Experience Survey, 87% of patients felt hospital staff gave them information about support groups available to them. 95% of patients said staff told them who to contact if they were worried after going home from hospital.
- For patients with cystic fibrosis, social workers, psychologists and members of the chaplaincy team were available to support them.
- Staff we spoke with told us if they were worried about a patient's mental health they would refer them to the appropriate doctor for clinical assessment to determine whether they were suffering from anxiety or depression. This meant the service acknowledged patients may require emotional support.

Are medical care services responsive?

Good

The responsiveness of medical care services at City Hospital was good.

Care was reviewed and where necessary altered to reflect the demand and needs of patients. Processes were in place to ensure access and discharge for patients was appropriate, although there were sometimes delays in the discharge of older people. Hourly rounding was in place to ensure patients' individual needs were met. We could not be assured that learning from complaints was shared with all staff.

Service planning and delivery to meet the needs of local people

- The trust were in the process of opening additional beds in some wards to meet increased demand over the winter period, especially for patients with respiratory diseases, to ensure local people had access to the medical care services they required. This was a planned initiative due to start in November 2015.
- The trust's chaplaincy service was able to deliver spiritual and pastoral care to patients and staff across

the City Hospital when requested to do so. This included people of different faiths to reflect the multicultural society living in Nottingham and the surrounding area.

- Staff on Berman Ward delivered care for patients who had experienced a stroke. They were able to receive patients with a suspected stroke directly from the acute ambulance service so that effective care was delivered in response to patients' needs. Audits of the service showed 50% of these patients had not experienced a stroke and were discharged home following relevant investigations.
- Visiting hours on wards could be flexible for relatives of very sick patients being cared for throughout the medical care services.
- Because of the demand for medical beds at the hospital, discussion was underway in the trust about an ambulatory care unit to assess, treat and discharge suitable patients within a short time frame. Ambulatory care is a patient focused service where some conditions may be treated without the need for an overnight stay in hospital.

Access and flow

- The England average bed occupancy in NHS acute hospitals varied between 88% and 91% for the year 2014/2015. The trust's bed occupancy was either at the same rate or below it with a rate of between 87% and 88%
- Patients accessed medical care services at the City Hospital via their GP or by direct admission through the acute ambulance trust.
- Site matrons and bed managers met regularly throughout the day. These meetings looked at how the flow of patients could be safely managed through the hospital and supported arrangements for the discharge of patients who were fit to go home or elsewhere.
- Patients spent more time in City Hospital for planned care in medical care services for some specialties than the England average. For example, clinical haematology patients spent 12 days in hospital compared to the England average of 5.2 days. In other specialties the time was less, for example cardiology was one day compared to the England average of two. For emergency admissions, the average length of stay was slightly below the England average. In stroke medicine it was 10.6 days against an average of 11.4 days. Overall, data showed the length of stay for planned admission was 4.1 as opposed to the England average of 4.5 and for emergency admissions 7.0 days compared to the England average of 6.8 days.
- Bed capacity plans for medical care services were presented to the trust board. This included details of actions already taken to address bed capacity issues and further actions the trust was planning to take.
- Patients with haematology conditions were accommodated on two wards. However, those wards also admitted patients from other specialties so at times there was difficulty in accommodating their own specialty patients. The matron for the area had raised this at a as a concerning issue.
- Staff told us about delays in the delivery of patients' medicines to take home and how this could cause problems. Discharges were often delayed for older patients because of the wait for suitable placements and care packages especially when they had complex needs. Length of stay target for patients requiring stroke rehabilitation was 24 days although we were informed patients frequently stayed longer.
- Referral to treatment times from April 2014 to March 2015 were met across all medical specialities within the trust; we did not have specific data for City Hospital.
- Data received from the trust indicated that 25,412 patients were admitted to the City Hospital between April 2014 and June 2015. 60% of these patients had moved more than once during their stay. 10% had moved twice and 2% had moved more than four times. This meant patients were at risk of not receiving continuity of care.
- Between April 2015 and June 2015 35% of medical patients in City Hospital were outliers. (Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of available beds)

Medical care (including older people's care)

- Information supplied to us by the trust showed there were 1,882 outliers, from 1 April until 2 October 2015. Of those, 1,572 were medical outliers. The data relates to both Queen's Medical Centre and City Hospital.
- The trust was in the process of introducing 'specialty tagging' of patients admitted through the emergency department. This was to facilitate the allocation of patients to the right specialty beds throughout the trust.
- There were medical outliers throughout the wards in the medical care service at the City Hospital. Outliers are patients placed on wards other than the specialty they were originally admitted for. For example, on the 15 September we found five outliers on Secole Ward, an acute medical ward caring for patients who had experienced a stroke, who had been transferred from the care of the elderly wards at the Queen's Medical Centre. Staff informed us outlying patients could stay for up to two weeks at a time or longer. We found one patient had been on Secole Ward for 30 days awaiting the outcome of an application for a continuing health care assessment.
- We spoke with a senior member of staff who told us oncology services in the trust were expanding. They said that although there was an admission avoidance team to prevent admissions where possible, oncology patients often had to be cared for on other medical wards in the hospital.
- There was a triage system for patients who required haematology services. This meant they could be admitted straight to a ward if this was required. This meant patients could access treatment much more quickly.
- Safe discharge planning for patients was a focus on each ward we visited. Multidisciplinary meetings on Southwell Ward focussed on discharge planning and in the neuro-rehabilitation ward a ward based discharge co-ordinator worked with social workers and external agencies to facilitate timely discharges when appropriate.
- On Berman Ward discharges at weekends were seen as essential to ensure a flow of patients.

Meeting people's individual needs

- On admission patients had their individual needs assessed by medical and nursing staff .We saw input from other members of the multidisciplinary team where required, for example dieticians and physiotherapists.
- We spoke with staff about access to interpreter services for patients whose first language was not English. The trust used a local interpreter service when required which included telephone access when appropriate. Some staff spoke other languages and were able to translate or interpret when this was necessary. Patients who required a British Sign Language (BSL) interpreter were asked to let staff at the trust know who would then arrange for an interpreter to be present at a specific time: staff knew they could access this service.
- Leaflets displayed were all written in English, but staff told us they could order leaflets in different languages if they were required. We saw an interpreter on one ward explaining the discharge process to a patient.
- Pictorial menu cards were available for patients who had difficulty reading or understanding a written menu.
- Patients with a hearing aid had access to an audiologist on request by ward staff. Patients who required help with their hearing aids could receive support from the audiology department.
- The trust had a dementia strategy in place. This outlined the care that patients' living with dementia should expect if they were admitted to the hospital.
- The trust used an electronic system to capture information for all patients who were over the age of 75 years and were admitted as an emergency. This enabled them to screen these patients for dementia as required by NHS England.
- The trust employed a dementia specialist nurse and dementia 'champions' were in place on every ward. Their role was to support ward staff in the provision of appropriate care to patients living with dementia.
- A document called 'About Me' was used across the medical wards for patients who were cognitively impaired. The aim of the document was to capture essential information about patients to ensure person-centred care could be provided, for example

important aspects of their normal daily routine, favourite foods and memories that made the patient feel happy. The document was completed by the patient's family or carer as soon after admission as possible but the quality of the information provided was dependent on the information shared by patient's family and/or carers. Some documentation was of a better quality than others which meant staff did not always have the information they needed to provide patient-centred care tailored specifically to the patient's needs. There were no specific care plans or pathways for patients living with dementia.

- Overall, we found that there were arrangements to ensure patients were cared for in single sex facilities and had access to single sex washing and toilet facilities.
- Although patients on Berman Ward had access to (MRI) scanning facilities, the equipment was not adjacent to the ward. Patients had to undergo a journey on a trolley to reach the facility; we were informed it could take 10 minutes to reach it.
- On Southwell Ward, a ward providing care for patients with respiratory diseases, we spoke with staff about availability of pillows. For some patients with respiratory diseases having sufficient pillows was essential to aid their breathing. Staff told us that generally they had enough to meet patients' needs; when they did not they had to borrow from other wards.
- A relatives room had recently been created on the Specialist Respiratory Unit which staff felt was a great improvement to support relatives of very ill patients. The room had comfortable chairs, a drinks facility and information leaflets.
- For patients who did not like plain water to drink we saw staff supply them with a fruit squash to ensure they were able to keep themselves hydrated.

Learning from complaints and concerns

- Information on how to raise a concern or complaint was displayed in all ward areas. Comment cards were available for patients and their relatives to give feedback on the service they had received at the hospital.
- The trust was specific in their policy about the responsibilities of staff in managing complaints and concerns throughout the trust as well as comments and compliments.
- Before our visit we were made aware of a complaint made to the trust about one of the medical wards at the hospital in relation to the care a relative had received there; we visited the ward during the inspection. A member of staff we spoke with knew a complaint had been made but the issues raised were not discussed at a ward meeting for all staff to learn from the complaint. A letter was sent to the family acknowledging the ward's mistakes although the letter was not dated. During our visit we found an action that should have been taken as a result of the complaint had still not been addressed.
- The trust board received monthly information on the number of complaints and timeliness of responses through the trust's integrated performance report. Complaints and concerns were also monitored on a quarterly basis by the quality assurance committee.
- Ward sisters were involved in investigating complaints about their area. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible.
- Staff told us there was learning from complaints at ward level. However, we were not assured that learning from complaints was shared across the divisions in relation to the medical wards at the hospital.

Are medical care services well-led?

Good

The leadership of medical care services was good.

There was an effective governance framework in place to support the delivery of quality care with annual plans in place for each medical specialty. Wards had the ability to set up their own councils and directly influence decision-making as close to patients as possible. Senior staff were visible and staff felt supported.

The medical care services had an open culture with staff respecting each other. They felt able to raise concerns without fear of reprisal.

Medical care (including older people's care)

Vision and strategy for this service

- The trust had no overall vision or strategy for the medical care delivered at the City Hospital although annual plans were developed for each specialty, for example respiratory, stroke and cardiology. We reviewed the plans for 2015/2016 and saw the actions identified reflected the trust's objectives and were measurable. A member of staff was identified as being accountable for the action required and completion dates were in place, the majority of which were March 2016.
- The trust's vision for the future of their hospitals was 'working together to be the best for patients'. Through patient and staff engagement there were three areas the trust had pledged to work on. These were proud people, team work, innovation and continuous improvement.
- The trust was in the process of redesigning its directorates; senior doctors and nurses were aware of this and told us they thought the plans were a 'step forward'.
- Some individual wards had taken ownership of their areas and developed their own improvement plan. For example on one ward five members of staff were involved in improving quality of care for patients through the implementation of a relative's room. This enabled relatives to stay on the ward when patients were seriously ill. In the neurology rehabilitation ward some senior nurses were learning how to improve communication with patients and their understanding of patients' experiences. This would ensure the unit had more specialised nurses to deliver the required care.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the division's annual plan and quality care. Each specialty within medicine conducted its own governance meetings with some specialties meetings planned for the full year, for example oncology and radiotherapy and nephrology. The infectious diseases governance group had only two planned throughout 2015. We reviewed minutes of the governance meetings and saw minutes were comprehensive and covered such issues as the risk register, incident analysis, learning from complaints and clinical effectiveness.
- Each ward displayed key performance data, for example hand hygiene audit and infection rates, and staffing numbers so patients and their visitors as well as staff could see how well the ward was performing.
- The trust undertook a rolling programme of audits, both internal and national. These included cleaning, hand hygiene, medicines and continence as well as clinical issues such as adult asthma and heart failure. This ensured the trust was monitoring the quality of the provision of care in the medical care services at City Hospital.
- Risk registers were produced for each specialty within the medical care services, for example oncology, respiratory, nephrology and stroke. On reviewing the registers it was noted the identified risk was logged with the controls in place to reduce the risk and a date for review. The adequacy of the control was also noted in the risk register, However one entry in the respiratory risk register stated the date of review of the item was 31 July 2012 and the adequacy of the control was 'inadequate' The issue related to the lack of achievement of the 62 day target for patients with lung cancer. There was no update with regard to the issue.
- The directorate was committed to ensuring good governance processes and this was prioritised in the directorate's annual plan. One of the objectives identified in the acute medicine annual plan was to strengthen governance processes within acute medicine and ensure strong clear governance structures were in place to communicate messages to front line staff.
- The trust had a programme of shared governance. Wards and departments were empowered to set up their own councils where they could discuss issues within their own areas. This gave them power and the chance to directly influence decision-making as close to patients as possible. The councils then fed into senior teams.

- In discussion with staff and managers we found there was an agreement on the risks and challenges facing medical care services in the hospital and at trust level. This showed an awareness of risk issues across the service.

Leadership of service

- Medical specialty wards at City Hospital came under a number of different directorates including cardio-respiratory, stroke and cancer and associated specialties. Each directorate had a clinical lead and a matron who was responsible for a number of wards.
- Staff told us that clinical leads for the directorates visited regularly. Staff spoke highly of the chief executive. Two members of staff said the executive team were visible when wards were busy or if they were struggling to find beds for patients.
- Each ward had a senior nurse/sister who provided day-to-day direction and leadership for members of staff on the ward. Staff generally felt well supported by their ward sisters and matrons and felt able to raise any concerns with them. We spoke with one ward sister who told us about an issue they had raised about medicine wastage. The ward was now working with the pharmacy team to reduce the amount of medication wasted in their area.
- We were informed about another area where in the past the trust had supported the ward and undertaken several months of development with staff including team building. This had resulted in improved patient care and staff morale. At the time of our inspection and in the same area some members of staff felt they could not raise issues with senior members of nursing staff because of a barrier with communications relating to staff development and shift allocation.

Culture within the service

- Staff of all grades were positive about working for the trust, and understood the contribution they made personally to the care and treatment of patients. They felt there was a culture of openness through the trust. During our inspection we observed that staff were respectful of patients and of each other in all disciplines.
- Without exception, staff of all grades told us they were proud to work for the trust. They spoke positively about the culture within their own areas and throughout the trust as a whole.
- There was a culture of flexibility and willingness among all the staff we met. Team work was evident in all areas with staff working well together.
- Patients acknowledged a caring and positive culture amongst staff.
- We asked staff if they felt they could raise issues of poor practice by colleagues. One member of staff informed us they had done that in the past and were supported through the process. The member of staff added they would feel comfortable to do it again if it was required.
- For the previous four years staff sickness rates across the trust were below (better than) the England average which varied between 3.7% and 4.7%. The trust's sickness rates during this period varied between 2.8% and 4.2% In January 2015 the staff sickness rate was at 3.6%

Public and staff engagement

- The trust introduced shared governance in 2012. Shared governance gave staff the opportunity to create councils for each ward or department and any level of staff could join the council. It was a 'bottom up' model of management which aimed to empower frontline staff to make decisions about patient care at the point of care delivery. It also gave staff the opportunity to discuss any issues in their area. This information was then taken to senior management meetings. Staff we spoke with told us they felt valued, engaged and involved through the shared governance councils.
- All wards and clinical areas held ward meetings to keep staff informed and to enable their contribution to the development of services. We found through our discussions with all grades of staff they felt informed and involved with the day to day running of the service.
- Staff informed us the Nottingham University Honours awards had helped to boost morale amongst staff throughout the trust. Certificates were issued to staff

and teams who had won awards and went to the individual or team in each directorate who had 'gone the extra mile' to improve patient, carer, or staff experience.

- A counselling service and peer support were available for those staff who were affected by a patient's death.

Innovation, improvement and sustainability

- We saw examples of innovative practice in order to reduce risks to patients. On Southwell Ward we saw patients wore a coloured wrist band when they required oxygen to ensure they received the correct rate. This ensured staff could easily identify the patient's required rate and dangerous levels of oxygen would not be administered.
- Patients receiving oxygen through a nasal cannula were at risk of developing pressure ulcers where plastic tubing went over the tops of their ears. Sponge covers were placed over the tubing to prevent this from happening. (A nasal cannula is a lightweight tube which splits into two prongs placed in the nostrils and from which a mixture of air and oxygen flows).
- Because of financial constraints within the trust a range of cost improvements were in place across all directorates. Senior medical clinicians informed us they were able to challenge the executive team if they felt any of the plans were having a negative impact on patient safety.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Outstanding
Overall	Good

Information about the service

Surgery services at City Hospital fall within four directorates: Cancer and Associated Specialities, Cardio-respiratory and Stroke: Digestive Diseases and Elective Orthopaedics. From January to December 2014, there were 19,753 spells of surgical care at City Hospital, 33% were day case and 51% were planned operations.

There are 13 surgery wards in City Hospital including two wards used for admission and a surgical short stay unit. A Day Case Centre deals with breast, gynaecological, renal, orthopaedic, plastics, general surgery, and chronic pain, and has two theatres and two treatment rooms.

City Hospital opened four new theatres, an admissions suite and a recovery area in May 2015. In total, it has 19 theatres, two of which are for day surgery. There is also a day surgery treatment room for patients with pain problems.

Trent Cardiac Centre at City Hospital has two theatres, which work Monday to Wednesday. One theatre works on Thursday and there is on-call work on Friday Saturday and Sunday. There is emergency work once or twice a month.

We visited 10 wards, the admissions suite, theatres and recovery. We also visited the Day Case Centre and the Trent Cardiac Centre.

We spoke with five matrons/ managers, four doctors, nine sisters/ward managers, 14 nurses or operating department practitioners, one administrator, 25 patients, three relatives and five patient escorts, (porters). We observed care and treatment and looked at 10 patient records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. We reviewed performance information from, and about, the hospital.

Surgery

Summary of findings

Surgery services at City Hospital had systems to protect patients from harm. They managed and responded to risk effectively. The specialities and theatres had reliable processes to analyse learning from mistakes. Patient areas were visibly clean. There were robust arrangements for monitoring safety and cleanliness.

Staff were conscientious about mandatory training and ward managers had good local induction processes. Although there were wards with staff vacancies, ward managers ensured that patients were safely cared for. However, some equipment checks were not up to date, and some staff were unclear about their role in a major emergency.

The services were effective because they planned and delivered patient care and treatment in line with current evidence based guidance, standards, best practice and legislation. Managers and senior clinicians monitored this through audits and at governance meetings. Patients had comprehensive assessments of their needs. There was good multidisciplinary teamwork.

Staff were supported to deliver effective care and treatment including through meaningful and timely supervision and appraisals. Staff understood and documented arrangements for consent and understood how to apply the Mental Capacity Act.

Nurses, doctors and care assistants treated patients with dignity, respect and kindness during all interactions with staff. Patients felt supported. They were involved and encouraged to be partners in their care and in making decisions. Consultants and nurses spent time talking to patients, or those close to them. Patients received information in a way that they could understand. Staff found innovative patient orientated solutions to everyday problems.

The hospital had a new, modern admissions suite for planned surgery, did outreach work with the community and provided enough capacity to meet demand for operations. Services worked well to meet the needs of individual patients, such as people living with dementia.

However, some facilities such as the old theatres waiting area were less patient friendly.

Plans and strategies in surgery reflected a vision of continuously improving patient services. Governance arrangements promoted performance improvement and problem solving.

Services used innovative approaches to gather feedback from people who used services and the public. Surgery services welcomed constructive challenge and feedback from the public and comparison with similar organisations.

Staff and leaders communicated a shared purpose and encouraged staff to express concerns or make suggestions for improvement. Innovation and achievement were celebrated and publicised.

Surgery

Are surgery services safe?

Good

We assessed safety as good.

Surgery services had systems to protect patients from harm and abuse. They managed and responded to risk effectively. The specialities and theatres had reliable processes to analyse learning from mistakes. Patient areas were visibly clean. There were robust arrangements for monitoring safety and cleanliness. Staff were conscientious about mandatory training and ward managers had good local induction processes. Although there were wards with staff vacancies, local leaders ensured that patients were safely cared for.

However, there were some environmental problems. One ward was too hot for patients, and some equipment checks were not up to date.

Incidents

- City Hospital reported two never events within 2014/15 financial year. A never event was defined at that time as a serious largely preventable patient safety incident. These occurred in the elective orthopaedics speciality. There was an operating theatre surgical error in June 2014 and a ward drug incident in December 2014. In September 2015 at QMC there was a suspected never event involving an epidural given intravenously, Managers and clinicians were investigating this when we inspected, and incident details were shared across the trust, with a view to providing a full report in December 2015 The hospital reported ten serious incidents to the Strategic Executive Information System (STEIS) over the same period. Five were grade three pressure ulcers and there was one hospital acquired infection, one drug incident, one surgery error and one 'other.'
- We saw that clinical staff and managers investigated these incidents fully and took action to amend procedures, reinforce training arrangements and share learning across the trust. Theatres responded with a safety improvement programme. The elective orthopaedic speciality also responded by making patients' names more visible above beds, better controls and checks, and measures to improve pre-operative assessment.
- Staff learned from incidents on a systematic basis. They discussed them in weekly ward and theatre meetings. At mortality and morbidity meetings held monthly, clinicians from relevant disciplines analysed the reasons for deaths and complications. They noted any learning points and made any necessary changes. They reported findings to clinical governance review meetings, which analysed findings and monitored resulting actions.
- In theatres, there was a changing flat screen television positioned prominently in a corridor. This displayed learning from serious incidents such as 'never events' for staff to read.
- Staff understood their responsibility to raise concerns. We spoke with nurses and other care workers and reviewed the electronic incident reporting system. It was clear that staff at all levels including patient escorts (porters) were reporting concerns and incidents. However, the trust had surveyed staff and found that 45% of theatre staff needed help to report concerns on the electronic incident reporting system. Barriers to reporting included poor access to computers and no time to complete the report. Staff also identified areas that could improve such as handovers from theatre to recovery. Managers addressed these issues and fed the result back to staff.
- Surgery staff understood and implemented the 'Duty of Candour'. This is a regulation introduced in November 2014, requiring that all NHS bodies should act in an open and transparent way about treatments and mistakes. The burns unit raised awareness of this through posters, emails and intranet training. The upper gastro-intestinal ward explained to us how they apologised and explained to a patient who had fallen on the ward and damaged a bone in their spine. They also presented their investigation of the incident to the falls group, whose remit was to analyse and reduce falls, and to the governance committee.
- Surgical site infection rates were not routinely measured on quality monitoring dashboards. Staff working in plastic surgery told us that their rate was one per cent. Staff in urology did not measure these infection rates. Hip and knee surgical site infection rates were similar to the national average. The orthopaedics speciality was working with the university to develop a consistent and comparable way of measuring surgical site infection.

Surgery

Safety thermometer

- The NHS safety thermometer is a tool used to record four common, and largely preventable, harms to patients: pressure ulcers, falls, urinary tract infections in patients with a catheter, and new venous thromboembolisms (blood clots). The safety thermometer provides information for frontline teams to monitor their performance and to make improvements to eliminate patient harms.
- Safety thermometer information for City Hospital showed low numbers of harms recorded for patients. For the year September 2014 to September 2015, the surgical wards recorded high rates of harm free care: between 85% and 100% each month, with few exceptions.
- Wards and theatres at City Hospital monitored safety performance and compared these with other wards/ theatres in their directorate and in the trust.
- Ward sisters and safety leads reported to specific trust-wide safety groups such as the pressure ulcers operations group. They had to explain any shortfalls in performance and develop actions to improve. This led to shared knowledge about the problem and action taken.
- Ward managers and matrons had to explain the reasons why if their safety scores fell below target. The orthopaedic ward showed us that when their pressure ulcer scores dipped, they had to give assurance to pressure ulcers operations group and pressure ulcers safety group. This encouraged problem solving at ward level and a common approach.

Cleanliness, infection control and hygiene

- Wards, theatres and patient toilets we visited were visibly clean. However, the staff and visitor changing rooms (female) in theatres lacked privacy and cleanliness.
- Surgery services monitored cleanliness in a variety of ways. For example, Morris Ward nursing staff (cardiac surgery) surveyed patients about cleanliness. June 2015 responses showed that most patients found the ward and toilets to be clean. Theatres carried out risk-assessed fortnightly joint cleaning audits with the cleaning contractor. The most recent audit, at the end of August 2015, showed 97% compliance.
- Domestic staff cleaned theatres after each procedure: 'The Clean Sweep'. Wards were cleaned once a day. There were no cases of methicillin resistant staphylococcus aureus (MRSA) bacteraemia in surgery in 2014/15 and 31 cases of hospital acquired illness such as clostridium difficile (C. difficile). However, more recently there was a case of MRSA in urology, and the patient acquired the infection in theatre. Staff were investigating how this could be avoided in future.
- Surgery services promoted hand hygiene and monitored it. We saw that staff used hand sanitiser gel frequently. However, when accompanying patients to theatre, we observed that patient escorts (porters) did not always use hand sanitiser. Surgery wards monitored hand hygiene monthly by using the '5 moments of hand hygiene.' Hand hygiene results in July 2105 for surgery directorates showed that they were between 92% and 100% compliant.
- Services screened new patients for MRSA or C. difficile at pre-operative assessment. They took action to reduce any infection so that patients could have their operation. They also screened for new types of antibiotic resistant infection such as mycobacterium chimaera PVE. They looked at root causes of any infection at a weekly MRSA review meeting and took preventative action.
- City Hospital had arrangements to isolate patients needing emergency surgery from patients who were waiting for planned operations. There was one theatre for emergency surgery and patient escorts (porters) took patients there directly, so emergency patients did not mix with other patients. Other patients either waited in the theatres holding area or the new admissions suite. This lessened the risk of infection between planned operation and emergency patients.
- The post theatre recovery area was visibly clean. Staff wore disposable gloves and aprons. Nurses kept to designated bays to avoid potential cross-infection. There was also an enclosed privacy bay for patients needing isolation. Nurses followed a special protocol for this bay, 'Recovery care of infected patients', to help ensure that infection did not spread.

- Theatres had arrangements to ensure that instruments were sterile and clean. They sent instruments to the Sterile Service Department based at Queen's Medical Centre (QMC) with a 24-hour turnaround, and on occasion could be fast-tracked by taxi.
- The trust had an approach to getting rid of clutter. An intranet 'Dump the junk' campaign asked staff to leave unwanted items outside the ward on a designated Saturday and they would be removed. This helped keep the environment clean.
- We observed staff using protective equipment appropriately, except for one member of staff who was cleaning theatre table attachments without protective clothing.

Environment and equipment

- The City Hospital environment sometimes did not help to keep patients safe. Patients told us the thoracic ward was too hot; 'unbearable,' and they had difficulty sleeping. We visited in the afternoon and noticed that the ward was very hot. Staff told us that the temperature sometimes reached 28C. Some patients had fans to provide ventilation. The heat also limited patient's use of the ward's exercise bike. The ward manager checked the temperature and reported the problem regularly but the heating was still difficult to regulate.
- Due to building work, the burns ward kitchen was temporarily located in a side room outside the ward. Nurses and care staff had to carry washing up to the kitchen upstairs where there was hot water. This represented a safety risk to staff and patients.
- Equipment and electrical safety checks were sometimes late. Barclay (the thoracic ward) had a portable suction client drain unit to enable patients to mobilise after an operation, a feed pump and a feed pump plug, which had gone beyond their service dates. We noticed other equipment on surgery wards did not have up to date checks. For example, the daily suction machine and blood sugar machine in the burns unit.
- Staff checked theatres and theatre equipment regularly. We checked equipment such as the fridge in the anaesthetic room. We noted that staff checked the temperature daily. A senior manager in theatres asked staff to email her about any equipment issues and maintenance needs. An equipment officer managed the checks and ensured there were equipment spares in stock. Theatres had a medical device trainer who ensured that staff were competent to operate specialist equipment. Theatres had a rule that items should be accessible within three seconds, so helping to keep the environment tidy.
- We checked resuscitation trolleys in the Day Case centre, burns unit, orthopaedics wards, thoracic wards, and theatres. All trolleys were complete and checks were up to date. Staff had signed records to show they were checking the trolleys. The checking file contained photographs of equipment alongside technical names to help staff identify components.
- Specialist equipment was available. The burns unit had equipment such as specialist baths, and an IQ Air machine to help manage MRSA infection of burns. There was a gym, which the Burns Network had funded. The burns ward included two isolation rooms for use in case of infection or very severe injuries.
- Hand held electronic devices were used for facilitating patient care. Clinicians could enter observations and the device would alert them if a patient had signs of sepsis. Staff found that they worked very well. Ward staff kept a stock of these devices for agency and locum doctors. However, on Barclay Ward, staff had the devices but without access to the patient information system, which limited their use.
- Theatres at City had special gowns for obese patients and theatres had operating table suitable to treat patients up to 300kg.

Medicines

- City Hospital had procedures to ensure the safety of medicines. Arrangements for prescribing were safe and nurses and clinicians noted patients' allergies on documentation. In most cases medication was locked away within a coded door. Surgery services audited medicines management. Theatres carried out an audit in February 2015 and were preparing an action plan.
- Staff carried out daily checks of controlled drugs to ensure these were correctly reconciled and accounted for. We checked the balance of controlled drugs in the cupboards and found the balance correlated with the controlled drugs registers.

- We looked at four medication records of patients on Barclay Ward. All except one was accurately completed; one patient was using oxygen but did not have a prescription for this.

Records

- We checked five patient records in the day case unit and records were complete with the exception of one consent form that the clinician had signed but not dated. We reviewed five sets of notes in the burns unit and found that none had the discharge section completed.
- We found that staff completed appropriate risk assessments before the patient's operation including the patient's risk of falls and pressure damage and the risks associated with moving and handling.
- Staff kept patient notes private and safe. Patient escorts (porters) suggested and implemented the idea of black zipped bags to transfer patient notes. This kept patient notes safe when patients moved from the admissions ward to theatre and afterwards from theatre recovery to ward.
- Theatres also audited notes and carried out a six monthly retrospective audit. They produced an action plan following the audit.
- Before accompanying patients to theatre, patient escorts checked patient records on the ward. They noted the patient's temperature and the last drink time on the care plan and on the theatre management computer system.

Safeguarding

- The services had processes in place to safeguard vulnerable adults. Ninety per cent of staff in surgery specialities had training up to level two on adult safeguarding. Staff were familiar with the trust's Safeguarding Vulnerable Adults policy. They told us how they used the policy in practice. The trust had a learning disabilities team and a safeguarding team.
- The burns unit gave us an example of how they had to react to protect a patient with a learning disability. They made enquiries with relatives and the GP, and involved the trust's learning disabilities team. The learning disabilities team assessed the situation fully and ensured that the patient was safe. The burns unit did not need to refer to the safeguarding authority. Theatres at City Hospital gave us examples of safeguarding incidents at QMC where staff had shared the learning with them.

Mandatory training

- Surgery services held training events at least quarterly. These events covered mandatory training topics, such as equalities, the Mental Capacity Act, Deprivation of Liberty Safeguards, incident reporting, level two safeguarding and the Duty of Candour. This enabled staff to update their learning on a number of topics on the same day. Theatres held 'Divi Days' every two months. They used these days to develop specialist theatre competencies, such as the standard operating procedure for implants, and moving and handling patients in theatre.
- Managers organised mandatory training for an employee's birthday month. We saw in the burns unit that staff used a spreadsheet to monitor this. At City Hospital, in the Digestive Diseases and Thoracic directorate, 89% of staff were up to date with mandatory training, in Elective Orthopaedics 93% and Specialist Services 86%. The trust's target was 90%.
- Surgery services were developing a system to ensure that all bank and agency staff were up to date with their mandatory training.

Assessing and responding to patient risk

- Surgical specialities took action to minimise patient risk. Theatre clinicians in City Hospital theatres used the World Health Organisation (WHO) 'Five Steps to Safer Surgery', supported by training and a standard operating procedure. We saw the briefing and debriefing stage of this process.
- There was a strict policy of escalation in place to the trust's Medical Director for any non-compliance from surgeons. The hospital audited compliance annually and there was a debrief compliance of 85%. This ensured that clinicians communicated vital information on patient safety. Consultants used the checklist effectively, for example, to confirm the surgery sites and to record any complications of the surgery.
- Theatres carried out a robust audit of their compliance with this checklist. The audit comprised ninety seven patients at City Hospital and a hundred and ninety three

patients at QMC. There were eight areas that were 100% compliant and two of these were at City; Cardiac and Obstetric theatres. However, Combined Specialities and the Day Surgery Unit scored below 79%.Theatres developed an action plan to strengthen signing in, signing out and time out procedures.

- Surgery staff attended specific groups set up to problem solve across safety themes, for example the pressure ulcers operations group and the falls operations group. These helped share learning and problem solving on safety issues. There were printed and intranet format newsletters to disseminate patient safety messages, in theatres and 'Sign up to safety' trust-wide. The trust had an annual patient safety conference where staff presented safety improvement, training on safety topics such as rescuing the deteriorating patients, and individual patient safety awards.
- Theatres had 'patient safety champions'. Their role was to promote a safety culture within theatres and share learning with the trust-wide safety team and patient safety lead. They also cascaded information to their team from other teams in the trust.
- Nurses carried out risk assessment for patients before an operation. This included manual handling risks, MRSA screening, (carbapenem-resistant enterobacteriaceae (CRE) admission assessment, pressure ulcer, malnutrition, catheters (including consent arrangements), falls and bed rails. For older people, these assessments included moving and handling, a safety care plan, a falls care plan informing patients about bedrails if there was a risk of falls after an operation and a healthcare needs checklist. For fit, younger people, the service recorded allergies, medication and all women under 55 had pregnancy tests.
- Surgical services had a process to manage deteriorating patients effectively. The trust had an early warning scoring system to assess key observation details. The Day Case Unit used the same early warning scoring system and knew when the trigger points were to alert a surgeon, anaesthetist or the critical care outreach team. Observations of deteriorating vital signs also triggered an alert on the nurses and doctors hand held electronic device. This enabled them to take action quickly on problems such as sepsis.
- Staff in post-theatre recovery knew what action to take if a patient's condition worsened after surgery. Staff were vigilant in case a patient's blood pressure dropped, for example, and had a procedure to refer to.
- Theatres had a system of 'red flags' around safety. Situations such as low staffing levels, lack of critical care capacity and recovering in theatres automatically triggered an escalation, and led to senior management review.

Nursing staffing

- Surgical wards and theatres used National Institute for Health and Care Excellence (NICE) guidance on safe staffing. In the burns unit, cardiac unit and plastics, there was one nurse for three patients. Carrel Ward (renal) which was shared with medical specialities had a ratio of one nurse to 2.4 patients.
- Ward managers told us that staff sickness levels were manageable. Sickness levels for surgery specialities in August 2015 were between 1.6% in Digestive Diseases and Thoracic and 4.3% in Elective Orthopaedics. This was higher than the trust's target of 3.5% but similar to the England average.
- There were some nursing vacancies. Carrel Ward was recruiting 4.5 full time equivalent nurses. This would improve the ratio to one nurse to two patients. Edward 2 (orthopaedic) was recruiting 3.7 full time equivalent nurses. The burns unit had one vacancy. If there were insufficient staff, the services shut down part of a ward or used bank staff. Wards used bank staff to fill gaps and that their use of agency nurses was minimal.
- Ward managers used the Association of UK University Hospitals acuity tool to help decide staffing levels. Teams discussed the level of patients' needs at shift handovers and there was a scoring system to show this.
- There were some seasonal or night-time gaps in staffing. Staff told us that on the upper gastrointestinal ward it was more difficult to care for patients in winter, as there were generally more patients at risk of falls and more patients from other wards. Staff on Harvey 2 ward (urology, 27 beds) reported that sometimes they were stretched during the night or if several patients suffered

sepsis. Another ward reported that sometimes fewer staff were available in the week than planned, particularly if staff had to take time off in lieu after working at the weekend.

- Staff turnover levels were a challenge for surgery services. In the Specialist Support directorate, which included theatres, staff turnover rates increased from 8.9% in September 2014 to 10.3% in August 2015. Turnover levels reduced in the Elective Orthopaedic and Digestive Diseases and Thoracic directorates over the same year, at 8.5% and 7.4% respectively in August 2015. These rates were slightly higher than neighbouring acute trusts.
- Ward and theatre managers made efforts to attract and retain staff. Carrel Ward had vacancies and offered taster opportunities to attract staff. Edward 2 (orthopaedic) also had vacancies. The ward manager designed a rotation programme for new starters designed to retain them. This involved six months on Edward 2, six months on the male ward, then six months in the short stay unit. Afterwards the employee could choose their place of work.
- Nurses handed over effectively. They updated their colleagues on falls and pressure ulcer risks, and early warning scores. Staff also reviewed the handover process. We saw notes from a staff meeting at Winifred 2 (upper gastrointestinal) where they reviewed some of the changes.

Surgical staffing

- Medical staff skill mix was similar to the England average with slightly more registrars at this trust than the average.
- Surgery services had clear arrangements for cover at night. The 'Hospital at Night' team of doctors and nurses were on call for all wards. For cardiac surgery, there were experienced nurses available from the cardiac ITU, a registrar and a consultant on call. Other wards had similar arrangements. For example, a doctor attended elective orthopaedic wards from 7:30 am to 5:30 pm. If the ward needed a doctor outside these hours, nurses would bleep the critical care outreach practitioners (CCOP). This ensured out of hours cover at weekends and nights.
- There was consultant anaesthetist cover for the emergency theatre at City Hospital 24 hours a day, seven days a week, though resident overnight cover was from a trainee anaesthetist. Anaesthetists documented their handover on a specific form.
- The specialities minimised the use of locums but where consultants were difficult to recruit, they engaged long-term locums.

Major incident awareness and training

- Not all wards were aware of arrangements for a major incident. The trust had a Major Incident Plan issued in 2010 and staff knew about City Hospital's role. While orthopaedic wards were very familiar with the detail of what they should do in case of a major incident, the burns unit was planning to incorporate training into their quarterly training days. All wards were up to date with their fire training.
- As the trust prioritised QMC for emergency procedures, staff at City Hospital thought it unlikely that they would have to defer planned operations in an emergency.

Are surgery services effective?

Good

The effectiveness of surgery services was good.

Staff and clinicians planned and delivered patient care and treatment in line with current evidence based guidance, standards, best practice and legislation. Managers and senior clinicians monitored this through audits and at governance meetings. Patients had comprehensive assessments of their needs. There was good multidisciplinary teamwork.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisals. Staff understood and documented arrangements for consent and understood how to apply the Mental Capacity Act.

Evidence-based care and treatment

- The surgical specialities used National Institute for Clinical Excellence (NICE) and other guidelines to ensure that operations and reporting arrangements were in line with expert practice. For example, they used NICE

guidelines on giving patients anticoagulants to prevent blood clots after an operation. Staff supported people to be mobile before and after their operation in line with NICE guidance CG92 on reducing blood clots. The elective orthopaedic service saw patients in outpatients and for pre-op assessment before admission. They used the opportunity to give important information about hips and knees, help them prepare for the operation, do beneficial exercises (Hip and Knee school) and prepare for their return home. An externally-sponsored (Care 4 Today) pack went to every patient having hip and knee surgery and this included informative booklets, a DVD and information about websites.

- Staff demonstrated their awareness of the risks of sepsis and the action to take if they suspected sepsis. Sepsis is a potentially life-threatening response to an infection. Early identification and specific treatment is essential to reduce the risk to patients. We saw that nurses took appropriate action if monitoring of physiological observations showed possible symptoms of sepsis.
- The services offered an Enhanced Recovery After Surgery (ERAS) programme for some patients having planned surgery. Nurses identified patients suitable for ERAS through pre-operative assessment. The aim of enhanced recovery was to improve the patient's recovery from surgery so that they were able to return to their normal activities sooner. Using ERAS had led to shorter stays in hospital for those patients.
- Services acted on recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), including using a system that more quickly and easily identified patients at risk of postoperative mortality and morbidity. Staff also improved treatment by assessing the service against a NCEPOD tracheotomy self-assessment checklist. They created a multi-disciplinary tracheotomy incident review group and ensured that speech and language therapists saw patients within 24 hours.
- Staff kept to local policies and procedures and could identify where they were on the intranet. These policies ensured access to services based on clinical need regardless of social circumstances or mental health. In the new theatre recovery suite, a nurse showed us where we could find the procedure for treatment of infected patients who needed isolation.
- Theatres had special guidance for the recording and management of implants. They had a standard operating procedure for this and made sure through training days that all concerned understood the guidance.

Pain relief

- Patients told us that that nurses and doctors gave them pain relief when they needed it. Pain nurse specialists were available to provide wards with a daily review of their epidurals and patient controlled analgesia. The pain nurse specialists trained ward nurses in the use of pain control techniques. Anaesthetists visited wards to review pain control when needed.
- The pain relief team ensured that they cared for patients with more complex needs. They developed a pain assessment tool for people living with dementia. They also worked with a psychologist to help where a patient's mental or emotional health influenced how they felt pain.
- Nurses assessed pain at pre-assessment stage for post-operative pain relief. This included questions about the location and type of pain that the patient experienced before admission.
- Patients told us that nurses responded quickly to any need for pain relief although there were occasional delays at night.

Nutrition and hydration

- The trust raised awareness of hydration in a campaign it launched in March 2014. Patient consultation showed that patients were often thirsty before and dehydrated after their operations. It responded with the 'Think Drink' campaign, allowing patients to drink in most cases up until 2 hours before a planned operation. This outlined safe guidelines for eating and drinking before operations by type of operation. The trust was tracking outcomes against this and reported good progress.
- Meal times after elective surgery were 'protected.' This meant that visits were discouraged between 5 pm and 6 pm so that patients could eat undistracted.

- On Winifred 2 Ward (upper gastrointestinal) water jugs were coded with red lids for patients who needed to drink more, and blue lids for patients who needed to drink a bowel preparation. This helped ensure they received the correct care.
- The community parental nutrition team made it easier to discharge patients from the upper gastrointestinal ward as patients could go home with their drips. Nurses gave patients a hotline number to ring them on the ward if there was any problem.
- The specialities were piloting the use of acupuncture to help patients who felt nauseous after an operation. This was proving successful in many cases.

Patient outcomes

- Managers and clinicians routinely monitored information about the outcomes of patients' treatment. Patient reported outcome measures (PROMs) showed that trust wide outcomes improved for hip and knee replacements in line with national improvements. Groin hernia outcomes did not improve as much as nationally, slightly short of national improvements (only one of the measures)
- Managers and clinicians reviewed kidney transplant outcomes. These included survival rates, acceptance, and decline of organ donation. This helped clinicians understand why the service sometimes declined organs.
- Surgery services did national and local audit to improve outcomes. Local audit included a study on stoma care pathway (colorectal surgery). This audit included a patient evaluation. In response to feedback, clinicians then investigated how they provide information to patients and whether nurses could spend more time with patients.
- The burns service learned from peer review. Staff told us that the service was part of the National Burns Care service and participated in a rolling programme of reviews. In 2014, the service reviewed paediatric care in burns. The service developed new paediatric guidelines as a result. The service planned to review adult care in 2016.
- The transplant service tracked outcomes from kidney operations. They knew that their five-year outcomes were slightly worse than the national averages. After investigating, they found that some patients travelled from Lincolnshire and Derbyshire and that six monthly after transplant they are transferred back. This meant that it was difficult for the hospital to track outcomes for those patients, but a joint audit was in progress with other referring centres.
- Services used a wide range of performance dashboards to compare performance both inside and outside the trust. The burns speciality benchmarked its outcome measures, which compared favourably with neighbouring trusts, on the burns injury database. They also reported this information to the Clinical Commissioning Group. They recorded percentages of patients who healed within 21 and 31 days on a patient dashboard and investigated if patients did not heal within this time. They also discussed performance at directorate level. They discussed this with other hospitals at a quarterly network meeting, which helped staff learn from other trusts.
- Surgery carried out as day surgery was increasing at City Hospital. Spells (episodes of surgery care) increased from 41,330 in 2013/14 to 45,208 in 2014/15. Where routine surgery operations are concerned, day surgery is better for the patient as they can return home sooner, and more cost effective for the hospital.
- Re-admission rates for surgery at City Hospital appeared higher than the national average. We asked managers who told us that the figures included renal biopsies, which increased the relative figure. Re-admissions were also higher in some specialties than in others. City Hospital urology services had a higher than national average rate of readmission. The service had a task group to investigate the reasons why and improve.

Competent staff

- Surgery services developed future managers. Training for theatre staff encouraged empowerment at all levels. There were schemes to develop competencies and encourage progression at band 4 assistant practitioner, band 5 and band 6 levels. All of these schemes prepared trainees for the next level up by delivering coaching skills for example, and encouraged dialogue, new ideas and creativity. There was a special pack for newly qualified nurses, which included an acute skills course for seven days and a shortened version for existing staff.
- Ward managers developed leadership and specialist skills. Ward managers were on a leadership course and

they learned from other ward managers. The trust offered a coaching skills and difficult conversations course as part of the Band 6 leadership course. They also gave training on feeding patients by drip (parental nutrition).

- Student training was well organised in theatres. The training team developed rosters and allocated mentors to allow students to gain a broad range of experience. This programme attracted nurses and operational department practitioners.
- Induction training varied. On some wards, for example the burns unit, a clinical educator promoted and organised training for all levels of experience. On Edward 2, the ward sister also set up an induction programme for nurses that included antibiotic therapy training, sling application and traction. Other similar arrangements existed in other wards and there were comprehensive induction arrangements in theatres. However, on one ward (Edward 2) we spoke with trust grade doctors (FY2) who explained that they had half a day's induction to the trust and no induction to the ward.
- Appraisal completion rates in surgery services directorates were 88%, 92% and 92% in Digestive Diseases and Thoracic, Elective Orthopaedics and Specialist Services directorates respectively. This fell slightly short of the corporate target of 95%. We heard that managers used appraisals and one to one meetings to identify training needs and encourage staff to take on improvement work.
- The elective orthopaedic speciality had taken action to retain staff. They designed a rotation programme, which gave new nurses experience on the female ward, the male ward and in the short stay unit. After this period of training, they could choose where to work. There was also an induction programme tailored to orthopaedics that included outpatient antibiotic therapy, traction, sling application, and training on relevant equipment.

Multidisciplinary working

- Surgery services co-ordinated different professionals to ensure that treatment focused on the patient. For example, the burns unit had a multidisciplinary approach including an occupational therapist, a physiotherapist and an anaesthetist. This team met every Monday to discuss the best approach for individual burns patients.
- In renal services, there was a multidisciplinary team approach to putting patients on the transplant list, and which considered all aspects of care. There was also a one-stop clinic to deal with vascular access surgery issues for example, failing fistulas and grafts.
- The services liaised with families and carer when organising discharges. There was a multidisciplinary approach to the complex needs of older patients. This included a Care of the Elderly consultant, an occupational therapist, therapy support workers and a dietitian. This process started at the pre-operative admission stage when nurses contacted patients, carers or relative to plan ahead for discharge. This ensured support for patients when they returned home.
- There was also a multidisciplinary team to help patients get back to normal after gastrointestinal surgery. This team carried out ward rounds on three mornings each week and included a gastro consultant, nutrition nurse, dietitian and pharmacist. Psychological support was also available for patients who were not eating after surgery.

Seven-day services

- Some services at City Hospital showed flexibility in access time. For example, the burns unit would change dressings for patients out of normal working hours if patients booked an appointment. The Day Case unit was open from 7.00 am to 7:30 pm, five days a week but it planned to finish some surgery lists at 5:30 pm in November 2015. Doctors carried out daily surgery ward rounds seven days a week.
- Surgery services had clear arrangements for cover at night. The 'Hospital at Night' team of doctors and nurses were on call for all wards. For cardiac surgery, there were experienced nurses available from the cardiac intensive treatment unit, a registrar and a consultant on call. This ensured out of hours cover at weekends and nights.

Surgery

- There was surgery emergency night and weekend cover if needed. Two full teams were available in addition to an on call anaesthetist and support staff. Most emergency work was plastic or thoracic surgery but there was also an on-call orthopaedic team.
- Patient escorts (porters) were available over 24 hours. In theatres, they accompanied patients from the admissions lounge. Their shift arrangements were staggered so that there was cover in line with demand.
- At City Hospital, pharmacy working hours were limited. Staff at two wards we visited at City Hospital expressed concerns about difficulties obtaining medicines after 5pm (Monday to Friday) and 1pm on weekends, especially for patients going home. There was no pharmacist at City Hospital site after these times. However, the trust provided 24-hour cover at QMC.

Access to information

- Patient medical records were kept in trolleys for each bay on the wards so they were easily accessible for staff to use. Nursing care records were kept at the end of patient beds or with the medical records.
- Diagnostic test and x-ray results were available electronically. This meant staff had quick and easy access to test results and appropriate treatment for patients could be given promptly.
- The services communicated patient discharge to GPs in a timely way. Doctors prepared the discharge letter usually on the day before or on the same day as discharge. In elective orthopaedics, nurses rang and emailed key contacts in the community to make sure that patients received the help and support they needed on discharge. The services sent care summaries to the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Surgery services ensured that patients understood their treatment and consented appropriately. We heard how consultants held a specific meeting with patients to discuss consent.
- Staff discussed consent with patients. They informed them about any alternatives to the proposed treatment, types of anaesthesia and any benefits and risks of surgery. The trust carried out audits of consent. An audit of breast surgery showed that there were many areas of good practice, but staff did not always give patients a copy of the form, or fill out the interpreter section completely.
- The specialities reviewed consent if there was a change of plan. For example, if there was a last minute change of surgeon to carry out the patient's operation, the service informed the patient and asked for their consent to the operation again.
- Staff received mandatory training on, and understood, the Mental Capacity Act and deprivation of liberty safeguards. Elective orthopaedic staff told us they had treated patients with a deprivation of liberty authorisation. The speciality obtained the advice of the trust safeguarding team in complicated cases where there was no advocate or significant relationship. The trust carried out a two-stage test routinely to check whether patients had mental capacity, and especially over the issue of lawful and unlawful restraint and bed rails.

Are surgery services caring?

Good

The care provided by surgery services was good.

Nurses, doctors and care assistants treated patients with dignity, respect and kindness. Patients felt supported.

People were involved and encouraged to be partners in their care and in making decisions, with any support they need. Consultants and nurses spent time talking to patients, or those close to them. Patients received information in a way that they could understand. Staff found innovative patient orientated solutions to everyday problems.

Compassionate care

- Patients told us that nurses were kind and caring and had the time to interact with them. They compared care at City Hospital favourably with Queen's Medical Centre (QMC). Patients thought that staff communicated well, politely and on first name terms. Many patients were

impressed that doctors and consultants had the time to explain procedures to them in a clear way. They told us staff ensured privacy and dignity for patients when they were giving care.

- We tested and observed call bell answering. We found this to be prompt (within 5 minutes). In Winifred 2 the call bell system had been upgraded so all buzzers were working well.
- We heard examples of caring, patient-centred innovations on wards and in theatres. While waiting for theatre, patients became cold. Patient escorts (porters) noticed this and suggested a blanket warming machine. On Edward 2, the ward manager noticed that it was difficult for nurses to do paperwork and watch patients at risk of falls. She positioned study chairs for the nurses in between bays so that they could see these patients and prevent falls.
- There were arrangements to help patients live as normally as possible. Wards such as Barclay and Harvey 2 had day rooms to encourage patients to move about and watch television. Volunteer visitors came in to chat to patients for four hours a week and lunchtime volunteers assisted for one or two hours a week.
- Friends and family test results from August 2015 with a 49% response rate showed that 97.4% patients would recommend City Hospital Surgical wards. Data collected by Healthwatch in 2015 showed that 52% of patients had a positive experience in surgery at Nottingham City and 43% had a negative experience, with 5% with mixed views. Respondents felt most positively about staff. The top negative themes of experience were treatment and care, particularly administrative communication and safe discharge. This was however based on feedback from only 21 collected experiences.
- Alongside the new admission facilities, the hospital was still using a dingy reception area of theatres as a waiting area for patients. Patient escorts positioned patients very close together in front of a television. The area had no screening to give patients privacy. Patient escorts tended to gather around the reception area and chat between themselves, making it noisy for patients while doctors carried out routine checks. These arrangements lacked privacy and dignity for patients.
- Wards made efforts to improve patients' comfort. Patients in two wards told us that it was difficult for them to sleep at night because other patients were noisy. The services surveyed patients and 28% of patients in elective orthopaedic and 31% in digestive and thoracic surgery wards said that they were bothered by noise at night. Ward managers told us that they avoided moving patients in the middle of the night. On Edward 2 Ward, nurses gave patients earplugs to muffle the noise. The ward manager of Harvey 2 (urology) Ward had ordered soundproofed screens to put between noisy and quiet patients.

Understanding and involvement of patients and those close to them

- Patients told us that staff made time to explain treatment and procedures to them and to give pain relief if needed.
- Surgical specialities surveyed patients' carers, asking how likely they were to recommend the support the ward gave to carers. In June 2015, 80% of elective orthopaedic, 84% of cardiac and 86% of digestive or thoracic surgery carers responded that they were likely to recommend the ward's support. This was representative of feedback of the last few months.
- Carers could accompany patients to anaesthetic and theatre. Nurses documented this on care plans.
- They also surveyed patients between April and June 2015 to see if they felt they were as involved as they wanted to be in decisions about their care. In elective orthopaedics, 94% of patients agreed, and in digestive and thoracic surgery, 86% of patients agreed that they were sufficiently involved.
- Wards showed flexibility over visiting times. Normal visiting hours were 2:30 pm until 8:30 pm every day. City Hospital received an increasing number of patients from Lincolnshire and Derbyshire. Visitors therefore had to travel long distances to visit patients. Ward sisters responded by being flexible over visiting times
- The burns service showed sensitivity to patients by locating mirrors in bathrooms behind wardrobe-style doors. This meant that patients did not have to look at their injuries if they did not want to.
- At the Breast Institute, patient escorts met and greeted patients and showed them through the building to the right place. They showed patients where the changing rooms and lockers were, would fetch what they needed

and tried to put them at their ease. The Breast Institute also had 'Caring around the Clock '- a nurse visited the patient hourly to communicate between them and the surgery team.

Emotional support

- Some wards had quiet rooms and day rooms that were suitable for difficult discussions and emotional support. There was a quiet room in the burns unit refurbished by relatives' donations. This was available for difficult conversations. There was also a burns psychologist shared with the trauma centre. The burns service was recruiting for part time cover to ensure that a psychologist was always available.
- Surgery services offered pre and aftercare. The reconstruction package for breast patients involved regular contact by phone. Elective orthopaedic joint replacement patients have access to a help line between 8 am and 4 pm on weekdays and have an answer phone out of hours.
- Admissions managers in cardiac services offered emotional support to patients. They dealt with planned and emergency patients. The manager contacted the planned surgery patients promptly and informed that about what to expect, and dealt with any anxieties. For emergency patients, the admissions manager took all the details and arranged the admission with the appropriate consultant, streamlining the process and resulting in prompt service. Feedback on the ward's wall showed that patients appreciated this approach.

Are surgery services responsive?

Good

The responsiveness of surgery services was good.

The surgery services provided a new, modern admissions suite, did outreach work with the community and provided enough capacity to meet demand for operations. Services worked well to meet the needs of individual patients, such as people living with dementia.

Some facilities, such as the old theatres waiting area, were less patient friendly. Work to meet the needs of obese patients was on-going when we visited.

Service planning and delivery to meet the needs of local people

- Surgery specialities planned and took action to meet the needs of local people. The burns unit had an outreach team that provided burns nursing, such as changing dressings, in the community. There were plans to extend this service to the removal of surgical drains.
- Breast surgery and plastics surgery services were working on cross-covering microsurgery and breast reconstruction. This would provide more capacity in the normal working week to meet demand from patients.
- City Hospital was developing surgery facilities that were more appropriate for future needs. It built a new theatre block for orthopaedic and other planned operations with self-contained admission and recovery facilities. These were designed around patient's needs. The service consulted its patients who made suggestions about décor, and the chair of the patient partnership group advised on the design. Patients had separate cubicles and their own armchair and television set. The service staggered admission times to minimise waiting times in this new facility – 6:45 am, 10:00 am and 12:00 noon. There was a drinks station in the communal waiting area where friends and family could also wait. The admissions area was flexible, attractive and could be adapted to mostly male or female patients and offer privacy.

Access and flow

- Patients did not have to wait long for their planned operations. The national standard was for 90% of patients to receive definitive treatment within 18 weeks. In June 2015, the trust exceeded this standard and treated 93.4% of patients within 18 weeks. The trust carried out most planned operations at City Hospital. The specialties at City Hospital reported no difficulty in meeting the standard, and patients told us they had their operation any time between 4 weeks and 16 weeks after GP referral. The trust managed this process effectively and it identified that a previous dip in orthopaedic performance had been due to the delays at the outpatient stage. It responded by analysing and balancing consultant capacity against demand to ensure that treatment was not delayed in future.
- The trust achieved waiting time targets for breast cancer patients, although waiting times for reconstruction were

between six months and a year. The trust did not meet its cancer 62 days urgent referral to treatment targets in July 2015. It took action by analysing and improving communication and processes for urology, upper gastrointestinal and lower gastrointestinal surgery. This led to an improvement in performance from 78.2% in July to 84% in August, just short of the target of 85%.

- The hospital managed patient flow. We observed a bed management meeting where managers allocated available bed space. This involved assigning beds to patients transferred from QMC, dealing with any deteriorating patients, moving any patients who were not in the best ward for their condition (outliers), and ensuring that patients with planned operations had appropriate beds. Bed occupancy for the trust as a whole was 88%, and at City Hospital, staff told us that lack of beds was rarely a problem.
- Theatres managed their capacity effectively. The Day Case theatre had a 'bridging slot' at 10:30 for theatre lists, in addition to 7:30 and 11:30, which improved flow. The Day Case Centre did their own scheduling direct from input from outpatient's clinics. This meant that they could schedule patients according to the length of time of their procedure, recovery time and equipment needed. It tailored day case timetables to patient needs and ensured that theatres were not underutilised or overloaded.
- Some wards had outliers (medicine and oncology patients who are not normally treated in surgery wards). When we visited, there were outliers in the burns unit from the haematology and oncology specialties and patients with hand injuries. We heard from some wards how they had acquired extra skills to deal with outlying patients.
- The hospital was piloting a new pre- operations risk assessment system in orthopaedics. Staff risk-assessed patients about four weeks before their operation. Patients assessed as low risk had fewer pre-operative tests than those with high risk. Patients assessed as high risk were reviewed by a multidisciplinary (MDT) team, and this included a fast track social service referral if needed. Nurses telephoned patients three days before their operation to check that they were still fit for surgery. This helped to minimise cancellations on the same day, which were disruptive for patients, their working lives and their families. The hospital planned to extend this approach across all specialities.
- Staff planned discharges daily. The orthopaedics speciality held a daily MDT meeting. There was also a weekly meeting with partner organisations, which reduced the barriers to discharge for older patients requiring social services support.
- Patients were sometimes kept waiting on the day they left the hospital. This was due to delays waiting for medication (Morris Ward) or transport (Burns Unit). This was frustrating for patients and led to uncertainty if they were trying to arrange their own transport. Some wards resolved the medication issue by asking doctors to prepare the prescriptions the day before (orthopaedic), or introducing nurse led dispensing (Harvey 2). Other wards were still working to resolve the issue.
- Patients did not spend longer than necessary in hospital. Staff told us that discharge was usually straightforward unless patients had complicated needs, such as a need for a community bed with sensors, which could add another two weeks to a stay. The burns unit did a complex discharge audit and found that they their average length of stay compared favourably with similar services in Leicester and Birmingham.
- Average length of stay for planned surgery varied depending on the speciality. For example, this was 1.5 days in 2014 – 2015 in urology, lower than the national average of 2.1 days. In thoracic surgery, the average length of stay was 6.3 days, reflecting the complexity of patient's clinical needs, as the independent treatment centre at QMC treated patients needing straightforward surgery. The national average was 5.5 days.
- Surgical specialities coped well with potential cancellations. Same day cancellations were rare. In August 2015, there were 43 same days cancellations trust wide. The majority of these were at QMC, and 14 cancellations were due to emergency work taking priority there. Staff told us that when a theatre list risked cancellation due to consultant sickness, consultants co-operated to provide cover. Theatre staff told us that they had to cancel surgery four times in 2014/15 due to a lack of intensive care beds, rather than ward beds. As QMC carried out most emergency surgery, this did not

disrupt planned surgery work at City Hospital. City Hospital had one theatre specifically for emergencies and this had 24-hour cover from consultants, an anaesthetist and nurses, 7 days a week.

- City Hospital had adequate theatre and ward capacity for patients. The new elective admissions and theatres suite meant that from May 2015 elective orthopaedics could operate on 850 additional patients a year.
- Theatre utilisation (how fully theatres are used when they are booked) varied between specialities at City Hospital. In August 2015, thoracic speciality utilisation was highest at 85.5% and burns speciality lowest at 73.2%. Theatres had an initiative to increase theatre productivity, ensuring that surgical specialities had the best theatres for their need, on the best days for bed availability, and start and finish times which suited their caseload. They introduced theatre productivity meetings, a new weekly meeting which focused on what went well or badly the previous week, scheduling the following week, having mandatory leadership from the theatre clinical team and surgical speciality team. Ten out of 18 specialities were achieving 96% in session utilisation.

Meeting people's individual needs

- Staff understood and respected patient's personal, cultural, social and religious needs and took these into account. For example, surgery services showed an adaptable approach to hospital food. Although the menu was available in English only, it included four ethnic menus– Kosher, Halal, Afro-Caribbean and Indian. Staff could not always explain the menu to patients who had insufficient English. In the Burns unit, the relative of a Polish patient wished to bring food from home to be reheated for the patient. Nurses reheated the food and followed appropriate health and safety requirements.
- Patients told us that occasionally food was cold when served because a member of staff carried it on a tray the length of the ward instead of moving the hot trolley. Some patients on Barclay Ward mentioned that the gravy was too salty.
- The specialities were treating an increasing number of people who did not have English as a first language. Nurses could book interpreters on line and some prompt cards with pictures on were available. In theatre, one staff member knew sign language and could interpret for patients with hearing problems.
- Nurses took action to reduce patient falls. For example, the 'mobility club' which identified all patients at risk of falling and created a special area of the ward for them. A nurse was present all the time and physiotherapists concentrating on improving the patients' mobility. This reduced the number of falls in the cardiac ward and other wards then adopted the practice. Wards also delivered one to one nursing care for patients at high risk of falling. Where this happened, we saw the nurse interacting creatively with the patient and offering suitable mental stimulation such as crossword puzzles.
- In renal services, an integrated care pathway specific to each patient's needs led to improved outcomes. There was a standard operating procedure for this and staff understood the process very well. A patient information leaflet on the process fostered good communication.
- There were appropriate care arrangements in place when discharging patients with complex health and social care needs. For example, the elective orthopaedic speciality identified patients with complex needs when they came for their pre-admission checks. A scheme called Systematic Care of the Elderly (Scopes) meant that staff assessed these patient's needs at the outpatient stage. An orthogeriatrician (a specialist in the care of older people undergoing orthopaedic surgery) gave advice before and after the operation as part of a multidisciplinary team. The hospital then carried out a full healthcare review and ensured that the patient was as healthy as possible before surgery.
- Ward staff took care to discharge patients at the right time of day. This was especially important in the case of older or vulnerable patients. The burns unit told us that they would not discharge an elderly patient who needed transport after 4 pm in winter, as this would not be safe.
- The urology speciality piloted a new discharge lounge in a ward borrowed from elective orthopaedics. This was designed to help patients get used to their catheters and to make any necessary changes before they returned home.

- There were good arrangements for people with a learning disability. Carers came in to help people with a learning disability and those living with dementia with the documentation. A learning disabilities team supported and advised the wards.
- Surgery staff used a dementia test tool, which showed dementia status on their hand-held device. They started to use coloured crockery for patients living with dementia. We observed staff doing a crossword with a patient with dementia on Edward 2 Ward while providing one to one support. We found appropriate 'About Me' paperwork included in the patient records
- Surgery wards and theatres were starting to meet the needs of obese patients. The ward manager on Winifred 2 had ordered special beds and scales for upper gastrointestinal patients. Theatres had operating tables to treat patients up to 300kg.
- On one ward, a patient was not comfortable on an air mattress. Staff tried to reposition the patient more comfortably. However, they did not find out about other types of mattress that might have better suited the patient's needs.
- We spoke to two patients who were not happy with the amount of travel expected of them. One patient travelled by public transport from QMC to City Hospital and could not understand why he could not stay at QMC for treatment. Another patient complained of having to travel to the pre-operative assessment from Lincolnshire and then having to return to Nottingham the following day for the consent meeting.

Learning from complaints and concerns

- Staff encouraged patients to give feedback about the services. The trust had a clear system for monitoring and resolving official complaints but also sought to benefit from informal feedback. We saw that hospital staff informed complainants about the outcome of their complaint.
- Staff discussed patient complaints and concerns at their training days. In some wards, excessive waiting for transport or medication before discharge spoilt the patient experience.
- Surgery services handled complaints effectively and confidentially, and reviewed them at monthly clinical governance meetings.

Are surgery services well-led?

Outstanding ☆

Surgery services had a clear vision which was translated into measurable achievements by speciality action plans.

The leadership, management and governance of surgery services assured the delivery of high quality, person-centred care. Surgery leaders worked in partnership with other organisations to improve care outcomes.

Governance arrangements were strong and quality, performance and risk management promoted continuous improvement. Governance meetings included staff and used patient feedback and benchmarking to innovate. Management arrangements were strengthened by trust wide theme groups which ensured that learning was transferred across the organisation.

Services used innovative approaches to gather feedback from people who used services and the public. Surgery services welcomed constructive challenge and feedback from the public and comparison with similar organisations.

Staff and leaders participated in continuous improvement and staff were accountable for delivering change. Innovation and achievement were celebrated and publicised.

Vision and strategy for this service

- Surgery services had a clear vision. Staff at all levels understood how they contributed to the vision, values and service plan objectives which applied to them, especially the key priority which was 'Enhancing Patient Experience.'
- Strategic planning reflected best practice. Surgery speciality action plans interpreted the full range of corporate objectives, providing staff with a 'golden thread' to see how their work contributed to the organisation as a whole. Action plans also integrated actions resulting from audits such as the WHO theatre checklist audit Progress against these action plans was reviewed at directorate level on a monthly basis and half yearly on a corporate basis.
- The annual service plans for surgery services contained robust and stretching strategies for achieving the trust's priorities. The plans explained clearly how continuous

improvement project work at speciality level contributed to the trust's four key corporate objectives. As a result, staff understood their role in improving patient care, and initiated and contributed to improvement work.

- Staff at all levels were clear about the vision and values, and that enhancing patient experience and safety was their key priority. Leaders worked in partnership with other organisations making treatment more convenient for patients. For example, the elective orthopaedic annual service plan showed that they planned to deliver carpal tunnel surgery and pre-op assessment for minor operations in the community.

Governance, risk management and quality measurement

- Surgery services had a strong governance framework which supported improvement and innovation. Specialities held governance meetings monthly. These included discussions of performance, clinical effectiveness and risk management. These meetings fed into directorate and corporate governance meetings which enabled effective communication up and down the organisation.
- Governance meetings included performance and quality management arrangements which supported continuous improvement. Managers asked for corrective actions when performance dipped. They had monthly quality monitoring dashboards for safety, nutrition, pain, patient observations, pressure ulcers and respect and dignity and had a systematic programme of clinical and internal audit. Leaders identified key risks and took action to mitigate them.
- At the same time, management arrangements were strengthened by themed trust-wide groups, such as the Infection Control Operational Group or the Falls Operational Group. This meant that leadership was effective across the range of surgical specialities and across both City and QMC sites. These themed groups enabled learning to be shared across the trust, and information was fed back to speciality level meetings. They also contributed to the strong collaboration between services.
- There was effective two way communication between senior leadership and ward staff. Staff representatives from each ward attended joint staff and management governance council meetings held monthly. Staff discussed issues such as learning from incidents, and presented ideas for improvements. Speciality plans were discussed at these meetings, giving staff an opportunity to contribute. The meetings fed into a trust wide meeting attended by the chairperson of each council
- The trust-wide shared learning was strengthened by a system of meetings between staff of the same grades or interests. These promoted networking and discussion about solutions to shared problems. We heard how ward managers presented their ideas for improvement at similar ward based meetings, for example, the ward manager from Edward 2 (orthopaedics) presented their idea to 200 band six nurses. This was to provide study chairs on the ward so that nurses could position themselves near enough to respond quickly to patients at risk of a fall.
- Ward managers met their teams on a weekly basis. They communicated upwards to a speciality ward managers' leadership team that also met weekly. There was a standard agenda for on-going issues. Managers encouraged staff at all levels to take on projects, for example developing standard operating procedures for minor surgery patients, to ensure that they were treated and mobile as soon as possible. They standardised letters about pre-operative fasting, which clarified arrangements for patients. There were also link nurse meetings for falls, pressure ulcers and nutrition every two months.

Leadership of service

- Ward and theatre staff were positive about leadership. Ward managers were clear about their role in delivering good care and encouraging others to do so. They were clear about their role in managing performance, risk and sickness levels.
- The Chief Executive, Medical Director, Assistant Director of Nursing and non-executive directors did walk rounds in the wards at City Hospital. Staff spoke positively about the leadership team.
- Staff at all levels were encouraged to progress in their career. They were supported to improve their leadership skills through training provided by the trust.

Culture within the service

Surgery

- Surgery services showed a culture of empowerment and continuous improvement in wards and theatres. Staff at all levels were encouraged to contribute suggestions and to take action. A 'Just Do It' project encouraged band two staff upwards to initiate improvements. There was an emphasis on teamwork, reinforced by, for example, a theatres initiative which promoted good etiquette in theatre briefings.
- The culture in surgery services was patient-centred. Teams worked together well and there was a variety of multidisciplinary teams designed to work for the patient.
- Staff felt respected and valued. They told us that City Hospital was a good place to work. Staff we spoke with told us they were proud to work for the trust and of its achievements.
- Theatres staff successfully standardised practices and processes at City Hospital and QMC to ensure safe ways of working and reduce cultural differences. The theatres safety improvement programme implemented a variety of safety projects. It ensured that all theatre staff were trained on team etiquette. This emphasised safety, mutual respect, effective communication, accountability and situational awareness. As a result, theatres ran more safely and efficiently.
- The culture encouraged candour, openness and honesty. Staff told us they felt free to speak openly with managers and patients and report any matter of concern.
- Staff told us that the trust promoted diversity, and a policy officer organised intranet news bulletins and network meetings. We heard that it was supportive of staff with disabilities. It also held a special meeting to assist staff with disabilities and lesbian, gay, bisexual or transgender staff who might have had difficulty progressing in their career.

Public engagement

- Surgical services gathered public views in a variety of different ways. In addition to the Friends and Family Test, the service gained feedback using the electronic hand held device and surveyed carers. Surgery services provided the Friends and Family test in different formats to try to make it easier for people with dementia or learning difficulties to respond.
- Surgery used public and patient feedback effectively to improve the service. Lack of parking was a problem and staff told us that some patients missed their appointments due to this. However, staff did what they could to help. For example, the burns unit heard how patients struggled to find a space and the ward. The unit responded by routinely sending out directions with the nearest car park indicated so that patients could park nearby.
- The burns unit did prevention work and raised public awareness of burns. Staff met the public at the National Burns Awareness Prevention Day around the end of October. They reviewed where the majority of burns referrals came from and set up a stall outside a local supermarket with the Fire Service.
- More than 1500 patients shared their feedback with theatres between April 2014 and June 2015. The service achieved national recognition for its work. Nursing Times shortlisted the service in 2015 for its Enhancing Patient's Dignity awards. The feedback led to actions at City Hospital such as staggering admission times to urology theatres to reduce patient waiting times, providing appropriate theatre gowns for obese patients and the 'Think Drink' campaign to respond to patient's comments that they felt thirsty while waiting for surgery.

Staff engagement

- Staff at all levels in surgery services initiated improvement work. Ward sisters started projects and passed them on to other nurses and health care workers on the ward. For example, we heard how one ward sister started to redesign the local induction programme and then passed it to a band 6 nurse to design and complete.
- Surgery services had schemes to encourage staff suggestions. The 'Just Do It' staff suggestion scheme encouraged and rewarded staff who put ideas forward. In theatres, patient escorts made innovative suggestions to the 'Dragon's Den' event, such as fitting a smaller oxygen cylinder to patient trolleys to reduce the weight, a sealable folder for confidential patient records and blanket warmers to ensure that patients were comfortable and warm while waiting for their operation.

Innovation, improvement and sustainability

Surgery

- There was a strong focus on continuous learning and improvement for all staff in surgery services. This included a development programme for staff working in theatres. Support workers, (band four staff), in theatre were supported and provided with training to develop and improve their skills and experience. Staff working at bands five and six were given support and training to develop competency within their role and their leadership skills. This meant these staff were able to move more easily into more senior roles and were able to support the service in the absence of team leaders.
- Theatres benchmarked activities against their own standards and compared their practices with external organisations. For example, they compared some of their processes with neighbouring hospitals and improved processes in as a result.
- The service worked with partners in the community to ensure services were financially sustainable and continued to improve. For example, the trust's League of Friends donated £64,000 for eight trolleys in the Day Case centre. Staff donated £200 back from their coffee funds to show their appreciation.

Critical care

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Outstanding
Overall	Outstanding

Information about the service

Adult critical care services at Nottingham University Hospitals, NHS Trust (NUH) are provided on two sites Queens Medical Centre (QMC) and City Hospital Campus.

This location report refers primarily to critical care provision on the City Hospital campus. However, the general adult critical care provision at the City Hospital campus is under the same management team and the two services work together.

The City Hospital campus includes the Trent Cardiac Unit. This is a specialist cardiac care centre with eight level three (L3) cardiac intensive care beds (CICU) for patients requiring support for two or more vital organs, and eight level two (L2) cardiac high dependency beds (CHDU) for patients requiring support for one or two vital organs. The eight CHDU beds were closed during our visit due to consultant annual leave and unplanned consultant sick leave.

The adult critical care department (CCD) at City Hospital consisted of two areas separated by the main hospital corridor. One area had ten beds including one single room and the second area had eleven single rooms giving a total of 21 beds. All the CCD beds could accommodate L3 or L2 patients as required, however the second area was primarily used for L2 patients.

CCD and CICU provided a service 24 hours 365 days a year. CHDU also provided a 24 hour but was temporarily closed for the duration of our visit.

Additionally there was a Critical Care Outreach Team (CCOT) that supported the identification of the deteriorating patient through staff education, direct referral and by following up patients after transfer to the ward from critical care. The CCOT service was centrally managed and worked across both QMC and City Hospital campus as one team.

NUH CCD is a member of the Mid Trent Critical Care Network (MTCCN)

We spoke to four consultants, ten nurses, one specialist nurse, three junior grade doctors one physiotherapist, five patients and their visitors. We visited the two CCD areas, which were situated opposite each other and accessed from the hospital main corridor, the CICU which is situated in the Trent Cardiac Unit of the City Hospital and spoke with patients on cardiac wards following transfer from CICU.

Critical care

Summary of findings

We found the adult critical care services in CCD and CICU were good for safe, effective and responsive and outstanding for caring and well led.

There was a genuinely open and honest culture in which incidents and concerns were shared across the services and changes implemented to improve patient safety. National, trust, and local audit data was used to support service improvements.

Internal training and support for staff development was of a good standard and well established, however, we did have concerns about limited access to the critical care module for registered nurses in CCD.

Care was patient centred and continually assessed on an individual basis. Emphasis was placed on the safeguarding of patients who were unable to communicate due to their clinical condition.

Patients and visitors consistently expressed satisfaction with the care and treatment they received stating that staff were very kind, caring, and nothing was too much trouble.

There was a collective enthusiasm across all staff groups with a clear knowledge of the vision, values and strategic goals for the adult critical care and cardiac critical care services.

Staff told us they were proud to work in the department, felt very supported in their work and their opinions were valued.

Are critical care services safe?

Good

The safety of adult critical care services provided at the City Hospital campus was good.

There was an openness and transparency about safety with patients receiving a sincere and timely apology when things went wrong. Staff were encouraged to report incidents, and lessons learnt were communicated widely to support service improvement.

There was a low level of hospital acquired infection and local infection control procedures were followed.

Equipment was maintained and readily available as required.

Medical and nurse staffing numbers met the minimum recommended levels and access to a consultant intensivist met the 30 minutes requirement within the intensive care core standards document. There was established internal training and development for staff, although the number of nurses with a recognised post registration critical care qualification was 26%, which fell below the recommended 50%.

Mandatory training attendance met, or exceeded, the trust target in all areas.

Medicine storage was safe. However, there were concerns relating to the safe checking and administering of medication at the bedside in the critical care areas.

Incidents

- Incident management in the critical care department (CCD) and cardiac intensive care unit (CICU) reflected the open and honest approach evident across all of the adult critical care services in the trust.
- Staff in both units told us they understood and fulfilled their responsibility to report concerns, near misses and incidents on the trust's electronic reporting system. New staff were given guidance and support in this process.
- Lessons were learnt and shared to support improvement. An example was revised documentation relating to skin assessments that had resulted in a fall in avoidable pressure ulcers (there had been no avoidable

pressure ulcers since July 2015). A 14 day handover tool was used by the CCD to ensure staff were informed of incidents and alerts. The 14 day tool was a handover sheet which ensured information was communicated every day for 14 days to capture as many staff as possible. CICU staff verbally handed over information and there was a communication folder for all staff to access.

- There were regular critical care patient safety council / governance meetings attended by all staff groups. Meetings were held alternately at QMC and City Hospital campus. We reviewed four sets of meeting minutes and saw that actions were updated and outcomes shared.
- There was a quarterly report for staff called 'Sweet Treats' covering patient and non-patient related incidents. The July to September 2015 edition included a range of topics from needle stick injuries to communication problems.
- Staff generally understood the Duty of Candour, (this is a statutory requirement to providers to be open and honest with patients when errors occur) Staff told us that patients would be informed of any mistakes and this would be documented in their medical notes. There were no examples available to review on critical care units at the City Hospital at the time of the inspection. However, evidence of documentation was seen at the Queen's Medical Centre location.

Safety thermometer

- The safety thermometer is a NHS tool used for measuring, monitoring and analysing patient harm. This included four key areas, pressure ulcers, falls, urine and urinary catheter infections and blood clots. Information about the safety thermometer was clearly displayed for staff and visitors to see.
- A combined adult critical care data sheet entitled 'Performance at a glance' was provided. For May and June 2015 there had been no reported incidences of clostridium difficile (C Diff), methicillin-resistant staphylococcus aureus (MRSA) or patient falls. There were three reported pressure ulcers, which were investigated and action plans were in place
- Data provided by the senior nurse in CICU showed no reported infections or falls for the period May / June 2015. There was one reported hospital acquired pressure ulcer, which on investigation was found to be unavoidable.

Cleanliness, infection control and hygiene

- CCD and CICU were visibly clean and uncluttered.
- Staff followed the trust's policy on infection control including bare below elbows policy. Personal protective equipment (PPE) such as gloves and aprons were readily available. We observed staff changing PPE when moving between patients.
- There were hand cleansing gel dispensers throughout the departments, and hand washing facilities located between bed spaces.
- The trust commissioned cleaning services from an external provider who undertook cleanliness audits. Cleaning audits are undertaken at a frequency determined by the risk category of the area, critical care is designated very high risk and was scheduled to be audited fortnightly. These audits showed compliance of 91% – 97%. Both units reported concerns about the allocated housekeeping provision which they had raised with the housekeeping provider. One example provided was that waste bins were not always emptied due to the limited time allocated to them.

Environment and equipment

- CCD and CICU areas appeared clean and well maintained.
- CCD had been refurbished and met, or exceeded, the standards identified within the Core Standards for Critical Care (2013). Patient hoists were integral at each bed space and facilities were able to support the care of heavier (bariatric) patients. CICU was older but met the required standards.
- Portable hoists for moving and handling patients were available in CICU.
- Electronic equipment was serviced by the trust's medical electronics department and staff told us there was never a problem accessing equipment when needed.

- Emergency equipment including resuscitation and airway management trolleys were easily accessible. Records showed staff checked these daily for correct content and use by dates.
- Equipment in CICU was in working order but in need of updating. The trust was aware but replacements were not being funded because there was a plan to refurbish the cardiac theatres.

Medicines

- There had been 26, no harm, medication incidents reported within adult critical care (including QMC and City Hospital campus) and three non-harm medication incidents reported within CICU in the four months prior to our inspection. Medication safety was included in the critical care risk register and actions to improve medicines governance and safety was in the adult critical care plan for 2015/16.
- We observed two nurses checking and administering medication but they did not follow trust policy and procedure.
- Prescription medicines were stored safely in locked rooms which staff accessed by electronic finger print recognition system. The electronic system also monitored stock levels including controlled drugs; however, a manual check of controlled drug stock was carried out on each shift. These were found to be consistently correct. CICU had locked drug cupboards and controlled drug records were all accurate and up to date.
- There were fridges for temperature sensitive drugs. Temperature levels were recorded daily and were within an acceptable range.
- There was a pharmacist review of all patients on the daily multidisciplinary team round Monday to Friday with on-call provision at a weekend. There were plans in place for a one month trial of weekend pharmacy review.

Records

- Records were stored in a secure way that ensured patient confidentiality.
- We looked at two patient records, which were correctly completed, legible, dated, and signed. This included times of referral and admission times in accordance with National Institute of Health and Care Excellence (NICE) guidelines.
- There was a daily sheet outlining the patient's treatment and nursing plan. These were completed and updated throughout the shift.
- Doctors and nurses recorded conversations with relatives in the patients' records.
- A project group to digitalise medical and nursing notes was established with all staff being involved in the early design stage.
- Both units used a paper based record system.

Safeguarding

- Safeguarding was given a high priority within the adult critical care areas, supported by the matron and lead consultant. Staff understood their responsibilities and knew how to report safeguarding concerns.
- Ninety eight per cent of staff had completed adult safeguarding training to level 2. Level 2 is for staff with professional and organisational responsibility for safeguarding adults.
- Information about safeguarding was displayed in each adult critical care area.

Mandatory training

- Mandatory training across all staff groups within CCD and CICU was well attended and records showing 95-100% completion. This met or exceeded the trust target of 95%. Mandatory training included conflict resolution, manual handling, fire safety, infection control, health and safety, values and behaviours information governance and safeguarding adults.
- The trust mandatory training DVD reported as being accessed by 99% of all staff.

Assessing and responding to patient risk

- Risk assessments completed daily for patients on CCD and CICU. This included mental capacity assessment, and observations for the development of delirium. Delirium is an acute, reversible, mental disorder, which can occur as a result of disordered sleep-wake cycles,

resulting in a range of symptoms from withdrawal to agitation. Research has identified this can occur in up to 80% of acutely ill patients and can affect their long-term recovery.

- In CCD each bed space had a booklet which staff could refer to for current guidance regarding patient assessments. Staff in CICU had access to current guidelines in paper form and via the intranet.
- Observation charts were completed comprehensively and any signs of deterioration were reported to the nurse coordinator or doctor promptly. CICU also employed specialist practitioners who were able to make clinical decisions regarding patient treatment. Specialist practitioners were nurses who had undertaken additional higher education and were assessed as competent to make clinical decisions. They worked alongside medical staff.
- The modified early warning system (MEWS) was used across all units. MEWS is a nationally recognised patient assessment tool that scores a patient in relation to regular clinical observations such as temperature, pulse, blood pressure, and respiratory rate. The score is an aid to recognising a deteriorating patient and gives clear instruction for escalation; from increased frequency of clinical observations, to urgent medical intervention.
- Electronic observation recording was in use in most areas of the hospital but was not yet implemented in critical care, although this was being considered.
- The nurse to patient ratio and immediate access to medical staff meant there was no delay in recognising and escalating the deteriorating patient.
- We reviewed four sets of notes across CICU and CCD and each set included completed and evaluated risk assessments. The Critical Care Outreach Team (CCOT) reviewed patients who had a score of four upwards on the modified early warning score (MEWS) within a set timescale of 60 minutes and those with a score of six plus within 30 minutes. Audits of these response times showed maximum response rates of 59 and 28 minutes.
- Members of the CCOT did a comprehensive risk assessment of patients transferred out of critical care with a tracheostomy (artificial airway) in place. CCOT staff provided on-going support for these patients on the ward they were transferred to.

Nursing staffing

- The total number of nursing staff for adult critical care within QMC and the City Hospital met the requirements of the critical care core standards. Level three (L3) critical care patients were cared for at a ratio of one nurse to one patient, and level two (L2) high dependency patients were cared for at a ratio of one nurse to two patients. In addition, a senior nurse, band six or seven, was supernumerary as shift clinical coordinator.
- Additionally CICU employed six specialist nurse practitioners who provided 24 hour specialist cover to the CICU and were supernumerary to act as the shift coordinator.
- Nurse vacancy rates were 3.7% which was in line with the Royal College of Nursing acceptable level of an average of 4%
- Sickness absence rates for nurses averaged 4%. This reflected the national average according to the Royal College of Nursing figures.
- Adult critical care was actively involved in trust and local recruitment activities, including recruitment fairs and open days.
- There was a full nursing handover at the start of each shift which included use of the 14 day handover tool. The 14 day handover tool was used to inform staff about incidents, complaints, policy changes and news for 14 consecutive days, ensuring all staff received relevant and current information. This was followed by individual patient handover at the bedside.
- The use of bank and agency staff was minimal, with only two shifts covered by agency staff in the week preceding our inspection.

Medical staffing

- There was a suitably qualified and experienced consultant intensivist / anaesthetist as head of service for adult critical care.
- There were eight consultant intensivists working on CCD. This enabled a rostered ratio of one consultant to eight patients (1:8) Monday to Friday and one consultant to 17 patients (1:17) at weekends. This partially met the recommendations of the intensive care core standards, which states the consultant patient ratio should range

between1:8 – 1:15 for intensive care (L3) patients. However, CCD, although equipped to take up to 21 L3 patients, consistently had a number of L2 patients for whom the level of dependency was less.

- There were intermediate / advanced trainees (at registrar level) with access to consultant advice by telephone or at request could attend within 30 minutes as required by the core standards.
- There were three consultant vacancies in adult critical care. One consultant was appointed to commence work February 2016. The other two positions were being advertised.
- Nursing staff told us they were well supported by medical staff and there was always medical assistance available when required. Locum consultants were occasionally employed at weekends, rotas indicated an average of one weekend in four.
- Handover between night shift and day shift staff was attended by consultants, doctors, a physiotherapist, and the bedside nurse. This was followed by allocation of patients to the doctors on duty who undertook a full examination of their allocated patients. At 11:30, there was a full multidisciplinary round including medical staff, a physiotherapist, nurses, a pharmacist and other health professionals when a daily plan was agreed for each patient.
- CICU had five consultant anaesthetists covering two operating theatres, CICU and CHDU and an on-call registrar to support emergencies. The nurse specialist practitioners were able to work at junior doctor level providing twenty-four hour support.

Major incident awareness and training

- QMC was designated as a major trauma centre in April 2015 and there were transfer arrangements between QMC and CCD for single or multiple patient transfers.
- There were current major incident policies and procedures available on the trust intranet and staff told us they were able to access these.

Are critical care services effective?

Good

The effectiveness of critical care services at City Hospital was good.

Care and treatment was planned and delivered in line with current evidence based best practice and there were active and effective audits providing guidance for service improvement.

Patient's nutrition, hydration and pain management needs were assessed and appropriately managed.

New staff were well supported and there was a positive culture of personal and professional development. However, the CCD did not meet the critical care core standard of a minimum of 50% of nurses with a post registration critical care qualification.

Staff demonstrated good awareness of the Mental Capacity Act (MCA) and the application of the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Patients' care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice, including those set by the National Institute for Health and Care Excellence (NICE).
- Staff had information readily available in booklet format or via the hospital intranet. This included guidance and explanation of risk assessments and access to current policies and procedures to ensure staff followed best practice.. This included care bundles, for example ventilation and sedation hold for weaning patients from respiratory support, and identification of sepsis.
- The adult critical care service was an active member of the Central England Critical Care Network (CECCN) and adhered to the agreed policies produced by the network. This included admission and transfer policies. The CECCN is a group of geographically close critical care units which work together to provide consistency of treatment and care through shared audits and common policies.

- Audits within critical care were led by a critical care consultant supported by the clinical governance lead, nursing audit lead, and corporate audit officer.
- We reviewed the audit report for 2014/15 and found there was a comprehensive range of audits carried out on both CCD and CICU. These included national, trust and critical care specific audits. A paper was produced with a description of each audit, the outcomes and any recommended actions. This paper was available to all staff in critical care.
- Staff were informed of audit outcomes through presentations, e-mail, governance meetings and newsletters.
- The CCOT was developing a 'tracheostomy passport' (information booklet for patients who have had a tracheostomy). This was based on recommendations from 'On the right trach', published in 2014 by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD).

Pain relief

- We saw evidence of pain scoring and appropriate administration of pain relieving medication. However, patients' response to analgesia administration was not always recorded in the daily treatment and evaluation plan.
- A behavioural pain scoring approach was being introduced within adult critical care. A behavioural pain score is a nonverbal assessment based on facial expression, upper limb movement and acceptance of mechanical ventilation.
- The pain management team visited daily to assess patients with epidural analgesia in place. Other patients were seen by the pain team on referral.
- Three patients we spoke with in CICU told us their pain was kept under control and nurses asked them regularly about pain using a scoring system of one(no pain) to ten(severe pain).

Nutrition and hydration

- All patients had their nutritional needs assessed by a dietician within 24 hours of admission to critical care Monday to Friday with on-call service for advice at the weekend. A dietician attended the multi-disciplinary team round for patients receiving long-term critical care.
- Nutrition and hydration was maintained in a variety of ways depending on the patient's clinical condition.

Patient outcomes

- Intensive Care National Audit and Research Centre (ICNARC) provides comparative data of patient outcomes in critical care. This includes the incidence of patients readmitted to critical care within 48 hours of discharge, a measure applied nationally to assess whether patients are discharged from critical care appropriately. Data for this service showed a readmission rate of 0.5% – 4%, which was in line with national average of 0.5% to 5%. There was no readmission within 48hours in the month prior to our inspection out of 83 patients treated.
- Readmissions post 48 hours were at the higher end of the average for similar sized units at 9 %, (average is 6 to 12%). This was due to the number of patients with complex conditions returning for further planned surgical procedures.

Competent staff

- Staff within CCD and CICU were competent and confident in caring for patients at L3 or L2 and told us they were well supported within their role.
- CICU had six specialist nurse practitioners trained to an advanced level who were able to work at a level equivalent to junior doctors. These practitioners were competent in assessing and treating patients and were able to undertake airway management (intubation) and other emergency procedures as required.
- There was a positive culture of learning and professional development although funding for external post registration critical care awards was limited. Only 26% of qualified nurses had completed a post registration award in critical care nursing. This did not meet the minimum standards recommended within the core standards for critical care. Discussions were ongoing to facilitate this course in-house with affiliation to a local university.
- There was a comprehensive induction process for new members of staff to both units with a six week supernumerary period and a named mentor. A newly employed staff nurse told us that the support provided from nursing and medical staff was excellent.

- There was a practice development nurse who facilitated in-house classroom and one to one bedside teaching. There was also a clinical educator to train staff in the use of equipment.
- There was minimum bank and agency employment within adult critical care. When bank and agency staff were used, an induction and competency check process was in place, and a welcome booklet provided.
- 93% of nursing staff had received an appraisal for the period 2014/15, which was below the trust target of 95%.
- Data provided for medical staff for the same period showed 100% completion.
- There was evidence of innovative staff training in the trust's simulation centre. We observedmedical and nursing staff developing the skills required for sensitive support of patients and their families during the process of organ donation.
- The CCOT included a band seven educator who managed an established programme of training. This included input from respiratory medicine, cardiology and other specialities.

Multidisciplinary working

- People received coordinated care from a range of different staff, teams, or services. All relevant staff were involved in assessing, planning, and delivering people's care and treatment. This was evident in the medical and nursing documentation.
- There was a multidisciplinary team (MDT) approach with daily ward rounds and a specific MDT round each week to monitor those patients receiving long-term critical care at the CCD.
- MDT rounds were inclusive of all professional expertise with active debate regarding patients' care and rehabilitation needs.
- There was a close working relationship between the three critical care units at QMC and the CCD at the City Hospital campus.
- There was an established CCOT across all critical care units providing follow up on the ward for patients transferred from critical care, especially those with tracheostomies in place. CCOT worked closely with physiotherapists and speech and language teams in planning post critical care monitoring and rehabilitation.

Seven-day services

- The CCD and CICU provided care seven days a week with nursing staff levels that met the core standards for critical care.
- Medical cover met the core standard recommendations although this was dependant on locum staff at the weekend, due to current vacancies. A recruitment plan was in place.
- There was consultant presence on the CCD unit from 08:00 until midnight. Outside of these hours consultants were available for advice and admission approval. Access to a consultant was within the 30 minute standard as described within the core standards for intensive care.
- CICU had specialist nurse practitioners 24 hours who were competent to assess, treat and prescribe as required.
- Allied professional services were available as follows:
- Physiotherapy – seven day service including night time cover and on-call.
- Dietician –patient review within 24 hours of admission; Monday to Friday, no dedicated weekend service - this service was under review.
- Pharmacist – daily patient review; Monday to Friday, trial of weekend provision in progress
- Speech and Language – referral service only Monday to Friday
- Occupational Therapy – referral service only Monday to Friday,
- Pain service – daily patient review with epidural plus referral service.
- The CCOT was available seven days a week from 08:00 to 20:00. The service was piloting 24 hour weekend working at the time of our inspection on the city campus. Following a review of the pilot the trust was hoping to extend this to seven days a week.

Access to information

- There were no reported problems with access to patient records and test results, including blood results and x-rays which were available electronically.

Consent and Mental Capacity Act

- Staff sought consent from patients when providing treatment or personal care.
- Seventy five percent of consultants had completed consent training. The trust target for this training was 95%.
- Staff on CCD and CICU demonstrated a good knowledge of the Mental Capacity Act 2005 and completed a mental capacity assessment as part of their daily patient assessments.
- Deprivation of Liberty Safeguards (DoLS) were used when patients were unable to give informed consent, or where their personal safety was at risk. This was appropriately documented and discussed with relatives or those close to the patient. DoLS status was reviewed daily. Deprivation of Liberty Safeguards (DoLS) form part of the Mental Capacity Act 2005. They aim to make sure that people in hospitals are looked after in a way that does not inappropriately restrict their freedom.
- During the inspection of CICU and CCD at the City Hospital campus no patients were subject to DoLS however there was documentation that mental capacity had been assessed

Are critical care services caring?

Outstanding ☆

Care for patients using the critical care services at City Hospital was outstanding.

Feedback from those people using the service and those close to them was continually positive telling us staff treated them with respect and offered support at a difficult time. The care they received exceeded their expectations.

Staff demonstrated an understanding of people's individual needs and showed determination and creativity to overcome obstacles and deliver outstanding care. Bed spaces were personalised and individual preferences catered for wherever possible.

Patients and those close to them were involved in treatment choices and kept fully informed of any changing clinical condition.

Medical and nursing staff demonstrated good interactions with patients and their carers, answering questions with empathy and sensitivity.

Follow-up clinic was available for patients and those close to them to discuss their time within critical care following discharge.

Compassionate care

- Feedback from people who used the critical care services at the City Hospital campus, those close to them, and stakeholders was consistently positive. This was evident from family and friends data and from talking to patient visitors during the inspection.
- There was a strong person centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted individuality. We saw patients were consistently treated with kindness and respect.
- We observed a patient who was having full respiratory support, long term, taken outside to 'feel the fresh air'. Staff told us they tried to make life as normal as possible for patients. This included dressing them in their own clothes, bathing and applying make-up if possible.
- Staff made every effort to maintain patient and family contact using mobile telephone and electronic tablets. We observed this in practice when staff gave the ward telephone to a patient to speak to the caller. One visitor said they called to enquire about a patient's condition after surgery and staff allowed a brief conversation with the patient. In this, the visitor found, "Great relief" and reassurance.
- Families were encouraged to bring in photographs and written messages for patients. Staff were observed reading such communication received to the patient.
- Staff used facilities available within the critical care department (CCD) to enable long-term patients to have supported showers or other personal care such as hair washing.
- Medical and nursing staff demonstrated good interactions with patients and their carers, answering questions with empathy and sensitivity.

- Staff were particularly mindful of the need to protect patient's dignity and ensured that curtains or blinds were used whenever a patient was to be exposed in any way. We observed staff talking to patients in respectful and informative ways during any contact, whatever the patient's level of consciousness.

Understanding and involvement of patients and those close to them

- Staff gave patients a full explanation of their care and treatment whatever their level of consciousness.
- Visitors were engaged in conversations about their relative and given updates and reassurance as needed.
- Two patients explained that their family were called after their operation and the surgeon was available and happy to talk to family members. As soon as patients were able, nurses helped them to have mobile phone contact with family members.
- All risks and benefits of cardiac surgery were explained to patients prior to them giving consent. All of those we spoke with told us they and their families had been involved in care planning.
- Staff took patients and carers views into account in the care planning process.

Emotional support

- Patients and relatives were given emotional support whilst on the critical care units. Family members told us staff always found time to talk and nothing was too much trouble. We observed friendly and open banter between staff and visitors.
- Multidenominational spiritual support was available on request.
- Following discharge from critical care patients were visited on the ward by a senior nurse to answer any questions they may have about their time in critical care.
- Letters were sent following discharge from hospital to those patients who had been in the critical care units giving them the opportunity to return to the hospital to discuss any outstanding concerns.
- Post trauma patients who were rehabilitating at the CCD had access to a psychologist as part of the major accident service.
- We saw staff spend time with patients including reading correspondence and discussing menu choices.

Are critical care services responsive?

Good

The responsiveness of critical care services was good.

Services were provided in a way that met the needs of local people and innovative action was taken to prevent cancelled planned surgery.

Staff had a thorough understanding of data and used outcomes to plan and improve care.

Individual needs were taken into account when planning care, such as for patients living with dementia, or those with disabilities.

There were few complaints made to the service. Complaints were taken seriously and responded to in a timely way.

Service planning and delivery to meet the needs of local people

- The service included the critical care department (CCD) providing L3 and L2 care for planned surgery and long term respiratory care. The cardiac intensive care unit (CICU) provided L3 and L2 care for patients after heart surgery or for other critical heart conditions.
- Despite being managed under separate directorates, there was an established working relationship between the coronary intensive care unit (CICU) and CCD providing support to each other at times of peak activity. Patients requiring long-term respiratory care could be moved from CICU if required.
- The two services met the needs of the local population and were actively seeking ways to continually improve. An example was the successful bid through the trusts 'Dragons Den' to secure funding for two band four assistants. These assistants worked with the occupational therapists, nurses and physiotherapists to support patients in their rehabilitation following long-term critical care.
- The CCD service had adopted a 'just do it' approach to planned surgery management to reduce operations

cancelled on the day. Booked planned surgery went ahead first thing each morning without first establishing that a critical care bed was available. There had been no cancelled planned surgery due to a lack of critical care bed since the introduction of this.

- Patients were admitted to CICU following heart surgery or as emergencies for other heart conditions. During our visit activity was low due to annual leave and unplanned sick leave. Patients requiring cardiac high dependency unit (CHDU) care were being accommodated within the CICU.
- Two therapy assistants were employed following a successful bid through the trusts 'Dragons Den' initiative. These individuals had a key role in supporting the rehabilitation of long term critical care patients
- Three months following discharge from hospital, critical care patients were sent a letter inviting them to return and discuss any outstanding queries or concerns they may have.
- There was an electronic ear system in place that gave a visual indication when noise levels were high by changing colour. Red for high, amber moderate and green for acceptable noise levels.

Meeting people's individual needs

- The CCOT supported patients with tracheostomies (artificial airway inserted through the neck into the windpipe) transferred from critical care to the wards. These patients were seen immediately following transfer from critical care and a post critical care action plan was put in place.
- Visiting hours in critical care services were adjusted to meet family needs.
- Patients living with dementia had a "This is me" care plan in place. This is a tool that people living with dementia can use to tell staff about their individual needs, likes, dislikes, and interests. It also enables health and social care professionals to see the person as an individual and deliver person-centred care. The unit had a dementia care champion.
- There was an awareness of delirium experienced as a result of treatment in a critical care environment. A paper published in August 2015 by critical care consultants at the QMC entitled 'Guide for the Detection and Management of Delirium in Adult Critical Care' had been widely distributed amongst staff within critical care across critical care.
- Staff used an interpretation and translation service when necessary for patients who did not have English as their first language. Staff we spoke with said they had limited experience of this service but knew how to access it. Additionally, critical care staff came from a wide range of nationalities and were able to use their language skills if needed.
- The trust had learning disability nurses who were able to offer support and advice when patients with a learning disability were admitted to critical care.
- There was a range of communication tools available to assist staff and patients to communicate when physically unable to do so. This included electronic devices and picture boards.

Access and flow

- The trust provided us with data relating to admission and discharge of patients for the adult critical care services for QMC and City Hospital campus. This showed the length of stay for patients matched that of other similar sized units.
- Bed occupancy ranged from 80% to 85%, which was in line with the national average of 84%. However, this was above that recommended by the Royal College of Anaesthetists (2012) of 70% occupancy. This level enables a critical care department to meet the demand for critical care beds avoiding cancellations and the need to transfer patients to other units for non-clinical reasons.
- Admissions to CCD were on the whole planned elective patients and there was no evidence of delays in transfer from theatre, following surgery.
- Patients were booked through a centralised on-line service. This enabled individual consultants to plan admissions effectively and avoid cancellations due to lack of bed availability.
- Patients requiring long term respiratory support or prolonged intensive care rehabilitation were transferred from QMC.

Learning from complaints and concerns

- There were three complaints recorded for 2014/2015 and all were responded to in a timely manner. Staff told us information about complaints was shared at the shift handover using the 14 day handover tool. As there were no recent complaints, we did not witness this when observing the shift handover.
- Information about how to make a complaint was available in all visitor areas.
- Staff told us they were confident to deal with any issues brought to them or would escalate to their immediate team leader.

Are critical care services well-led?

Outstanding ☆

We found the adult critical care service demonstrated outstanding leadership.

There was a collective enthusiasm across all staff groups and a clear knowledge of the vision, values and strategic goals for critical care.

This report is primarily related to the City Hospital Nottingham, however the service is over the two NUH sites QMC and City Hospital between which there is strong collaboration and support for improving the quality of care within critical care, there is an embedded culture of working together.

There were high levels of staff satisfaction across all professional groups. Staff were proud to work for the organisation and very proud to be working within critical care.

Staff told us managers encouraged personal development and were open to comments and suggestions for service improvement.

Information in the form of data analysis and audit was used to proactively drive service improvement.

Vision and strategy for this service

- There was a clear vision and strategy for adult critical care across the trust.
- The senior management team told us with great enthusiasm of their plans and aspirations for developing the service. Leaders were inspirational and motivational. This was reflected when speaking to staff across the service who spoke positively about their work and their future.
- Information collected through Intensive Care National Audit and Research Centre (ICNARC) and all audits were analysed and used for service developments.

Governance, risk management and quality measurement

- Governance processes were established across adult critical care with active involvement from all staff groups.
- The Critical Care Patient Safety Council / Governance Meeting took place fortnightly covering the full range of governance topics including incidents, nursing dashboard, guidelines, performance, and complaints. There were clear actions with names of staff responsible identified throughout. We reviewed four sets of meeting minutes and saw actions were followed up and outcomes shared. The meetings were held alternately at QMC and City Hospital sites.
- Key information was shared using the 14 day handover tool.
- The critical care outreach team (CCOT) governance arrangements were aligned to critical care. Any issues or incidents related to the CCOT team were reported through the electronic reporting system.

Leadership of service

- There was strong, visible leadership within adult critical care which was supported at board level.
- Senior nursing and medical staff met the recommendations of the core standards in qualification and experience.
- Staff unanimously spoke highly of the local leadership and said they felt supported and able to raise concerns or challenge decisions about patient care.
- Staff were encouraged to seek professional development and were supported to attend in house training sessions, which we were told were of a good standard. However, funding was limited and there were several nurses who had been waiting up to four years to

attend a postgraduate critical care nursing module. This meant the service did not meet the recommended core standard of 50% of nurses with a postgraduate level certificate.

- One nurse in the cardiac intensive care unit (CICU) had been successful in gaining external support for a prestigious course promoting the education of ethnic minorities within the NHS. The nurse planned to share the outcome of their studies across the trust on completion of the course.
- The CCOT had clear leadership with all members of the team saying they were very well supported within their role

Culture within the service

- We found the care and service delivered throughout adult critical care demonstrated a strong cohesive team approach. It was clear that an open, transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- There was collaborative working and positive relationships with other departments within the hospital. There was strong collaboration with the critical care service at Queen's Medical Centre with a common focus on improving the quality of patient care.
- During our inspection we saw staff were positive and caring towards patients who used the service. We also observed a caring and respectful culture towards each other, their immediate teams, and the organisation as a whole.

Public engagement

- There was public consultation regarding the refurbishment of the public waiting areas and during the refurbishment of the critical care department.
- Staff lanyards within critical care were changed to indicate a person's role as a direct result of concerns raised by members of the public about difficulties identifying who was who. Visitors reported that it was useful to know who was a doctor and who was a nurse so they could talk to the appropriate person.

Staff engagement

- There was open access to any member of staff to attend governance meetings.
- Staff reported feeling involved and consulted about changes in the trust. They felt very confident they would be listened to if they had a suggestion or a concern about the service.

Innovation, improvement and sustainability

- A critical care consultant at the trust was developing a tool to support the complex decision making process for critically ill patients. The tool was based on an ethical and balanced approach to selecting a suitable treatment plan for patients and act as a base for further clinical decisions. The tool would then be used as a tracking system so that clinicians understood previous treatment choices and clinical outcomes. This was supported by colleagues and was considered to be an innovative development in tracking the decision making process in treating critical care patients.
- The use of the trust's simulation centre had helped staff in developing advanced communication skills.
- Innovative approaches were used to gather feedback from people who used the service. One example was that patients and carers were invited to the opening of a new bed area to get their views on patient privacy.
- There was a project preparing for complete digitalisation of patient records including medical and nursing notes and all patient investigations. This was a complex process and had no implementation date at the time of our inspection.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Maternity and gynaecology services provided by Nottingham University Hospitals NHS Trust are located on two hospital sites, Queen's Medical Centre, and Nottingham City Hospital. Services at Queen's Medical Centre are reported on separately. However, services on the two hospital sites are run by one maternity and gynaecology management team. They are regarded within, and reported upon, by the trust as one service, with some of the staff working across the two sites. For this reason it is inevitable that there is some duplication contained in the two reports.

The maternity unit at Nottingham University City Hospital included the Antenatal Baby Care unit (ABC) (an antenatal baby assessment unit), antenatal clinic, fetal medicine, maternity ward (antenatal and postnatal), the delivery suite, and a "birth sanctuary." The ABC has five beds providing antenatal care and a triage service. The labour suite provides care to women during pregnancy, labour and after giving birth. On the labour suite there are 12 birthing rooms, a pool room, and two theatre suites. The birth sanctuary midwifery led unit has four birthing rooms. There are two maternity wards each having 27 beds. One maternity ward cares for transitional care babies and the other maternity ward has a four bedded induction of labour suite.

Twenty two community midwifery teams provide maternity services in partnership with general practitioners and health visitors.

Between June 2014 and May 2015, there were 5311 births at Nottingham City Hospital maternity unit.

The gynaecology service offers an inpatient ward with 20 beds for planned surgery. A team of gynaecologists are supported by gynaecology nurses, support workers and allied health professionals.

During our inspection we visited all the ward areas and departments relevant to the service. We spoke with 12 women, five relatives, and 36 members of staff, a further 26 members of staff attended cross site focus groups, and we reviewed 13 medical records.

Maternity and gynaecology

Summary of findings

Overall we found maternity and gynaecology services to be good.

There was a culture of openness and transparency within the service. Staff felt well supported by their managers and many told us they were proud of their roles. Staff across all levels also told us that senior managers were approachable.

At ward level staff supported governance processes. A number of innovative projects had been developed by staff to improve the experience for the women accessing the service. Governance had also been strengthened to ensure serious incidents were reviewed. The senior team had made good progress closing 335 in the last three months.

National reports were used to assess the quality of the service and actions identified were put in place. The senior team were aware of the improvements needed in the service and told us of robust plans to address them. The senior team told us they had good working relationships with the trust board.

There was an inability to split the maternity dashboard outcome data to each maternity unit, which meant that any specific issues at one hospital were not clearly identified.

Staff were not aware of a maternity strategy and could not explain any goals from the annual plan. The vision and values of the service were not well developed within the maternity plan.

Are maternity and gynaecology services safe?

Requires improvement

The safety of the service required improvement.

The planned and actual staffing levels were displayed at the entrance to most wards. Senior staff told us that most of the time they met targets. However, staff were used flexibly throughout the service and were moved to the area of greatest clinical need on a daily basis. The midwifery and medical vacancy rate was being acted upon, but there were difficulties in recruiting staff, which meant they were unable to meet the national standards for safe staffing.

Incidents were initially reviewed by the maternity risk team, who referred the incident to the appropriate member of staff to review, but they were not closed in a timely manner, causing a large backlog which could delay identifying themes and learning.

It was not clearly identified in the women's hand held records if she was high risk (consultant led) or low risk (midwife led). High risk women were not always cared for in the most suitably equipped and safest environment to give birth, due to bed pressures. Records were legible, dated and signed. However, the woman's name and hospital, or NHS number, were not documented on each page in the majority of hand held records. This posed a risk of detached pages not being returned to the correct records.

Staff reported that babies had been born on the ward rather than labour suite. Five babies had been born on the ward rather than labour suite from September 2014 to September 2015. We reviewed these incidents and three of the women were not able to be transferred to labour suite because it was too busy. Women were at risk because they were not giving birth in an area intended and equipped for this.

Midwives training cardiotocograph training (monitoring the baby's heart rate) attendance did not meet the required target.

The entrance and waiting area to the hospital was not clean, signage was poor, and there was no receptionist

available to greet people and direct them to where they needed to go. The doors were open and unmanned all of the time leading staff to be concerned about security of mothers, babies and staff.

Staff reported incidents and lessons learned shared widely in practice. There was an effective process for the investigation of serious incidents and a good understanding and use of the Duty of Candour.

Medicines were managed safely in the hospital. Staff were aware of safeguarding processes and a female genital mutilation (FGM) specialist midwife was available to support women and colleagues.

Incidents

- Staff understood their responsibilities to raise concerns, record, and report safety incidents, and near misses.
- There were 16 serious incidents reported to the NHS strategic executive information system (STEIS) by the City Hospital maternity service between May 2014 and April 2015. We reviewed summary notes in relation to five reported serious incidents. We saw recommendations and signed off actions demonstrating a culture of learning from such incidents.
- There was good evidence of learning from incidents. Staff received information about learning from incidents from a range of sources such as individual feedback, minutes of meetings and a maternity and gynaecology governance (MAGG) newsletter. Staff gave an example of learning from a drug incident that led to an improved system of checking medicines.
- At the time of our visit maternity services trustwide had 303 outstanding incidents. The majority of these incidents were no harm incidents that dated back to January 2015. All Incidents initially were reviewed by the maternity governance team. All moderate/severe harm incidents were prioritised and escalated for a higher level of review. All other incidents were assigned to the correct handler. No harm incidents were not always closed in a timely manner causing a large backlog which could delay identifying themes and learning within them. There was a plan in place to address the backlog and the senior team were reviewing the processes.
- Staff we spoke with had a good understanding of the Duty of Candour Regulation. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. This requires NHS trusts to be open and honest with patients when things go wrong. We saw evidence of feedback to the women in the serious incident action plans we reviewed.
- Risks identified within the service were scored and agreed at the risk management meeting and then signed off at the directorate clinical governance meeting. We reviewed three risks on the register and found all had action plans that were reviewed regularly.
- The service held monthly multidisciplinary perinatal mortality and morbidity meetings. Babies that had difficult births, became ill after the birth, or had a poor outcome were discussed. Improved care and treatments were shared and the agreed actions were monitored at each meeting.

Safety thermometer

- The maternity safety thermometer was launched by the Royal College of Obstetricians and Gynaecologists (RCOG) in October 2014. This is a system of reporting on harm free care. The recommended areas of harm which have occurred included; perineal (area between the vagina and anus) and/or abdominal trauma, post-partum haemorrhage, infection, separation from the baby and psychological safety. Also included were admissions to neonatal units, and babies having an Apgar score of less than seven at five minutes. (The Apgar score is an assessment of overall new born well-being).This is a system of reporting on harm free care specific to maternity services. The service was not using the maternity safety thermometer nor expressed any plans to introduce it in the future. This meant that they were not able to demonstrate harm free care in the specified areas of the maternity safety thermometer.
- Maternity services had engaged with the trust wide safety thermometer (where relevant). Results from the maternity and gynaecology wards showed that harm free care in relation to those indicators was consistently provided 100% of the time. The results were not displayed in areas for the women and public to see.

Cleanliness, infection control and hygiene

- The entrance area of the maternity unit was not always clean; however all of the ward areas we visited were visibly clean.
- Equipment in the maternity service was not labelled when cleaned. Staff told us that they relied on the health care support workers to have cleaned the equipment. The gynaecology ward used 'I am clean stickers' which clearly identified what items were cleaned.
- There were sufficient hand gel dispensers with instructions on how to cleanse hands. We observed that staff followed good hand hygiene and were bare below the elbow. However, midwives were seen to be wearing clear nail varnish.
- There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the trust policy.

Environment and equipment

- The entrance to the maternity unit was unmanned. We asked the matron why there was not a receptionist but they were unable to provide a reason. The doors were open and unmanned all of the time leading staff to be concerned about security of mothers, babies and staff.
- The doors to gain entry to the ward areas were locked and staff gained entrance with swipe cards. Staff identified visitors and who they intended to visit, and then allowed them entry. We were asked to present our identification badges by most staff when first gaining entry to the wards.
- There was a system for checking equipment. Staff generally completed daily checks on lifesaving baby resuscitation equipment. There were missing signatures ranging between two to five occasions each month.
- Adequate equipment was available to run the service safely. On the gynaecology ward a hoist (used to lift patients) had not been tested since 2014. We informed the ward staff and this was dealt with straight away. The equipment had been inspected by the end of our inspection visit.
- Staff on the labour suite used an intercom connected to all of the birthing rooms to contact staff members. We heard staff calling for other staff to go to the desk, and on another occasion to a labour room. Staff reported that at times this system could be intrusive, particularly if a baby was being born or when sensitive conversations were being held with parents.
- Staff reported that babies had been born on the ward rather than labour suite. Five babies had been born on the ward rather than labour suite from September 2014 to September 2015. We reviewed these incidents and three of the women were not able to be transferred to labour suite because it was too busy. Women were at risk because they were not giving birth in an area intended and equipped for this.
- Cardiotocograph (CTG) machines were available for women whose babies needed monitoring. This monitors the baby's heartbeat in high risk cases.
- Staff followed best practice with infection control and prevention principles in relation to management of waste, including sharp items, and clinical waste.

Medicines

- Medicines were stored in locked cupboards, in locked rooms, and disposed of safely.
- Controlled drugs were checked according to trust policy in all areas. Staff referred to their medicines policy, the up to date British National Formulary (BNF), or they asked for pharmacy support if necessary.
- Staff told us they checked the equipment and intravenous fluids. However we found out of date intravenous fluids in the clinical room on the labour ward: three of which had expired in May 2014. A number of blood bottles had also expired. There was a risk that any blood tests taken would not give accurate results. We told the manager and they were removed immediately.

Records

- Medical records were kept securely in all areas.
- Hospital records were paper format. Midwives gave mothers their records to keep with them and bring to every appointment.
- Mothers were given the personal child health record, often called the red book, before they were discharged home. The red book was used to record the child's health and development.

- We reviewed eight sets of maternity records. They were legible, dated and signed. However, the woman's name and hospital, or NHS number, were not documented on each page in the majority of hand held records. This posed a risk of detached pages not being returned to the correct records.
- We reviewed four records for patients on the gynaecology ward. The records were legible, dated and signed.

Safeguarding

- All staff we spoke with were aware of the trust's safeguarding policy and the reporting procedure. Staff followed safeguarding legislation and local policy for reporting concerns to safeguard adults and babies from abuse.
- There was a named safeguarding midwife and five champion safeguarding midwives across the service who provided support and supervision. Midwives told us they were able to raise concerns and knew how to report a safeguarding incident. If there were any known safeguarding issues, there was a tab to identify this in the medical records and an alert on the electronic system to alert staff.
- Staff were aware of the trust's abduction policy, all ward doors were locked. There were no CCTV cameras. Babies had electronic tags which set off an alarm if the baby was removed from the ward, providing an additional safety measure. Agency staff were employed to monitor visitors to the maternity wards following a recent near miss safeguarding incident.
- The service had a female genital mutilation (FGM) specialist midwife and a guideline for staff to use if there was a woman identified in their care who had undergone this procedure. They used a sign for the baby's red book which denoted if the mother had undergone FGM. Staff explained to the mother that the sign highlighted the issue to other professionals.
- At Nottingham City Hospital (NCH) maternity and gynaecology, 88% of nursing and midwifery staff had received level two and three safeguarding training.

Mandatory training

- Staff described attending yearly multidisciplinary skills and drills training. This included maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of the severely ill pregnant women, manual handling, epidural update, suturing update, perinatal mental health and safeguarding updates, physical examination of the new-born, infant feeding, and bereavement. In addition to this, half yearly maternity forums were held to train staff on these and other topical issues such as completion of patient observations and early warning score charts. The content of these sessions altered according to identified areas of learning. Middle grade doctors and obstetric consultants were 90% compliant, and hospital and community midwives 80% compliant in training.
- Trust wide mandatory training was described as 'birthday training' as this was completed in the month of their birthday for each member of staff. The maternity and gynaecology department recorded 90% compliance in all compulsory training.
- Staff in the trust's Family Health division were not all trained in the use of medical equipment. Information from the trust showed a 67% shortfall in staff completing training on the use of medical equipment (August 2015).
- Newly qualified midwives had a comprehensive training programme to complete in their preceptorship period.
- CTG training compliance was reported in 2015 at 90% for all middle grade doctors (excluding locums) and obstetric consultants. At NCH midwives were 56% compliant and community midwives were 98% compliant, against the trust target of 75%.

Assessing and responding to patient risk

- There were five triage beds in the antenatal baby care unit (ABC) to assess women who arrived with medical conditions, complications associated with pregnancy, or to determine if they were in labour. Outside opening hours women were assessed on the labour suite.
- Completion of the venous thromboembolism (a blood clot in the deep veins of the leg) risk assessments were inconsistent. The assessment sheet was difficult to find as it was filed in various places. It was missing in three of the eight medical records we reviewed.

- It was not documented if the woman was high or low risk in the medical and handheld records we reviewed. This meant that it was not easy to quickly recognise what care and treatment the woman should receive.
- We observed equipment to evacuate a mother from the birth pool in an emergency. There were pool evacuation nets for water birth. Training had been given to staff supporting women having a pool birth.
- Staff used early warning scores to monitor women to identify when their condition may be deteriorating. Early warning scores enabled early recognition of a patient's worsening condition by grading the severity of their condition and prompting staff to get a medical review at specific trigger points. The charts we saw were completed and scored correctly. The unit did not use Neonatal Early Warning scoring charts to assist in the early recognition of deterioration of new-born babies. Staff were currently using a paper observational chart system to monitor babies physiological readings.
- At the time of our visit the service had reviewed two charts for possible introduction at the hospital. The preferred chart was to be piloted. Staff were currently using a paper observational chart system to monitor babies physiological readings.
- We were told the obstetric anaesthetist supported midwives and medical staff with the care and management of critically ill women. Women defined as level two high dependency care (increased amounts of one to one observation) were transferred to the critical care service.
- We observed good communication and teamwork in the operating theatre on the labour suite. The theatre staff followed the five steps to safer surgery (designed to reduce the number of surgical errors) appropriately to ensure patient safety.
- Three gynaecology patient risk booklets were available to be reviewed; all the risk assessments were completed. Early warning scores were completed appropriately by the nurses.

Midwifery staffing

- The trust reported a midwife to birth ratio of 1:29, this was similar to the Royal College of Obstetricians and (RCOG: Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour) recommendation of 1:28.
- Expected levels and actual levels of staffing were displayed on notice boards for patients and visitors to see in most ward areas. There was no board on the labour suite or the birth sanctuary. Senior staff told us that most of the time they met targets. If they were short staffed due to sickness they would follow their escalation policy.
- The annual Supervisor of Midwives (SoM) report for 2013-2014 showed the ratio for SoMs to midwives was 1:25 making the trust non-compliant with national expectations. The trust had arranged to employ two midwives as full time SoMs and for two more midwives to complete the SoM training. This would improve the support given to the midwives. Supervisors of midwives help midwives provide safe care and are accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for a SoM is to have a caseload of 15 midwives. Staff told us that they currently had a ratio of 1:22 SOMs. This was supported by the unit data of a ratio of 1:22.6 between June 2014 to April 2015. This meant that supervisors had less time to support individual midwives and reported feeling under greater pressure. However, at the time of our visit a full time supervisor had been employed to reduce the pressure.
- It was planned that labour suite coordinators were supernumerary, so they could have an oversight of the department and be available for any urgent or emergency situations. We were told by staff that this was achievable.
- The labour suite used an acuity tool to determine staffing levels in response to the amount of care the women needed. The staffing tool calculated the required staff on each shift based on one to one care for women. Staff told us the acuity tool identified staff shortages and supported their decisions to follow the escalation plan when it identified staff shortages to ensure the safety of the women in their care.
- Midwives rotated to the delivery suite and the maternity ward as this allowed flexibility when the unit was busy.

- Staff worked mostly 12-hour shifts on the gynaecology and maternity wards. There was also flexibility for staff with certain requirements choosing to work shorter shifts.
- The ABC was staffed with two midwives on each shift and their breaks were supported by the labour suite midwives. If a woman needed an urgent transfer to labour suite it was possible that a midwife could be left alone for a period of time.
- Support workers were on duty in all areas to provide additional support to midwives. Support workers attended a specific training day. They did not undertake extra duties unless trained.
- Senior staff told us the staff vacancy rate was 26 whole time equivalent (WTE) midwife posts. They had recently offered posts to eight members of staff and were continuing with the recruitment drive.
- The average staff absence rate for maternity was 4.%. An innovative text messaging and social media system was used to advertise vacant shifts.

Nursing staffing

- The staff on the gynaecology ward had been increased to staff the ward with one nurse to eight patients. When the gynaecology ward beds were used for patients from other specialities, the service increased the ratio to one nurse to six patients.
- Sickness absence in maternity and gynaecology was 3.96%. Staff worked extra shifts in an effort to cover these shortfalls.

Medical staffing

- There were 68 hours a week of dedicated consultant cover on the labour suite with a consultant on call at all other times. This was not in line with national recommendations. For the number of babies born on the unit each year there should be 168 hours a week. There was a plan to increase the dedicated cover on the labour suite and they were in the process of recruiting two consultants to increase resident cover to 78 hours a week. There was a plan to submit a case of need to the trust board for two more consultants which would further increase the hours. The senior team were confident the trust board would support their application. They used locum medical staff to fill in any gaps and they did not have a dedicated elective caesarean section list.
- It was rare to have to use medical locums at short notice. If used, locums were directly supervised to ensure they were competent.
- Medical staff told us that colleagues were supportive, and consultants would step down to cover middle grade shortages to ensure a safe service.
- There was a dedicated on call consultant obstetric anaesthetist who supported the resident on call anaesthetist. Two middle grade anaesthetists told us that they were supported whilst on call and to attend training. The anaesthetists supported the medical and bariatric (obese women) antenatal clinics.

Handovers

- Medical staff multidisciplinary had handovers three times a day, which included discussion of inpatients, births, and admissions. We observed three handovers which were structured and flowed well. All the information needed was handed over but they did not completely follow the 'situation, background, assessment, recommendation' (SBAR) format. This format is recognised good practice in maternity services. The information was discussed but not in a structured format.
- Midwives handed over twice a day. Staff individually handed over their woman to the midwives on the next shift using the SBAR format.
- We observed a multidisciplinary handover by the theatre team of a women on the elective caesarean section list, which followed World Health Organisation (WHO) safer surgery guidelines

Major incident awareness and training

- The hospital had a major incident business plan on the intranet. Staff were aware of the policy and had extra information via booklets and DVDs, which covered processes when there were no beds available, and major external emergencies.
- Practical obstetrics multi-professional skills drills training was developed for the maternity services. This is

an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the new-born.

Are maternity and gynaecology services effective?

Good

The effectiveness of the service was good.

Care and treatment reflected current evidence-based guidance, standards and best practice. Patients' pain was well managed. The trust promoted breastfeeding and women were supported in their chosen method of feeding.

There was an excellent multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of women using the service. Staff respected one another and valued each other's expertise. Staff had the right qualifications, skills, knowledge and experience to do their job.

There was no evidence of risk for maternal and neonatal readmissions. This showed that safe and appropriate discharges were arranged and women had the right support in the community.

Outcomes were monitored and findings discussed, although they were not displayed for staff to see.

Some staff had difficulty locating guidelines, which caused delays in accessing them. There was no up to date guidance for staff about the admission of women to the midwifery led unit.

Evidence-based care and treatment

- Guidelines and policies were based on guidance issued by professional and expert bodies such as the National Institute for Health and Care Excellence (NICE), and the Royal College of Obstetrics and Gynaecology (RCOG) safer childbirth guidelines.
- Guidelines were developed across both maternity services so that staff on each hospital site used the same guideline.
- We reviewed 14 guidelines/policies, which were all based on NICE or RCOG guidelines. They were in date and version controlled. Staff had access to the policies and guidelines using the trust's intranet. Some staff told us they found it difficult to find the guideline they required easily, which delayed access to information. We witnessed this on three occasions where staff typed in the name of a guideline and could not find it first time using the search engine.
- There was no up to date guideline available for the admission of women to the midwifery led unit. It was removed from the intranet whilst it was being reviewed.
- The service did not meet the national neonatal audit programme standards for temperature taken at birth, and mothers receiving steroid medication in the antenatal period. Steroids should be given to mothers when they are at risk of an early labour but this was not always happening.
- A CTG, used to monitor the fetal heart should be reviewed and classified every hour with a review from another colleague (NICE Intrapartum care 2014). We reviewed five CTG traces and they each had hourly reviews documented. This meant there was adequate monitoring of the fetal heart.
- The service had completed an audit about midwives asking women routine safeguarding questions. It was identified that staff were not always asking these questions. We saw the completed audit. The highlighted gaps in practice were actioned with a plan to do another audit after the actions were completed.

Pain relief

- The sanctuary birthing unit offered a range of options for pain relief for women in labour. Options included a pool birth, aromatherapy, Entonox, (a medical pain relieving gas) and stronger painkillers by injection.
- Women attending the labour suite were offered a pool birth, aromatherapy, Entonox, and stronger painkillers by injection. An anaesthetist was available so women had the option to have an epidural inserted to numb the body from the waist down to the toes. This was available 24 hours a day, seven days a week.
- Women told us they were able to access pain relief during birth and post operatively in a timely way.
- In gynaecology analgesia was offered regularly. Women we spoke with felt their pain was managed well.

Nutrition and hydration

- The trust promoted breastfeeding and the important health benefits known to exist for both the mother and her baby.

- The service was awarded UNICEF Baby Friendly Initiative full accreditation 21 July 2015. The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breastfeeding.
- Breastfeeding statistics for initiation within 48 hours of birth were 71% to 73% against a trust target of 73%.
- Women we spoke to told us that they were supported by staff on the maternity ward with feeding their baby day and night. All breastfeeding mothers received a copy of a leaflet on "Breastfeeding support in Nottingham." All bottle feeding mothers were given a copy of the infant feeding café flyer (a support group for mothers to meet) and the Department of Health leaflet on "Guide to Bottle Feeding".
- We attended the Baby Café breastfeeding group; two women, their partners and babies were present. It was facilitated by midwives to ensure women were supported. A mother and her partner said it was good to get extra tips for breastfeeding.
- The infant feeding coordinator was qualified to divide tongue tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers.
- Women told us the meals were on time and were good quality. The women could ask for snacks out of meal times if necessary. Women on the maternity wards who were mobile were unable to have meals by the bedside and had to use the dining area which accommodated 12 places for a 27 bedded ward. Women left their babies in an adjacent nursery, which had a very large window so they could see their babies. We asked staff why this rule was in place and they said that it was to prevent women dropping their tray of food and scalding themselves.
- On all of the wards, protected mealtimes were in place. Drinks were available at all times, and fluid balance charts were completed if necessary.

Patient outcomes

- The maternity department maintained a trust wide maternity dashboard which reported on clinical outcomes before, during, and after delivery. The outcome indicators document contained manually collected data. The documents were not displayed for staff to see.
- The targets on the trust dashboard set by the maternity service were national key performance indicators (KPIs). A number of indicators were rated at amber for several months, meaning they were not being achieved. This included booking women for maternity care by 12 weeks and six days into their pregnancy. The senior midwifery team could not demonstrate effectively the processes in place to improve the amber ratings and could not clearly articulate any actions taken.
- In 2014 and 2015, 62.3% of women had a normal delivery, which was below, (worse than), the trust target of 66%. The home birth rate was 1.2% and this was less than the national average of 2.3%.
- The trust wide caesarean section rate was between 19% and 26% which was generally lower (better) than the national average of 25.5%, and the trust target of 26%. Staff told us they thought their performance was due to the success of the birthing clinic which supported women with their fear of childbirth, and helped reduce the number of women choosing caesarean section.
- The trust wide instrumental delivery (forceps and ventouse extraction) rate was between 12% and 19%. This was higher (worse) than desired, but did not exceed the trust target. All cases of instrumental delivery were reviewed by a midwife and the medical lead of the governance team to identify trends or practice issues. Feedback was given to the member of staff and trends were discussed at labour ward forum.
- The service performed the same as other trusts in all areas in the CQC Survey of Women's Experiences of Maternity Services 2015.
- Between May 2015 and June 2015 maternity services readmitted 0.4% postnatal women, this was much lower (better) than the national average of 0.9%.
- The number of women at NCH between January 2015 and March 2015 who had third degree perineal tear rates following birth was 3% and fourth degree tears was 0.1% this was in line with the trust's target of 4%. All were reviewed by a midwife and medical lead the governance team to identify trends or practice issues this was feedback to the member of staff and trends were discussed at labour ward forum.
- The rate of women who had obstetric haemorrhage (bleeding following birth) greater than two litres was 1.5% and had been just above the trust target of 1.9% for five of the last 12 months.
- National antenatal key performance indicators were reported electronically for screening in pregnancy data, the database identified actions for any data that did not meet national standards.

- At City Hospital four women (0.3%) developed sepsis following birth between January 2015 and March 2015. Staff completed MEWS charts to identify cases appropriately.
- The audit and results of maternity notes regarding the routine enquiry into domestic abuse by midwives during pregnancy was shared with the inspection team. The audit identified areas for improvement and a date for re-audit.

Competent staff

- Newly qualified midwives completed a competency pack before progressing to a higher grade. Staff told us it took around 12 months to complete.
- Midwives reported having access to, and support from, a Supervisor of Midwives (SoM). SoMs provided an on call service. The service had recently appointed a full time supervisor of midwives to enable them to have a smaller caseload than the national recommendation of one to 15 midwives.
- Midwives' competencies were maintained by working for three to six months at a time in each area of the service. A small number of midwives did not do this which enabled stability and expertise in that area.
- All of the staff we spoke with had attended an annual appraisal. Staff told us they found appraisals very useful to discuss any issues they had and to plan their objectives for the following year. The data the service provided showed up to August 2015 between 86% and 90% of staff within the service had completed appraisals.
- Medical staff in training told us they had educational supervisors and regular appraisals. They felt they were well-supported by the consultants who they reported as being very approachable.

Multidisciplinary working

- The maternity service promoted multidisciplinary team working, including staff working in the community. Community midwives, health visitors, GPs, and social workers were all linked through joint working with women and their families to plan the women's care throughout the pregnancy and after birth.
- Physiotherapists supported mothers with third and fourth degree tears and after caesarean section.
- The physiotherapists and occupational therapists supported patients after surgery on the gynaecology ward and for assessments prior to discharge home. We saw a patient being assessed on the stairs prior to being discharge home.
- There was joint working with the mental health teams, who held clinics alongside the antenatal clinics.
- Staff reported good working relationships with the neonatal team which included joint monthly meetings.
- The gynaecology ward had effective team working with all disciplines and allied professionals.

Seven-day services

- Maternity and gynaecology services were available 24 hours a day seven days a week. Women accessed maternity care by telephoning the labour suite, through referral from the antenatal clinic.
- Physiotherapists were available seven days a week during day time hours. If they were required urgently the respiratory physiotherapy team were available. Occupational therapy services were accessible five days a week.
- Portable ultrasound scanners were available in maternity and gynaecology which meant that medical staff could scan pregnant women, postnatal women, or gynaecology patients out of hours.
- A Supervisor of midwives was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided midwives with access and support at all times. Community midwives provided an on call service to facilitate home births**,** and were called to attend the hospital to supplement the staffing when it was too busy for the existing staff on duty to manage.

Access to information

- There was a white board on the wall of the labour suite which contained information about the woman's condition. It also stated the reason for the women's admission and any risk factors. This enabled staff to have a quick overview of the issues on the labour suite. Patients' names were not used to ensure patient confidentiality.
- Staff could access guidelines and leaflets from the trust intranet to deliver effective care and treatment to women.

- The women who were admitted for an induction of labour had their full names and treatment displayed on a board on the wall which could be viewed by the public.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women gave verbal consent for some of their care and treatment and we saw that this was documented in the women's records. We saw signed consent forms for operations in the maternity and gynaecology records we reviewed.
- Training on consent, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLs) and learning disability was part of mandatory training for all staff. 80% of midwives and 90% of nurses had completed their mandatory training. Information was displayed in staff areas on an explanation and definition of MCA and DoLs.
- Some of the information on the labour ward was in picture format, for example the insertion of an epidural, this assisted translation services for women who do not speak English, and women with a learning disability.
- Maternity and gynaecology staff had an awareness of the MCA. The majority of staff were familiar with Deprivation of Liberty Safeguards (DoLS) but could not fully explain the process. They knew how to access help from the safeguarding adults nurse. The safeguards aim to ensure that those who lack capacity and are in hospital are not subjected to excessive restrictions.

Are maternity and gynaecology services caring?

Good

The care provided to women using this service was good.

The women we spoke with told us staff were very caring and respectful. They felt information had been explained to them about their care and treatment and they were supported emotionally. There were numerous systems in place to meet people's emotional needs which included specialist clinics which support women before and after birth

Patients on the gynaecology ward were well informed and felt looked after by kind and compassionate staff. Staff spent time with patients to ensure they understood their condition and care.

Compassionate care

- Women and their partners were positive about the care they received. All of the women and partners we spoke with told us that they had been treated with kindness, dignity, and respect. We saw good interactions between staff, women and their relatives. For example, staff explaining how personal medication was managed in the hospital to a partner.
- Family and Friends Test (FFT) results were generally three to five percent better than England's average for antenatal care, birth, postnatal ward and postnatal community care between June 2014 and May 2015.
- Women told us that staff were, "Really great", "Brilliant", and, "Midwives care and they go that extra mile" and if they needed help, staff responded promptly.
- One woman told us that the best thing was the kindness and compassion of the midwives.
- We observed staff respecting the women's dignity by knocking and waiting to be invited in to rooms, or behind the curtains around the woman's bed space.
- The trust scored similarly to other trusts in the questions in the 'Care Quality Commission Survey of Women's Experiences of Maternity Services 2015'.
- The labour suite was very noisy at morning handover. Staff were heard talking about social and clinical issues whilst the phone was being answered to women calling for advice.
- There were no signs on the labour room doors to indicate if they were in use. We observed staff knocking and waiting to be asked to enter.

Understanding and involvement of patients and those close to them

- We heard staff support women to make informed choices and be involved with their care.
- The women we spoke with shared their birth experiences with us and told us that they were listened to and supported at all times by the midwife caring for them.
- Partners we spoke to were very happy with the care and their involvement.

- Women discharged home were provided with information about the signs and symptoms they should look for and told if they experienced any of them to seek advice.
- At the listening event we were told that gynaecology staff cared and explained everything before and after surgery.

Emotional support

- A midwife ran a specialist birthing clinic which supported women with psychological problems relating to childbirth. The midwife discussed issues raised to reduce the women's fear of giving birth.
- Staff dealt with bereavements compassionately. They provided support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide extra support.
- A dedicated perinatal mental health team supported those women identified as having mental health issues. A mother and baby unit was available to provide further support.
- We spoke to three women using the gynaecology service. All were happy with the nursing care they had received. Patients felt involved with the decisions made about their treatment, they felt that they were treated with dignity and staff respected them.

Are maternity and gynaecology services responsive?

Good

The responsiveness of maternity and gynaecology services was good.

Services were arranged to meet women's needs with a range of specialist clinics and midwives to support them. The maternity ward had implemented an initiative to improve the women's experience and early discharge home following a caesarean section.

Women were offered a choice of where to give birth. Women were informed at booking that they were booked to birth at the hospital of their choice, but due to bed pressures they may need to be admitted to the maternity unit at the other site.

Generally complaints were handled effectively and where appropriate lessons were learned from complaints and action was taken to improve the quality of care provided. Women and their partners told us they did not know how to make a complaint.

There was only one dedicated theatre list for women who needed a caesarean section. Women's operations were delayed and sometimes cancelled due to emergencies taking priority.

The birth sanctuary centre environment did not promote a 'home from home' model of care for women who wished to have the comforts of a home birth with the added reassurance of being alongside a high risk labour suite.

Statistics showed the bed occupancy rate in the maternity service was consistently higher than the national average.

Partners were not allowed to stay overnight unless there were exceptional circumstances.

Service planning and delivery to meet the needs of local people

- Women were given an informed choice about where to give birth depending on their assessment of clinical need. The community midwives offered an on-call service to support mothers who planned to have a home birth.
- The antenatal clinic had boards displaying pregnancy related information such as breastfeeding and reduced fetal movements.
- The Birth Sanctuary offered midwifery led care for low risk women. The area had four birthing rooms which were along the labour suite corridor separated by double doors. The women had to walk through the labour suite to arrive at the birth sanctuary. The model of home from home birth was not in place, the rooms looked very clinical and included equipment used for high risk women. When we asked staff about this they said they did not have areas to store equipment.
- Staff told us if a woman became high risk in the midwifery led unit (MLU) they did not always transfer to labour suite. Medical staff reviewed women in the midwifery led unit. If care became high risk, the women sometimes stayed in the room and received treatment there. This practice was not in keeping with the values of a MLU.
- During our visit the senior team acknowledged our concerns about the values of the MLU and agreed they

had not fully implemented the model of home from home care. They discussed options and organised a working group looking at how to meet the standards of low risk, home from home care.

- Babies who required extra monitoring and needed transitional care were cared for by midwives and support workers on the maternity ward. Mothers were able to stay with their baby until they were fit for discharge home.
- The fetal medicine service included a fetal care unit situated next to the antenatal clinic. The manager worked across site and a core of band six midwives were site based. There was a secure separate exit if needed to avoid the woman having to leave through the antenatal clinic.
- People using the maternity services could access clinical midwife specialists. This included midwives with specific skills, knowledge and experience to care for women with diabetes, alcohol and substance misuse issues, and women who may have undergone female genital mutilation, FGM). There was a midwife with special responsibility for safeguarding vulnerable women and a midwife who counselled women following a miscarriage or termination of pregnancy. .
- A midwifery sonographer team was developed in response to the shortage of sonographers. This improved the care for women because the midwife sonographer made referrals, explained procedures, and organised future care.
- Women had a choice regarding the management of miscarriage and were supported by the nurses, chaplaincy, and a bereavement midwife. There was no bereavement room for women to use after a loss.
- Antenatal education, water birth and breastfeeding workshops were provided by a team of midwives, and breastfeeding support groups were available for women to access.

Access and flow

- Trust wide maternity services reported 200 single site closures between January 2014 and June 2015. The closure of one of the maternity units did not stop maternity services at the trust
- The diversion of maternity services guideline identified the diversion of patients to the sister site as a last resort. Single unit closure occurred on 101 occasions during the period of January 2014 to June 2015. The trust did not collect data to identify how many women this affected.
- Women were seen by a midwife within 30 minutes of arrival. High risk women were usually seen within 60 minutes by medical staff. If medical staff were delayed by an emergency elsewhere and the women needed urgent treatment, staff said they would call a consultant to attend.
- Women were transferred to Queen's Medical Centre labour suite when there were no beds available at City Hospital. Staff prepared women for this at their first appointment explaining that when the labour suite had no beds or staffing was difficult they may need to be transferred to QMC.
- There were daily caesarean section theatre lists Monday to Friday, and a dedicated theatre list on a Wednesday. Staff told us if the theatre was busy with emergencies on the days without a dedicated theatre list, women could be delayed having their operation for a number of hours. If this happened women were allowed to sip water to avoid becoming dehydrated. Staff told us that rarely a case would have to be cancelled and said this happened about once every six months. However the maternity dashboard trustwide between June 2014 and May 2015 showed 12 cases were cancelled, and a senior member of the team told us that there were three in August.
- The ABC assessment unit was open from 7.30am to 7.00pm, situated near to antenatal clinic. When the unit closed, calls were transferred to the labour suite.
- The post birth baby examination was performed mainly by the paediatricians, although some midwives were trained to undertake this. Staff did not report any delays getting the baby examinations performed before the woman was discharged home.
- The service implemented the enhanced recovery programme after surgery (ERAS). This promoted early discharges for women following an elective caesarean section. A skin to skin guideline for theatre was developed to enhance the mothers and babies experience in theatre. Women were followed up and readmissions monitored. Data showed there had been no increase in readmission following the ERAS
- From January 2015 to March 2015, the maternity ward bed occupancy was 63%, and gynaecology bed occupancy was 82% this was worse than the national

average of 55%-60%. The senior team were not aware they were higher than the national average. However, there was on-going work in the trust to improve flow and an external company were to look at maternity services as part of the "Better for you" campaign, (improving the patients' experience of admission and discharge in the service).

- Women were delayed being discharged home at times because they waited for medicines from the pharmacy to arrive. A core team of midwives were trained to dispense medication at ward level to prevent the delays.
- Gynaecology wards had recently reduced the number of beds available. This meant they no longer had the capacity to admit medical patients who needed a bed due to pressure in other parts of the hospital and could now take their planned gynaecological patients.

Meeting people's individual needs

- Specialist midwives were available and ran a number of specialist clinics were available including counselling and psychological support, diabetes, birth planning, bariatric, fetal medicine, and mental health.
- Although staff carried out some assessment of patients regarding the risk of depression, this was not fully in line with guidance from the National Institute for Health and Care Excellence (NICE).We did not see evidence of the Whooley depression screening tool in use. The Whooley screening tool is used to determine which patients are at risk of depression and may require further clinical assessment. Use of the Whooley screening tool is recognised good practice in maternity care.
- Women, who needed complex fetal medicine management, were referred to the fetal medicine department for care.
- Staff used both telephone and face to face interpreting services for women whose first language was not English. Staff were able to refer to maternity leaflets on the trust intranet and the 'Pocket Midwife' electronic application when discussing care with women. All leaflets had a number for women to call to request a version in their spoken language.
- Midwives and gynaecology nurses knew how to access support from the learning disability nurse for women with a learning disability. Staff told us about using 'About me' documents for women living with dementia or with a learning disability.
- Staff we spoke with described how same sex couples were welcomed and how they had cared for surrogate mothers.
- There were quiet rooms in ABC, antenatal clinic and the labour suite, which enabled privacy for difficult conversations.
- A screening information package was in development for staff to use across sites to improve consistency of information given to women.
- Directional signage was poor and the maternity and gynaecology unit was difficult to find. This meant that people who needed to use the service may not have been able to find their way to the relevant department. We spoke with a woman who had been trying to find the parent craft class for 30 minutes.
- Birthing partners were not encouraged to stay overnight with women after the baby was born. Allowing partners to stay provides extra support to women and enables early bonding for the family unit. Partners were able to stay if it was considered there were special circumstances. One partner was told that it was a one off and although there was no change in circumstances, they could not stay the following night. There were no plans to enable partners to stay routinely.

Learning from complaints and concerns

- Patient Advice and Liaison Service (PALS) information leaflets were displayed in some areas. The leaflets informed patients of how to raise concerns or make complaints. Six of the nine women we spoke to did not know how to make a complaint. Information on how to complain was displayed in some areas.
- Complaints were discussed at clinical governance meetings. Information was fed back to the staff via ward meetings and via the supervisor of midwives. Ninety three percent of the services complaints were responded to within 25 days.
- One woman who we spoke with was not happy with the way the medical team had spoken to her, staff were informed and they went to discuss her concerns with her. Staff described the value of dealing with people's concerns promptly before they developed into complaints that were more significant.

Are maternity and gynaecology services well-led?

Maternity and gynaecology

Good

The leadership of the maternity and gynaecology services was good.

There was a culture of openness and transparency within the service. Staff felt well supported by their managers and many told us they were proud of their roles. Staff across all levels also told us that senior managers were approachable.

At ward level staff shared governance processes. A number of innovative projects had been developed by staff to improve the experience for the women accessing the service. Governance had also been strengthened to ensure serious incidents were reviewed. The senior team had made good progress closing 335 in the last three months

National reports were used to assess the quality of the service and actions identified were put in place. The senior team were aware of the improvements needed in the service and told us of robust plans to address them. The senior team told us they had good working relationships with the trust board.

There was an inability to split the maternity dashboard outcome data to each maternity unit, which meant that any specific issues at one hospital were not clearly identified.

Staff were not aware of a maternity strategy and could not explain any goals from the annual plan. The vision and values of the service were not well developed within the maternity plan.

Vision and strategy for this service

- The senior team had a clear plan for the development of the service, this was demonstrated within the document 'Obstetrics and Midwifery Annual Plan 2015/16'. The objectives were clear with actions and a named person to deliver the actions. However there were no vision and values aligned within the plan such as compassion, dignity and equality.
- The senior team were aware of the improvements that were required and actively sought to make a difference to improve services. It was difficult to identify a short and simple strategy for staff to be aware of and remember. The strategy was not displayed for staff to see and staff we spoke to did not know that there was a maternity strategy.

Governance, risk management and quality measurement

- A governance framework was in place for maternity and gynaecology services at both sites, Queen's Medical Centre and City Hospital. Meetings were monthly and multidisciplinary; all grades of staff were welcome to attend. The meetings covered topics including serious incidents, safety thermometer, the risk register, staffing levels, and patient experience. Previous actions were reviewed and monitored.
- The governance team had escalated problems with reviewing and clearing incidents to the executive team. They were supported to identify two members of staff to strengthen their governance team and investigate incidents. During our visit, the governance team told us that they had reviewed processes and agreed a new system to improve incident management. This was demonstrated by the improvement of a reduction from 616 to 303 open incidents in three months.
- Staff told us they had very good working relationships with the executive team. They were assured that escalated issues were reviewed, and the senior team was supported. For example, the medical staff had plans to increase consultant presence on the labour suite and they were confident the board would accept the proposal to maintain safety.
- We saw the maternity and gynaecology risk register was reviewed and updated regularly.
- The government had commissioned an independent investigation into a maternity and neonatal services nationally to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The maternity, neonatal, and paediatrics senior team had used the report to assess their services in June 2015. We saw a plan produced in response, which had a number of actions allocated to staff for completion in set timeframes. However, it was not clearly identified when the action was signed off.
- The shared governance council (a group of staff looked at ways to improve the service) was very active in

maternity services. Staff of all grades volunteered for a term and promoted their ideas to gain funding. For example, staff on the ward carried out an audit of the time it took to keep refilling water jugs. Staff presented the audit to the executive team and were granted funding for a self-service water dispenser. Staff were extremely proud of this project.

Leadership of service

- All midwives we spoke with told us they were supported and they had good working relationships. Some staff said that the senior managers were not always visible although the senior team told us they performed daily walks of their areas. Staff told us that the Head of Midwifery was not as visible as they would like but was supportive and friendly.
- The service had a maternity dashboard and local risk registers which were not displayed for staff to see. We asked several staff about the dashboard and they were unaware of its function.
- The senior team were quite a new team and demonstrated strength and determination to improve services and staffing to meet the needs of the service.

Culture within the service

- Staff we met were generally welcoming, friendly and helpful. They were passionate about their role and said they were happy working for the service.
- Staff told us that they felt maternity services had a high profile in the trust, especially since the appointment of the chief nurse.
- A few members of staff told us they were not happy that the birth sanctuary had taken away labour beds. Some staff were unhappy with staffing changes within the department. This disapproval was identified by midwives and medical staff who told us that it affected the atmosphere and some shifts were very tense. The senior team were aware of the issue and showed courage to continue supporting staff to make changes that benefited the service.
- Medical staff told us they were adequately supported by senior doctors and consultants. If the on-call consultant was busy, staff were confident to call another.
- There was a culture of openness, flexibility and willingness among all the teams and staff we met. Staff worked well together, and positive working relationships existed between the multidisciplinary teams and other agencies.
- Staff told us that should they need to raise a concern they felt confident and supported to do so.
- Gynaecology staff said they enjoyed their job and were very proud of their department. The staff we spoke with thought highly of their ward manager, they felt supported, and said the manager was visible on the ward area.

Public engagement

- Women could communicate their experiences using the trust website. This was available for the public to view. We reviewed the website and it invited people to share their experiences
- We reviewed minutes of the Partnership in Maternity meetings. This was a forum for maternity service users, providers, and commissioners of maternity services to work together ensure services met the needs of local women and their families. The team told us they had difficulties in getting service users to contribute to the group.
- The senior team explained that they actively sought women's views from the groups that they held. For example, the women of the antenatal classes named the antenatal assessment unit ABC.

Staff engagement

- Staff told us they felt engaged by the managers and that their opinions are reflected in the planning and delivery of services.
- The senior team were very proud of the staff who volunteered to be part of the shared governance team. The senior team recognised that this experience helped to develop staff.

Innovation, improvement and sustainability

- The majority of staff were very proud of the new midwifery led unit and felt it added to the services and choices offered to women.
- The midwifery team attended various regional forums to share good practice.
- A member of staff designed an electronic application specifically for women using the trust's services called the 'Pocket Midwife'. It was free to download and

anyone could access it. It had information about each stage of pregnancy, and all of the maternity leaflets and maternity guidelines could be accessed easily. The service could add news flash information to the application for women to see, such as sending a reminder to women about flu vaccinations.

- The maternity team were successful in an innovation bid and were granted money to fund a purpose built induction of labour suite which will open in the near future.
- Staff on the ward had an ongoing project called 'Smile'. If a member of staff smiled on duty due to the compassion or kindness of another staff member they wrote down that gesture. They were all collected in a jar and fed back to staff at team meetings.
- The managers were actively succession planning to sustain services. They looked for rising star staff members and actively developed them. This enabled the staff to apply for promotion when available.

Neonatal services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Children's services at Nottingham University Hospitals NHS Trust (NUH) are based at Queen's Medical Centre (QMC) and City Hospitals managed through the trust's Family Health Directorate. The only children's service provided at City Hospital is the neonatal service. This provides care for over 10,000 Nottingham births per year and those babies and families transferred in from other hospitals within the Trent Perinatal Network who require specialist care.

The NUH neonatal service is the lead centre for the Trent Perinatal Network and serves a population of 23,000 births per year. Care is centralised so that care of the smallest and sickest babies and those with surgical problems take place at NUH. Intensive care services are provided at both hospital sites.

The service operates as a single service, despite being based on two sites and has joint arrangements including clinical governance, training, guidelines, audit and clinical research. The service provides a tertiary service for the north of the East Midlands Network whilst the regional neonatal surgical service is provided at QMC. Babies with medical needs are treated and cared for at the City Hospital 20 cot neonatal unit. Babies with cardiac problems are stabilised and transferred to other hospitals that specialise in this field.

Transport for babies within the network is provided by the 'Centre Neonatal Transport Service', which provides a service across the Trent perinatal Network and Central Newborn Network. This service is jointly based in Nottingham and Leicester with transport teams based in both places to provide optimal support.

During our inspection of children's services at City Hospital, we visited the neonatal unit. We spoke with four medical staff, 10 nursing staff including managers, 13 members of the multi-disciplinary team and two parents.

Neonatal services

Summary of findings

Overall, neonatal services at City Hospital were rated as good. We found services for babies to be effective, caring, responsive and well led. However, improvements were needed for the service to be safe so that babies were protected from avoidable harm.

The Family Health Directorate recognised nurse staffing did not fully meet the 2011 British Association of Perinatal Medicine Guidelines (BAPM). This was because the ratio of one nurse to one baby in the neonatal intensive care unit was not achieved. Staffing issues had resulted in cot closures, which we were told by staff had taken place on average four to five times a month to maintain safety within the service.

The children's service workforce review document identified 25 vacancies within the neonatal service. Additional neonatal nursing staff had been and continued to be recruited following the receipt of this additional funding. However, due to staffing issues we were told that cot closures had taken place on average four to five times a month to maintain safety within the service.

There was a recognised shortfall in neonatal consultant cover during the out of hours period. Current practice meant the neonatal consultant staff covered both Queens Medical Centre and City Hospital neonatal units. This practice did not meet the BAPM standards. To mitigate the risk the service had recruited three additional consultants to help provide consultant level out of hours cover at both sites and medical cover for the transport service.

A lack of specialist radiology cover out of hours, meant babies were transferred to another hospital to receive this service.

Arrangements were in place to minimise risks to babies receiving care, and there was effective monitoring of quality and outcomes. Babies received evidenced based care and there was good multi-disciplinary working between children's services, external providers and the mental health team.

Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of openness, flexibility and commitment.

The neonatal service supports other neonatal units through its regional retrieval service and had good support from other NHS trusts when babies needed more specialist care and treatment.

Neonatal services were responsive and had mostly met babies and their parent's needs. However, due to staffing issues we were told that cot closures had taken place on average four to five times a month to maintain safety within the service. Currently 18 cots are open to admissions on the neonatal unit.

Transitional care within the neonatal service was nurse led and had prepared and supported babies and their families for discharge home.

Clinical strategies and priorities were in place, against which were action plans with identified start and finish dates. The objectives were representative of the concerns identified in the service risk register.

A clear leadership structure was in place for the service. Staff said they were well supported by their clinical matron who they saw daily.

Governance processes and known clinical risks were monitored. Public and staff engagement processes captured feedback from both groups.

Following the findings from the 'Trent Perinatal Network Review' on 3 November 2014, improvements had resulted in improved consultant and nurse staffing levels but recruitment was ongoing.

Neonatal services

Are neonatal services safe?

Requires improvement

The safety of the neonatal service at City Hospital required improvement.

Shortfalls in qualified nurses in the neonatal service at City Hospital meant current staffing did not meet best practice guidance, as one to one nursing care in the intensive care unit could not always be guaranteed. This shortfall in nurse staffing was an identified risk on the trust risk register. Staffing issues resulted in cot closures, which had taken place on average four to five times a month to maintain safety within the service.

A staffing review across the children's service resulted in recommendations, which were presented to the trust board in April 2015. Staff were involved in this review. The workforce review document (v76, 15 September 2015) identified 25 whole time equivalent vacancies across both hospital sites. The neonatal workforce data provided by the service confirmed that demand and dependency had informed the total of staff required.

Staffing rotas from the neonatal unit at City Hospital confirmed shortfalls in band six nurses qualified in speciality on day and night shifts. Additional funding through the safer staffing monies for nursing staff was identified and recruitment of nursing staff was ongoing. At the time of inspection, 7.5 wte band five nurses were appointed of these one nurse was appointed to work on the City campus. The remaining nurses appointed to work on the QMC campus. In addition to this two band five nurses had started work in the neonatal unit the week before the Care Quality Commission inspection However, challenges remained due to difficulties recruiting neonatal nurses trained in this speciality.

Neonatal consultants covered both Queens Medical Centre (QMC) and City Hospital neonatal units during the out of hours period. This practice did not meet the British Association of Perinatal Medicine (BAPM) standards. The service had recruited three additional consultants to help provide consultant level out of hours cover at both sites; they also provided some medical cover for the transport service.

The children's service had no planned out of hours radiology support, which constituted a risk to babies. This meant that babies were transferred to another hospital to receive this service.

A year-end compliance of 72% against a target of 90% was achieved for neonatal staff attendance at mandatory training in 2014 - 2015.

Clearly defined and effective systems were in place to protect babies' from avoidable harm and safeguarded from abuse. Staff were aware of these systems, which included incident management, checking of essential equipment, and mandatory staff training.

Incidents

- At the time of our visit, 154 incidents had taken place across the neonatal units from March until June 2015. Each incident was categorised, referenced, identified the actions taken and confirmed the incident status. There was no separation of this incident data to confirm which neonatal unit the incidents had taken place at, therefore we are unable to comment on the quantity of incidents at each site location. Since the inspection the trust confirmed that incident data could be separated through their incident reporting system.
- We saw an example of incident discussions taking place within the 'Directorate Report to Quality Governance Meeting' (17 July 2015). The minutes identified that since October 2014 five incidents were reported within the children's hospital and neonatal unit. Three incidents were graded as low harm incidents following investigation, whilst two incidents had initial Duty of Candour applied in that discussions had taken place with the parents and written information provided.
- Systems were in place to ensure that incidents were reported investigated and learnt from. Incidents, complaints and significant events were discussed at forums such as the ward meetings, clinical governance meetings, during the quarterly quality governance meeting and at monthly trust board level meetings.
- Medical and nursing staff confirmed that they were aware of how to report incidents. We received mixed views from staff regarding incident feedback. Some staff said they had received no feedback, although they recognised the reporting system had worked well.
- We tracked one incident, which initially was identified as a serious incident; following investigation, this incident was downgraded to incident status.

- The incident had a full root cause analysis completed and an action plan and was discussed at the relevant operational steering group and the family health directorate governance meeting. The learning from this incident related to interpretations and the consistency of use by staff of the Glamorgan pressure area tool. The Glamorgan scale assesses whether babies are at risk of their skin breaking down. Additional training was arranged for staff to ensure they were competent in the tool's use.
- Monthly mortality and morbidity review meetings attended by medical and senior nursing staff were reported through the directorate governance meeting. Minutes of the 'Directorate Report to Quality Governance Meeting' (17 July 2015) showed that learning and concerns from mortality data had been discussed and confirmed that there had been no mortality outlier reports for the neonatal service.
- The child death review nurse attended neonatal unit meetings and close links existed between the bereavement team, children's safeguarding board and child death overview panel.
- We spoke with one staff member at City Hospital about the 'Duty of Candour' and found they were knowledgeable in what the new regulation involved and how it was applied. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- We saw that the 'Duty of Candour' integrated into the incident reporting and complaints processes. A 'Duty of Candour' flowchart (v1) for incidents graded moderate harm or above was available for staff to access. The guidance within the flowchart reflected regulation 20. Staff told us there had been drop in sessions to learn about the 'Duty of Candour. We saw guidance on the hospital intranet, which identified what this regulation, was and that it was a new regulation applicable to all providers.

Safety Thermometer

- Monthly clinical performance data was recorded for the neonatal unit through the use of the NHS Safety Thermometer Survey. This included information about pressure ulcers, urinary tract infections and catheters. We reviewed three surveys dated August 2014, June 2015 and July 2015 and noted that none of the babies had been identified against any of these criteria.
- A screen shot of the results of the monthly metrics audit for City neonatal unit against nursing and midwifery metrics identified monitoring against specific areas including pressure ulcers. Scoring against each metric was identified from February to August. However, the year these metrics related to was not present which meant we were unable to ascertain whether the information provided related to the 2015 year. The scores, which related to pressure ulcers ranged from 92% to 100%. Additional information provided from the neonatal service team confirmed that a senior nurse from another area had completed these audits, that actions were identified monthly along with an email reminder and ward sister 'Thought for the week' letter.

Cleanliness, infection control and hygiene

- The neonatal unit had an infection control 'link' staff member who had six hours identified per month to undertake infection prevention and control work. Staff told us that they could easily contact the infection control team for advice and support.
- Cleaning schedules and infection prevention measures were in place, for example, infection prevention and control guidance and wall mounted hand gels. Hand hygiene good practice guidance was displayed for staff and parents to see.
- Generally, we observed good infection control practices by staff. However, we observed on occasion that some medical staff did not use hand gels on entering and leaving designated clinical areas. Staff were observed to be wearing short sleeved uniforms and were used personal protective equipment such as gloves and aprons when undertaking tasks.
- The Family Health Directorate scorecard confirmed the outcomes of audits relating to infection prevention and control, for example, cleanliness, hand washing and central line audits, (a central line is a fine tube inserted into a vein for giving fluids or medicine). The timescales for data collection ranged from 6 April 2015 to the 26 July 2015. The baseline scores to achieve compliance ranged from 95% to 100%. We saw that the neonatal unit at City Hospital had not always achieved against these levels of compliance. For example, the May 2015 cleanliness audit score was 75% and no score was

identified for June 2015. The Family Health Directorate did not provide any information to show how they would improve in those areas identified as falling below expected standards.

- Hand washing by doctors scored 56% and therapists 50% in April 2015, both of which had improved to 97% and 100% respectively by June 2015.
- Staff told us that the results of infection control audits were available on the hospital intranet system. We saw details and outcomes of these audits displayed on the neonatal unit performance board. We also saw that monthly monitoring of Clostridium difficile and Methicillin resistant staphylococcal aureus infections had taken place.
- Performance information outcomes were displayed on the neonatal unit's performance board. The measures assessed included infection control information. Cleanliness was rated as outstanding, and the August 2015 hand hygiene audit score was 99%.
- All staff had received infection prevention and control training as part of their induction and as part of their annual mandatory training. Staff confirmed they had also completed a handwashing assessment on the neonatal mandatory training day.

Environment and equipment

- The neonatal unit was suitably equipped to provide care for sick and premature babies.
- We found that resuscitation trolleys were sealed and equipment was in date. Staff had signed equipment-monitoring records to show they had made daily checks.
- Appropriate measures were in place to maintain security in the neonatal unit. Security cameras were located throughout the building and people had to ring a bell to enter the unit or use swipe card access.
- Babies in the neonatal unit had additional protection from an electronic tag, which was attached when other forms of clinical monitoring were not in place. We were told that this alarm automatically informed security who would come to the unit.
- One senior manager told us that since the previous Care Quality Commission inspection they estimated 90% of the clinical equipment had been tested. There had also been spot checks on clinical equipment. Following the inspection, we received the October 2015 equipment servicing compliance report. The report confirmed there were 2,491 items in the medical equipment service unit. Equipment was prioritised into three service priorities, high, medium and low. The equipment serviced to date within each priority category was high – 80%, medium – 45% and low 43%. These priorities were assessed by senior clinical engineering technologists taking into account both the intrinsic hazards related to the equipment and the likelihood that routine assurance testing or maintenance will reduce the associated risks. To support this decision, senior clinical engineering technologists complete an assessment using the assurance and preventative maintenance schedule template. The first page of the template guides the decision process on Servicing Priority, Assurance and/or Performance Testing and service frequency (based on manufacturer recommendations). The second page of the template allows documentation of any supporting information (which might have been relevant to the decisions on page 1) as well as allowing for explanations/justifications of any deviations.

Medicines

- Medicines management was in line with hospital policy, for example, medicines were locked in cupboards and the nurse in charge carried the keys for the controlled drug cupboards.
- We reviewed seven drug charts and no gaps were seen against prescribed medication. However, we observed that only one of the prescription charts had oxygen prescribed. Best practice is that oxygen is prescribed on the drug chart when babies require oxygen therapy. This was confirmed by one of the medical staff we spoke with, however, we could not confirm that this was usual practice, as we did not see oxygen prescribed on all of the babies' prescription charts that we had reviewed.
- To reduce medication errors we saw that nursing staff wore red tabards whilst on the medication rounds. This indicated to other staff, visitors and parents that the nurse(s) must not be disturbed. Medical staff had an identified 'prescribing space or corner on the ward' where they went to when reviewing and prescribing medication.
- A medicines' safety week had recently taken place at the trust where learning had taken place from medication incidents.
- Nursing and medical staff received medicines' training at induction. Local medicine competency documents were in place for nursing staff to complete. Neonatal

nursing staff told us they had completed a yearly competency assessment and two yearly medication administration papers. The annual neonatal mandatory day included a safety session, which detailed incident trends and medication management.

- Pharmacy link nurses were attached to the neonatal unit. Staff we spoke with told us they had attended quarterly multi-disciplinary team (MDT) meetings to discuss drug incidents and that the meeting minutes from these meetings had been cascaded to staff. Staff had also received a newsletter following the quarterly MDT pharmacy meetings. We saw the latest newsletter, which included information about a type of medication infusion.

Records

- We reviewed seven sets of nursing notes and three sets of medical notes. There were information gaps in one baby's nursing records in the orientation to the ward and facilities section. Staff signatures were missing on one staff signature sheet, the missing dates were 1, 2 and 9 September 2015.
- Reviews of babies' care had taken place and changes documented. Risks were identified through risk assessments, for example, the Glamorgan scale was used to assess whether babies were at risk of their skin breaking down. For those risk assessments we reviewed, we noted the scoring was correct and escalation pathways were adhered to.
- Babies care plans were pre-printed, standardised plans, though some had been individualised. We observed that where the care plan was not relevant to the baby's care the non-relevant section was crossed through. Two of the care plans for one baby did not have daily reviews by the nursing staff. There were one to 11 days between nursing reviews for one of these care plans. This meant staff may not have the most up to date information about the baby's condition and care needs.
- The neonatal unit had a white board in place, which identified the names of babies, their consultant and nurse.
- The trust wide medical health records keeping audit (in-patients) 2014 took place from April 2014 – October 2014 and involved the audit of 951 case-notes across specialities. The children and young people speciality within the Family Health directorate included an audit of 36 cases. We noted from the conclusions section that the Family Health directorate compliance levels ranged from poor compliance (below 85%) to good practice (above 95%). The Family Health directorate did not provide a copy of their action plan or progress made to date despite our request, which meant we were unable to judge what progress was made in these areas.
- A screen shot of the results of the monthly metrics audit for City neonatal unit against nursing and midwifery metrics which included patient observations, was completed from February to September (undated). Intermittent noncompliance was observed on one occasion. This was awarded a red rating; the score was identified as 73% in April. From May to September, compliance had improved with scores between 86% to 93%. Additional information provided from the neonatal service team confirmed that a senior nurse from another area had completed these audits, that actions were identified monthly along with an email reminder and ward sister 'Thought for the week' letter.
- Staff had received training in information governance on induction and as part of their annual mandatory training.

Safeguarding

- Safeguarding governance-reporting arrangements ensured that safeguarding processes were monitored trust wide. The children's medical director was the trust executive lead for safeguarding children.
- A dedicated children's safeguarding team was in place and close working relationships existed with the adult safeguarding team. The named nurse for safeguarding children was jointly appointed by the clinical commissioning group and led the children's safeguarding team. This nurse worked closely with the named midwife. The safeguarding structure included 3.6 whole time equivalent (wte) band seven nurses and one nurse domestic abuse lead. One band six-specialist midwife also worked closely with the team. There were 56 ward based safeguarding champions trust wide, with 17 based throughout children's services.
- Staff told us they had effective working relations with the local authority children's safeguarding team and other healthcare professionals, such as health visitors. All safeguarding referrals were discussed and attended by members of the multi-disciplinary team.
- Safeguarding teams supported families whose infants were placed under a child protection plan prior to birth. Follow the baby's birth the multi-disciplinary team were involved in the discharge planning process to ensure

that the appropriate measures and support were in place for the baby and family. We tracked an example of one such referral, including the discharge plan. We saw that the baby's and parents' needs were met by the measures put in place. For example, prior to discharge, staff had made sure the parents understood how to give oxygen to the baby at home.

- Staff demonstrated knowledge of the safeguarding guidance, what to do and who to contact should a concern or safeguarding situation occur.
- For those families who do not attend their outpatient appointments, a 'did not arrive form' was completed and put in the babies file. This document was reviewed by the paediatrician who decided if a safeguarding referral should be made.
- National Institute for Health and Care Excellence (NICE) safeguarding guidance recommends that qualified staff are trained to a level three standard in safeguarding children. Staff had attended child safeguarding training at trust induction and then during their annual mandatory training. Safeguarding training at level three was provided by the safeguarding team. In 2014-2015, we were told that 90% of nursing staff in children's services had completed this training. Following inspection we received some updated training information from the trust dated from 1January 2015 to 31 December 2015 which confirmed that 78.18% of medical and dental staff, 100% of nursing and midwifery staff and 86.67% of administrative and clerical staff had completed level three safeguarding training in the children's hospital during this time period.
- Two medical staff we spoke with confirmed completion of child protection training sessions.
- Safeguarding supervision was provided on an as required basis to members of staff when safeguarding concerns were raised and following a formal debrief after a complex safeguarding event. Staff from the neonatal family care team confirmed that they had received regular supervision sessions. The trust confirmed they did not monitor safeguarding supervision attendance as this type of supervision was at staff request.
- The safeguarding children annual report had been presented to the trust board in 2014 by the named nurse for safeguarding and medical director. The report identified work undertaken by the trust in 2014 to safeguard children and young people, learning and recommendations and key priorities for 2015. Progress against national and regulatory requirements showed that the trust had made progress in these areas. For example, in relation to safe recruitment practices, should any of the checks not be satisfactory, the recruitment team withdraw the offer of employment.

Mandatory training

- Staff told us they had received a range of mandatory training and training specific to their roles. This included incident reporting, neonatal resuscitation, manual handling, infection control and safeguarding. Staff told us that they attended yearly update mandatory training in their birthday month.
- The trust mandatory training target was 90% and the senior management team told us there had been an improvement of staff attendance at mandatory training sessions. Information provided by the trust inspection confirmed that compliance in attendance at mandatory training for 2014 – 2015 in neonatal services was 72%.
- The trust confirmed that all neonatal staff had completed their neonatal life support training. Staff completed advanced baby life support training on their yearly neonatal mandatory day.
- Training attendance information taken from the 'Provision of basic and advanced paediatric life support training at Nottingham Children's hospital (updated June 2015)' confirmed that neonatal life support (NLS) courses had been run on the City campus four times a year which had been attended by neonatal nursing staff and some medical registrars. It is pre-requisite that all junior medical staff hold a valid NLS certificate before they can work in the neonatal unit.
- A family support sister teaches neonatal resuscitation as well as other designated support staff who teach resuscitation skills to parents.
- Two medical staff we spoke with confirmed completion of neonatal life support training sessions.

Assessing and responding to patient risk

- The service had identified guidelines and protocols to assess and monitor in real time, and react to changes in risk level.
- ·Admission guidelines differed from the British Association Perinatal Medicine /Toolkit standards for registered nurses as the neonatal service delivered a 1:2 ratio for most intensive care, rather than a 1:1 ratio due to a shortage of neonatal nursing staff.

- Risks to babies on the neonatal unit were identified during their initial assessment and identified within care plans. These risks were reviewed daily or as required. At the shift handover at the start of each shift, safeguarding issues when identified were communicated to the staff on the next shift
- The neonatal early warning score (NEWS) was used to monitor babies who may be at risk of deterioration.
- The neonatal service had merged the neonatal early warning score assessment with the observation chart for level three and transitional care babies. The escalation plan, which incorporated information relating to situation, background, assessment and recommendation (SBAR), was also part of this document. Should there be a total score of six or above, clinical concerns or parental concern escalation would take place. The baby NEWS score is completed once per shift and escalated as required.
- The NEWS tool was not used for those babies who were on continuous monitoring because vital signs, pain levels and potential risks were identified through this monitoring.
- Each baby on the neonatal unit had its own personalised resuscitation box, which stayed with them until discharge.
- Transport for babies within the network is provided by the 'Centre Neonatal Transport Service', which provides a service across the Trent perinatal Network and Central Newborn Network. This service is based in Nottingham and Leicester with transport teams based in both places to provide optimal support.

Nursing staffing

- We were told that neonatal staffing did not fully meet the British Association of Perinatal Medicine guidelines (2011) (BAPM) in relation to one to one baby care not provided in the intensive care unit for all babies. These staffing shortfalls were recognised as a risk and were identified on the hospital risk register.
- The neonatal service had ten band five and four band six nursing vacancies. Recent recruitment had promoted three existing staff to band six nursing positions; five conditional band five nurse offers were in place. Of the five candidates with conditional offers, only one nurse was qualified in the neonatal speciality. The new band five nurses were due to start at the trust in September 2015.
- The neonatal service had received funding for 7.5 whole time equivalent band five nursing staff from the safer staffing budget.
- The neonatal matron told us that the neonatal service met the qualified in speciality (QiS) ratio of 70:30 and the registered to non-registered nursing staff of 80:20. In addition, specialist nurses for example, two family care sisters, one nurse clinical educator and 6.5 wte nurses who worked in the critical care and transport team were additional to the existing funded establishment. Eight neonatal nurse practitioners work across the neonatal service who contribute to medical rotas and provide advanced nursing support and education for neonatal nurses across the service.
- Staff told us they were concerned about staffing levels on the neonatal unit at City Hospital and about nursing staff leaving. However, we were told that escalation pathways had been used when staffing concerns were raised to ensure that appropriate support was put in place to maintain safety, for example, nursing staff worked across the units to fill any gaps in staffing. Agency nurses known to the service were requested a month in advance to replace staffing shortfalls. Cots were closed on average four to five times a month to maintain safety.
- Staffing shortfalls were discussed and actions planned with the matron on a daily and weekly basis, at the monthly ward sister review and shared at the monthly safer staffing meetings. Staff identified staffing shortfalls as 'red flag 'incidents and completed incident reports. when staffing for the shift fell below planned levels.
- The staffing review resulted in recommendations, which were presented to the trust board in April 2015. The staff we spoke with confirmed involvement in this review. Patient acuity and demand fed into the findings identified through the workforce review document which had been updated on 15 September 2015 identifying 25 wte vacancies across both hospital sites.
- At the time of inspection, 7.5 wte band five nurses were appointed. One nurse appointed to work on the City campus, the remaining nurses appointed to work on the QMC campus. In addition to this two band five nurses had started work in the neonatal unit the week before the Care Quality Commission inspection However, challenges remained due to difficulties recruiting neonatal nurses trained in this speciality.
- We reviewed three nursing rotas from the City Hospital neonatal unit. The rotas confirmed there was an

increase in band six (deputy ward sister level) from seven to eight nursing staff from the January 2015 duty rota. There was also an increase in band five nursing staff that were qualified in speciality from two in November 2014 to 15 nursing staff on 11 May – 7 June 2015 duty rota.

- Band six coordinator nurses were not available on six shifts from 11 May to 1 June 2015. However, the rotas identified the presence of nursing staff from within the transport and critical care and practice development teams for these shifts. Band five neonatal nurses qualified in the speciality also were identified on these shifts.
- The neonatal service had eight advanced neonatal nurse practitioner (ANNP) posts, which contributed significantly to medical rotas and provided advanced nursing support and education across the service.
- A family, continuing care and outreach team assist families during their baby's stay, discharge preparation and liaises with allied services in the community to ensure ongoing care and support is provided. We spoke with one staff member from the team who told us how she had enjoyed and had developed this service.
- A critical care and critical care transport team, which consists of experienced neonatal nurses, deliver expert nursing mainly within the neonatal intensive and critical care settings for transport in other hospitals.

Medical staffing

- The neonatal service had 14 consultant posts. Three newly appointed consultants contributed to resident out- of- hours cover and some of the medical cover for the transport service, (when transferring babies to other hospitals). The remaining consultants provide coordination and advice to the transport service when on call.
- Neonatal consultants covered Queens Medical Centre and City Hospital neonatal units during the out- of- hour's period. This did not meet the BAPM standards (3rd edition) which says, ''for all levels of unit it is not appropriate for a consultant to provide out of hours cover to two geographically separate sites simultaneously.'' Medical staff told us consultants were contactable by phone for advice or had come into the unit during the out-of- hour's period when required. Anaesthetic consultant and intensivists were available to provide anaesthetic advice and support including out- of- hours.
- Additional medical staffing include three 0.5 whole time equivalent (wte) academic consultants and two hybrid consultants. The hybrid consultant's time is split into, 33% traditional consultant role, 33% resident middle grade doctor (when working as a middle grade doctor another consultant provided cover) and 33% on the transport rota.
- Nine registrars, eight advanced neonatal nurse practitioners (ANNP) and seven senior house officers worked in the neonatal service. All the medical staff and ANNP provided cross-site support on both neonatal units.
- We observed a neonatal medical staff handover and saw they were thorough, respectful and informative. The discussions included reference to retinopathy screening and the NICE guidelines used when discussing treatments, for example, jaundice treatment.
- The trust identified out of hours paediatric radiology support as a risk on their risk register. A national shortage of radiologists has made it difficult for the trust to fill their radiologist vacancies, which meant babies, were transferred to other hospitals for radiology care. Specialist radiology cover was not available out of hours except Saturday mornings.

Major incident awareness and training

- The trust had a business continuity plan, which ensured critical services were delivered in exceptional circumstances.
- A trust major incident policy (version 2.3 - 2010) was in place. This policy identified staff specific roles and the measures to be put into place should a major incident take place.

Are neonatal services effective?

Good

The effectiveness of the neonatal service at City Hospital was good.

Multi-disciplinary team working within and outside of the neonatal service had resulted in positive outcomes for babies.

Neonatal services

Evidence based care was provided; evidence based clinical guidelines were reviewed by consultant staff and were mostly in date. However, 19 neonatal guidelines had passed their review dates so we could not be fully assured of the robustness of this monitoring process.

Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for babies.

The neonatal service had achieved a stage three 'UNICEF Baby Friendly accreditation.'

Trust appraisal statistics (2014) confirmed an improvement in staff yearly appraisal uptake in the last twelve months. However, we observed that shortfalls in staff appraisal rates remained despite these improved appraisal rates. Staff told us their training needs were supported and they had received development appropriate to their needs.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health (RCPCH) and the National Institute for Health and Care Excellence (NICE) were used to inform care. We looked at a selection of evidence-based guidelines and saw that most were reviewed up to date.
- We saw a list identifying 86 neonatal guidelines of which 47 were under review. The guidelines under review had an allocated person and estimated review date. However, we observed that 19 of the estimated review dates had passed. These review dates ranged from January 2015 until August 2015. No further information was available to confirm whether these guidelines were now updated. Despite these monitoring systems being in place we were not fully assured of the robustness of this monitoring system. We saw that discussions about clinical guidelines had taken place in the minutes of the 'Directorate Report to Quality Governance Meeting' (4 June 2015).
- The neonatal unit guidelines linked to network guidelines. For example, the 'guideline for cooling' was implemented two to three years previously across the network and had been agreed through the trust governance group.
- Clinical genetics staff attend a twice-yearly regional audit meeting with colleagues in Leicester clinical genetics service and a guidelines group, which meets on the same day.
- The neonatal unit followed evidenced based practice through the implementation of an electronic ear', which was placed in the high dependency area. The function of the ear was to monitor noise levels to alert staff to high noise levels, which could distress the babies. Where noise levels were too high the ear's colour would change. We saw this in action during the time we spent on the neonatal unit. We were told that staff had received annual reminders of noise levels on staff development days.
- The children's service practice development group was made up of nursing staff. Their remit included coordinating the link nurse groups within the service, training and initiatives such as pressure sore prevention.

Pain relief

- A designated anaesthetist and nurse led the children's pain management team. They were supported by anaesthetists, two nurse specialists and ward link nurses whom had additional training and time allocated to enable them to provide this care. Members of the pain team also attended oncology multi-disciplinary team meetings. The children's pain team had a service review undertaken in 2015.The outcome confirmed compliance with the 'General Paediatric Surgery Peer Support & Service Assessment Review 2014 Standards.' Overall feedback and results of the review were very positive.
- We reviewed two babies' records relating to pain management and saw their pain documentation was fully completed. Staff had followed escalation pathways correctly to manage babies' pain effectively.
- Babies had access to a range of pain relief. If babies were unsettled or appeared to be in pain, this observation was discussed with the doctor to determine whether pain relief was needed to settle the baby. Out of hours, an anaesthetist could be contacted to prescribe structured pain relief.
- Babies' pain scores were monitored monthly by the use of a nursing and midwifery metrics tool. Pain scores were documented from February until September and ranged from 93% -100%. However, the year these metrics related to was not present which meant we were unable to ascertain whether the information provided related to the 2015 year.

Nutrition and hydration

- A specialist service was provided across both hospital sites to support the nutritional needs of babies in the neonatal units. The neonatal dietician had developed ten guidelines for use on the neonatal units and across the neonatal network. These guidelines included parenteral nutrition, manufactured on site. (Parenteral nutrition is a method of feeding by giving fluids and liquid food directly into a vein).
- Infant feeding sisters support the promotion of breast feeding and enhancing feeding initiatives across the neonatal service.
- All mothers on the neonatal unit had lunch provided.
- We saw that nutritional assessments were completed in one baby's records. The neonatal nutritional care plan was reviewed every one to two days by nursing staff.
- The Baby Friendly initiative is a worldwide programme of the World Health Organisation and UNICEF established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding.' The neonatal service achieved stage three Baby Friendly accreditation in 2014. This assessment involved feedback from parents' experiences.
- A screen shot of the results of the monthly metrics audit for City neonatal unit against nursing and midwifery metrics was completed from February to September (undated). The nutrition metrics recorded two episodes where scores ranged from 78 to 79%. For the remaining months with the exception of September 2015, the metrics scores in this area ranged from 85 to 96%. Additional information provided from the neonatal service team confirmed that a senior nurse from another area had completed these audits, that actions were identified monthly along with an email reminder and ward sister 'Thought for the week' letter.

Patient outcomes

- The clinical audit plan for 2014 – 2016 identified which audits the service was participating in and the audit lead for each audit. Staff told us that the results of audits were available on the hospital intranet system. We saw details and outcomes of some audits displayed on the neonatal unit performance board, for example, patient observations.
- Discussions with the service lead identified that the neonatal service had taken part in national audits, for example, the National Neonatal Audit Programme (NNAP).
- The NNAP results showed shortfalls in the neonatal service, City Hospital had failed four of the five items in the audit programme and was identified as an outlier for the screening of 'Retinopathy of Prematurity' by NNAP on 2013 data. However, the trust identified that the shortfalls in compliance were a result of data recording failures, not because of a failure to comply with standards. No risks or safety issues were identified due to this. A business case was submitted to reduce the risk of data recording shortfalls in the future.
- In 2013 – 2014 on the City campus, 56 babies who were inpatients were screened for ROP from 80 eligible babies. Two babies had no first screen so alternative arrangements were made for their ROP screening. Twenty-two babies had their first ROP screen as outpatients. The conclusion was that the current system appeared robust but recording of information needed to improve particularly for those babies screened as outpatients.
- The document 'NICU Data Summary for CQC – September 2015' identified that NNAP outcomes had been audited separately on several occasions during the last three years and had shown the outcomes relating to the NNAP audit questions were better than presented in the NNAP dataset. There was recognition that outcomes could be improved further by better data collection. Yearly reviews of the NNAP report and data had taken place and improvements made.
- We reviewed the 2014 NNAP unit level data published on the 5 November 2015, which confirmed that the service had achieved one of the five standards identified within the NNAP audit. However, when we compared this data to the 2013 NNAP data for City Hospital neonatal unit we found improvements against four of the five standards, which meant that outcomes for babies had improved since the previous audit.
- The 2014 NNAP data identified that 98% (82 eligible babies) were ROP screened. The standard applied to RoP screening is 100%. Whilst, 84% (27 out of 32) of babies had a temperature taken within one hour of birth, (the standard is 98-100%) and 85% (112) of mothers had received antenatal steroids. The standard was achieved for mothers who had received antenatal steroids.
- The proportion of infants who received some breast milk on discharge in 2013 – 2014 was above the standard of 58%, falling mainly in the 60-70% range. The breast feeding item was identified as a CQUIN for the

service in 2014 – 2015 and the target was met which was a 10% improvement on the previous year. We observed shortfalls remained in babies feeding with their mother's milk in the 2015 NNAP data. The audit identified that 11 (24%) out of 45 eligible babies fed with their mother's milk at discharge.

- Audits to monitor consultation with a senior clinician within 24 hours of admission to the neonatal unit had taken place. In the 2012 audits, 118 cases (97%) of parents were documented as having been seen by a senior clinician within 24 hours. Because shortfalls in documentation were identified in the medical notes through the neonatal survey in 2013, this information had also been added to the nurses' admission to discharge paperwork. We observed from the results of the 2014 NNAP audit that consultation with parents had reduced to 78% (247 out of 316 eligible babies) within 24 hours of admission to the neonatal unit. The standard for this area is 100%.
- The service has undertaken research into neonatal physiology and adaptation at birth and optimising nutritional support.

Competent staff

- Formal processes were in place to ensure medical and nursing staff had received mandatory, role specific training, and an annual appraisal. Nursing staff told us they had received yearly appraisals and training specific to their needs. Information provided by the trust for the neonatal service identified that 82% of staff had an appraisal in 2014 - 2015. Since the inspection additional appraisal compliance data had been received which confirmed that the neonatal nursing appraisal rates were now 92%.
- Junior doctors had received regular teaching sessions following the 08:30 am medical handover sessions, including attendance at regional training days every two months. Consultants were described by junior doctors as keen on teaching. To discuss concerns a trainee forum was established. Junior medical staff described clinical supervision as good.
- Staff confirmed attendance and satisfaction with their corporate and local inductions. Comprehensive local inductions were in place for new starters, for example, neonatal service staff inductions included a six-month induction for band five nursing staff. The induction included monthly study days, completion of competency-based assessments, supervised and independent practice and working alongside the practice development team to enhance their skills. We saw the induction folder for a newly employed nurse, which confirmed the types of training and assessments to be completed during their induction.
- Neonatal nursing staff spent time in different areas of the neonatal service to enhance surgical and medical skills.

Multidisciplinary working

- Discharge planning for the baby included all those members of the multidisciplinary team involved in their care, for example, nurses, community teams, continuing care team, GP, social care professionals and therapists.
- Staff described examples of partnership working and we saw examples documented in babies records. For example, we saw records showing effective MDT working prior to the discharge of one baby from the neonatal unit. Staff told us systems were in place to enable them to follow-up social care referrals. These systems included multidisciplinary team involvement and meetings. We tracked one babies discharge plan and saw discharge planning agenda for this baby, which included community and neonatal unit staff.
- The neonatal service held joint senior nurse meetings with another trust in Leicestershire and quarterly governance meetings had taken place with the 'Trent Perinatal Network.'
- Consultant teams at City Hospital met together each week. These meetings were not formalised and as a result, no meeting minutes were taken to confirm discussions held between the consultant teams.
- Neonatal staff had weekly meetings with staff working in foetal medicine to discuss upcoming deliveries. (Foetal medicine is the care of women with high-risk or problematic pregnancies).
- The neonatal consultants and surgeons met weekly to discuss babies needing surgery.
- Joint monthly perinatal death review meetings took place with obstetrics and genetics.
- Good community links existed with the children's team and the child development centre. Both teams attended discharge meetings, and liaised and overlapped with the outreach team. Babies with complex health needs had follow up sessions at four to six weeks, which included an overlap joint meeting with the health visitor.

Neonatal services

- The neonatal unit had two Bliss Champions who were previously parents on the unit. Their role was to support and talk with new parents. Bliss is a UK charity working to provide the best possible care and support for all premature and sick babies and their families.
- Clinical nurse specialists, clinical psychology support, and eight advanced neonatal nurse practitioners were available for babies, parents, carers, and staff to access for support when needed.
- Representatives from the regional genetics service attend the East Midlands Genetics Network meeting three times a year.

Seven-day services

- Twenty-four hour neonatal consultant support was in place seven days a week. The consultant rotas provided details of which neonatologists to contact that week. Medical and nursing staff said they could access consultants out of hours and described the consultant team as supportive.
- Staff said they could access out-of-hours investigations, for example, urgent laboratory tests. Staff told us that pharmacy access and support was available.
- The dietetic department had a minimum cover system in place during busy holiday periods. Since Easter 2015 dietetic cover had been available at bank holidays and weekends, which had improved service provision.

Access to information

- Weekly multi-disciplinary handover meetings took place to discuss babies currently receiving support.
- The monthly neonatal grand round alternated across hospital sites on Wednesday afternoons.
- When babies were transferred to other hospitals or home discharge documentation and discharge meetings took place prior to the baby's discharge. We saw one baby's discharge information, which included discharge meeting minutes and their proposed discharge plan and what actions had taken place to-date in response to the discharge plan. We observed multidisciplinary team involvement throughout the discharge process.
- For those babies and their parents who received transitional care support the family care sister from the neonatal unit met with identified midwives to keep them informed about the baby and families status so that support would be provided where needed.
- Babies' test results were available electronically so that the multidisciplinary team could access them.

Consent

- Staff demonstrated through discussion that they were informed of and understood the consent process. Staff explained the consent process and told us that written consent was obtained prior to some investigations or procedures. We saw three examples of completed consent forms in babies' notes; for example, consent for photography and the insertion of a venous access line had been obtained.
- Information on the consent process was available for parents.

Are neonatal services caring?

Good

The standard of care provided by the neonatal service at City Hospital was good.

Parents said they had received compassionate care with good emotional support. One set of parents said they had felt 'empowered,' had been kept fully informed and involved in decisions relating to their baby's treatment and care.

The NHS England 'Neonatal Survey 2014 results for City Hospital identified some concerns by parents. In response to these concerns, the service identified actions within their neonatal service action plan.

The multi-disciplinary team provided support during babies' admissions, stay and in preparation for their discharge home.

Compassionate care

- Throughout the inspection, we observed members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies and their parents.
- Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- Parents told us they had felt 'empowered,' and described the care received as 'high quality care.'
- Parent feedback was captured from parents through the use of comments boxes, feedback cards and the NHS

England Neonatal Survey. We saw that positive feedback had been received from parents in cards displayed in the main corridor leading into the neonatal unit.

- The introduction of the 'Friends and Family Test (FTT)' is a method of obtaining parent feedback. The FTT was introduced to the City neonatal unit in May 2015. The information from this survey is shared at the senior nurse meeting. I have been unable to access any information to-date from this survey.
- Parent satisfaction surveys took place to capture parents' experiences of neonatal care in 2014. This was part of the NHS England Neonatal Survey 2014. The survey involved 72 NHS trusts and 88 hospital neonatal units, including the City Hospital neonatal unit. The NHS England 'Neonatal Survey 2014 results for City Hospital identified some concerns by parents. Two of the lower scoring areas included 'were you given enough information to help you understand your baby's condition and treatment (score 43) and 'did you feel prepared for your baby's discharge from neonatal care. (Score 81)' The scores were compared to the national average.
- In response to the survey findings, the service identified actions against eight areas within their neonatal service action plan. The timescales for implementation of these actions ranged from June 2015 until 2018. The majority of time scales were in 2015. The 2018 timescale related to the maternity and neonatal redesign plan.

Understanding and involvement of patients and those close to them

- Parents told us that they had been involved in the care and treatment their baby had received.
- NHS England Neonatal Survey 2014 survey results for City Hospital showed that some parents were not given written information to help them understand their baby's condition and treatment. This was included in the trust action plan as an area requiring improvement. The timescales for improvement ranged from June until November 2015. One of the actions identified included the development of an app for the information booklet called 'Baby Fax'. This information booklet which will be available to families has been developed and is about to go to print.
- Information was available for parents. This information was in English; however, staff confirmed that this information could be provided in different languages and formats on request.

Emotional support

- The needs of new mothers were re-evaluated regularly, demonstrating that appropriate emotional support was in place for both mother and baby. The neonatal service linked with the 'Butterfly Project' when families required respite. The 'Butterfly Project' supports people who are at risk of self-harming.
- An annual family bereavement day was organised by the children's hospital bereavement team.
- Play staff provided one to one and facilitated group play activities formally or informally to support siblings dealing with grief and bereavement issues.
- Parents were offered counselling sessions following the death of their baby.
- Parents from the neonatal unit could access coffee mornings every Wednesday at 11am and parents' support groups. We saw dates of these groups displayed in the neonatal unit.
- Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for families to access.

Are neonatal services responsive?

Good

The responsiveness of the neonatal service at City Hospital was good.

The neonatal service supports other neonatal units through its regional retrieval service and had good support from other NHS trusts when babies needed more specialist care and treatment.

Neonatal services were responsive and had mostly met babies and their parent's needs. However, due to staffing issues we were told that cot closures had taken place on average four to five times a month to maintain safety within the service. Currently 18 cots are open to admissions on the neonatal unit.

Neonatal services

Transitional care within the neonatal service was nurse led and had prepared and supported babies and their families for discharge home.

Service planning and delivery to meet the needs of local people

- The neonatal service supports other neonatal units through its regional retrieval service. Designated individuals from the service and outside of the service attend the regional neonatal network meetings. Discussions about practice, concerns and changes to current guidelines and practice take place and changes are agreed at these meetings.
- The service had good support from other NHS trusts when babies needed more specialist care and treatment.
- The neonatal unit had 20 cots; currently, 18 cots are open. The current cot configuration includes six neonatal intensive care, six high dependency cots (12 cots) and six special care baby cots.
- Parents with babies on the City Hospital neonatal unit could access accommodation. This accommodation includes six rooms, a sitting room and kitchen. An additional six rooms funded by the neonatal unit can also be used at the patient hotel on the City Hospital site.
- There were two parents' rooms on the neonatal unit for parents of seriously ill babies or babies who were receiving end of life care.
- Parents could access discounted parking. After a month of their baby being on the neonatal unit, parents received free parking. Additional support in the form of meal vouchers, snack boxes, information and social care support had also been provided to families whose babies received long term health care.

Access and flow

- Referrals to City Hospital by gestation and birthweight from April 2014 to March 2015 totalled 765 babies. Babies who required respiratory support totalled 1308 during this period.
- Due to staffing issues and to maintain safety within the service we were told that access to the neonatal unit had been reduced. There had been cot closures on average four to five times a month.
- Babies who required surgery were transferred across to the Queens Medical Centre neonatal unit.
- Families could access the regional genetics service, which is based at Nottingham City Hospital. The service provides integrated diagnosis, counselling advice and support for families with a wide range of inherited disorders for a population of 2.4 million across the East Midlands. Clinics took place in City Hospital and at outreach clinics in North Nottinghamshire, Lincolnshire and Derbyshire. The team includes six consultant clinical geneticists with approval to appoint two further posts. The wider team include two specialist registrars, 12 genetic councillors, one genetic nurse and a four-day research nurse.
- Staff working in the unit took the lead on transitional care arrangements, which were in place to support the baby and their parents. Prior to discharge some parents with their babies were encouraged to stay in a transitional care room supported by staff. In addition, the transitional care team had provided support to parents with babies who had been born at less than 34 weeks of age on the post-natal ward.

Meeting people's individual needs

- Parents confirmed involvement when planning and agreeing their baby's care. Care plans were up to date and appropriate for the baby. One baby's nursing documentation we reviewed confirmed that pre-discharge planning had commenced and had included information on hygiene precautions, which had been given to parents.
- Discussions with staff confirmed effective discharge planning pathways and arrangements were in place for babies who were to be discharged home. We tracked one baby's pathway and saw that discharge planning had commenced from admission to the neonatal unit. The baby's records confirmed that the parents were involved in the discharge planning process. They had received information about their local hospital and had completed the training required for them to support and care for their baby. Confirmation of parental training was seen in the completed home oxygen care pathway document and the teaching protocol for home oxygen was completed by the parents prior to the baby being discharged home. The multi-disciplinary team's involvement and attendance was confirmed by the discharge planning meeting agenda and meeting minutes dated the 8 September 2015.
- Some staff had received training sessions in equality and diversity training to assist their understanding in

these areas so that they could support the mothers and their baby's needs. We do not have the training figures for those staff that had completed equality and diversity training, despite having requested them.
- A lead nurse, designated doctor, bereavement nurse specialist and two palliative care nurses were available when there was a baby death.
- Interpreting and language line services were available to assist those parents whose first language was not English.
- Information was displayed and could be accessed parents. This information was presented in English, though could also be provided in different languages and formats on request. Those staff we spoke with confirmed this. Examples of some of the information available included baby-screening tests, staff photo boards, nutrition link information relating to the enteral feeding system, equality and diversity information.
- Parent information boards were located in the corridor and parents room of the neonatal unit. Examples of information seen related to faith, car-parking charges, what is comfort holding and breastfeeding support in Nottingham, immunisations up to 13 months of age.
- Facilities for parents were satisfactory.

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Patient Advice and Liaison service (PALS) or the trust complaints department. We saw complaints information leaflets displayed throughout the service.
- Staff told us they had been encouraged to be transparent in their communications and that complaints were referred to the ward sister or PALS.
- Staff had attended PALS basic training as part of their induction. All the ward managers had attended complaints training.

Are neonatal services well-led?

Good

The leadership of neonatal services at City Hospital was good.

Clinical strategies and priorities were in place, against which were action plans with identified start and finish dates. The objectives were representative of the concerns identified in the service risk register.

A clear leadership structure was in place for the service. Staff said they were well supported by their clinical matron who they saw daily.

Governance processes and known clinical risks were monitored. Public and staff engagement processes captured feedback from both groups.

Following the findings from the 'Trent Perinatal Network Review' on the 3 November 2014, improvements had resulted in improved consultant and nurse staffing levels but recruitment was ongoing.

Vision and strategy for this service

- Neonatal services had an 'Annual Plan 2015 / 2016 (v3)' which identified the achievements for 2015 / 2016 and a speciality plan to support trust objectives. The timescale finish dates against the neonatal speciality plan to support trust objectives ranged from April 2015 to March 2016. We observed that the speciality objectives related to some of the concerns that were identified through our inspection and which were identified on the risk register. For example, 'Improve the number of weekends with separate consultant cover for each campus' and 'move to toolkit standards for nursing establishment within three years.'
- The trust's vision and values were displayed in the neonatal unit. Staff were aware of the trust's value statement.

Governance, risk management and quality measurement

- There was a divisional quality governance structure in the Family Health division. The organisational diagram for governance showed a comprehensive governance system in place and identified the lead persons for each area.
- A practice development matron was responsible for quality, risk and safety. Monthly service management lead meetings and separate risk management meetings had taken place within the neonatal service. Consultant staff told us that clinical risk meetings had taken place

every two weeks across the City Hospital site and were attended by consultants, senior nurses and the lead neonatologist. Staff had received feedback from these meetings via email.

- Monthly discussions of risk and quality had taken place at a number of forums. For example, trust board, governance, quality, clinical risk and safety committee meetings. Escalation to trust board had been through the hospital leadership team. Quality, risk and governance information updates were communicated in team meetings, newsletters, senior nurse meetings and morbidity and mortality meetings. Some staff confirmed they had received feedback and emails following incidents and governance issues.
- Quarterly governance meetings across the Trent perinatal Network and Central Newborn Network had taken place and were attended by representatives from trusts within the region.
- Meeting minutes from the 'Directorate Report to Quality Governance Meeting dated 17 July 2015' included items such as, trust risk register, root cause analysis action plan update, environmental concerns, Neonatal planned peer reviews, progress against compliance with NICE guidance, clinical audit, clinical guidelines, outcomes, risks, incidents and complaints.
- The service had a performance dashboard and local risk registers, which were monitored monthly.
- Risk ratings and actions for each incident were approved through the governance group. Risk ratings of 15 and above were discussed at trust board, whilst those incidents with risk ratings of 10 and above had been discussed and reviewed monthly within each speciality. We observed that two of the areas we identified as potential risks during the inspection were identified within the services neonatal risk report (July 2015). This report identified areas of potential risk to the service, such as, lack of funded establishment to provide 1:1 nursing and lack of capacity for admissions on the NICUs in Nottingham (QMC Campus and City Campus). We saw from the actions they had identified that appropriate actions were going to be / had been taken to mitigate against these risks.

Leadership of service

- The management structure for the service identified clear lines of accountability. The neonatal matron spent 50% of their time on each neonatal unit, which are based on two sites, Queen's Medical Centre and City Hospitals. Staff told us they felt supported by the neonatal matron who they had seen daily.
- One staff member identified good communication existed between band seven managers and the trust executive team. However, we were told of perceived communication gaps between the band seven and band eight senior nursing staff and the staff on lower grades. For example, changes were not always communicated to the remaining staff by senior nursing staff.
- The service had designated professionals who led in identified areas, for example, safeguarding, governance and risk.
- Staff were provided with opportunities for leadership development in 2014. We saw evidence of this through previous study day agendas and by discussions with staff. One member of staff told us they had completed a leadership course in 2014. They had met with other band seven nurses in the trust. This for peer support where they had discussed and shared issues.

Culture within the service

- A culture of openness was demonstrated amongst all the teams and staff we met. Staff spoke positively about their service, although concerns were identified in relation to staffing levels.
- Staff described positive working relationships including those between the multidisciplinary teams and other agencies involved in the delivery of neonatal services.
- One staff member told us that should they need to raise a concern they felt confident and supported to do so.

Public engagement

- Engagement with the public has taken place through the 'Nottingham University Hospitals Patient Public Involvement (PPI)' steering group. Draft minutes of a meeting held on 11 August 2015 identified parent feedback relating to service improvements at the City campus. One improvement was the introduction of privacy screens for use in the low dependency areas. Parents said they would feel less isolated with this type of screen in use when breast feeding their baby. Two screens were purchased for each of the neonatal units.
- The NHS England Neonatal Survey 2014 survey results for City Hospital showed that most of the trust's ratings were in the intermediate 60% of all trusts taking part.

Some ratings for City Hospital were in the worst performing 20% of units. The shortfalls included adequate security on the neonatal unit and a lack of written information to help parents understand their baby's condition and treatment.

- Following the neonatal survey an action plan was produced which included information relating to actions and timescales for completion. The action plan identified the areas to concentrate on improving and was devised following attendance at a workshop facilitated by the Picker institute. Staff were given the opportunity to comment via email and at the multidisciplinary service improvement meeting. The majority of timescales on the action plan ranged fell within the 2015 calendar year. The maternity and neonatal redesign plan had a timescale identified as 2018.

Staff engagement

- One staff member told us that the trust's chief nurse had visited the neonatal unit three weeks ago. None of the other staff we spoke with confirmed that any other members of the executive team had visited the unit.
- Staff engagement had taken place through a number of forums, for example, ward meetings, via email correspondence, development and training days and at formalised meetings aimed at various staff groups such as senior nurse meetings.
- Staff had the opportunity to comment on the action plan addressing improvements needed following the NHS England Neonatal Survey 2014. Staff were able to comment by email and at the multi-disciplinary service improvement meeting where key actions were identified.
- Of the 31 indicators within the NHS Staff Survey, the trust had two negative findings, eight positive findings and 21 findings within expectations. Notably 13 of the 29 indicators previously used in 2013 had seen a lower score in 2014.

Innovation, improvement and sustainability

- The Trent Perinatal Network peer review of the neonatal service at NUH took place on the 3 November 2014. The action plan confirmed eight areas where improvement was needed. We saw progress had been made against some of these areas as the actions were completed. For example, the 'Nursing Service investment proposal to be re- submitted to Deputy Director of Nursing as part of safer staffing agenda' and the development of hybrid consultant posts that provide out of hours cover had been implemented to increase the consultant cover for the two neonatal intensive care unit sites.

End of life care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

At the City Hospital patients who need end of life care are cared for on the general wards. Hayward House is located on the grounds of the City Hospital site; this provides 20 beds for in-patient palliative and end of life care.

Between April 2013 and March 2014 there were 1221 in hospital deaths and between April 2014 and March 2015 there were 1598 in hospital deaths across the Nottingham University Hospitals NHS Trust.

Trust wide between April 2013 and March 2014, 1387 referrals were made to the Specialist Palliative Care Team (SPCT). Of these referrals, 1137 were cancer related and 250 were non-cancer related. Between April 2014 and March 2015 1432 referrals were made to the SPCT, 1432 were cancer related and 360 were non-cancer related.

During our inspection we spoke with 11 patients and/or their relatives and 20 members of staff, including nurses, student nurses, health care assistants, end of life care champions, allied healthcare professionals, members of the specialist palliative care team, doctors, holistic therapists, a discharge coordinator, a bereavement officer, a mortuary technician and a chaplain. We observed interactions between patients, their relatives and staff, considered the environment, and looked at 14 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and 14 medical and nursing care records. Before our inspection, we reviewed performance information from, and about the hospital.

Summary of findings

End of life care at this trust required improvement.

Staffing levels at Hayward House were at times compromised because the staff rota did not always reflect what was happening on the ward. This did not always ensure safe and effective care was delivered.

Although patient outcomes were monitored for patients who had been referred to Hayward House, patient outcomes were not monitored throughout the trust. There had been no auditing of patients preferred place of care or death. The trust was therefore unable to identify whether patients' wishes were respected at the end of their life. We did however see that discussions took place around preferred place of death and care, but we were not assured these discussions took place with patients who had not been referred to the specialist palliative care team.

Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were mostly made appropriately and in line with national guidance. However, we found the forms were not always endorsed by a consultant.

Care and treatment was mostly delivered in line with local and national guidance and a holistic patient-centred approach was evident.

There was good multidisciplinary working at Hayward House and throughout the ward areas at the City Hospital.

End of life care

The leadership for specialist palliative care services was evident; however this was not the case for end of life care throughout the hospital even though the leads were the same people. Staff throughout the trust were aware of, and spoke highly of, the specialist palliative care team but were unaware they also took the lead for end of life care. There was no vision or strategy for end of life care, although there was a specialist palliative care annual plan for 2014/15.

Are end of life care services safe?

Requires improvement

Overall we judged the safety of end of life services as requires improvement.

Patients were not always protected from avoidable harm because staffing levels did not always match the levels required to meet patients' needs. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. When incidents occurred investigations had taken place and we saw evidence of lessons learned.

Arrangements to minimise risks to patients were in place, with measures to prevent falls, malnutrition and pressure ulcers and staff demonstrated a good understanding of the early identification of a deteriorating patient. Monitoring of risks to patients was mostly positive with actions considered to minimise future risks. However, when we looked at incidents relating to shortfalls in staffing at Hayward House we found that between April 2015 and August 2015 there were 11 reported incidents where there were not adequate staff on duty to provide safe care for patients. The incidents reported the impact to patients, for example not being able to maintain adequate repositioning regimes and skin checks, delays in being able to administer pain relief and delays in providing personal care. This was because the systems for rostering staff on duty were not always as up-to-date as they should have been.

We saw elements of good practice including infection prevention and control, the safe management of medicines and patient records.

Dedicated end of life care champions were in place on the majority of wards although protected study time and time to teach others was not available to them.

Incidents

- Incidents were reported through the trust's electronic reporting system. All staff we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. Incidents relating to Hayward House were monitored by the leads for palliative and end of life care

through the Hayward House Quality, Risk and Safety Meetings. Incidents relating to end of life care throughout the trust were not discussed at these meetings.

- Between May 2014 and April 2015, two serious incidents relating to end of life care were reported at this hospital. These both related to pressure ulcers.
- Porters told us that in the event of an adverse incident occurring while transferring a patient to the mortuary they would contact a member of the mortuary staff.
- When a serious incident occurred we saw that learning took place. For example a project was set up and led by a ward sister at Hayward House following a high incidence of incidents related to falls. An independent falls expert was invited to scrutinise the environment and the day to day culture of nursing practice on the ward at Hayward House. This identified that although documentation was good, there was a lack of focus on patients who were at high risk of falling. Following the independent review, steps were taken to reduce the risk of falls on the ward. Two cohort bays were set up and a cohort nurse was allocated to each bay. [A cohort bay is where patients with similar risks, for example those at risk of falling are nursed in the same bay]. A member of staff was required to supervise the bay at all times.
- The cohort nurse wore a brightly coloured tabard to reduce the risk of interruptions and diversions. A colour theme was introduced to make it easier for patients to find their way around and equipment that had previously stored in corridors was removed. A six month review in June 2015 showed these changes had led to a 43% reduction in total falls, a 38% reduction in unwitnessed falls and a 67% reduction in repeated falls.
- Staff at Hayward House told us the porters were not always understanding or responsive when a patient needed transferring to the mortuary. It was sometimes hours before portering staff came to collect the deceased person. Sometimes porters would say they could not undertake the transfer at all. We saw reference to this in some minutes taken at Hayward House team meeting on 13 July 2015. Under these circumstances staff had to call a local undertaker to continue with the transfer. Staff had been asked to complete an incident report when this had happened. Information provided by the trust did not include any incidents relating to the transfer of deceased patients to the mortuary.
- The Duty of Candour regulation came into force in November 2014. It requires providers to be open and transparent with patients and sets out specific requirements that providers must follow when things go wrong with care and treatment. Senior staff were able to tell us that duty of candour referred to being open and honest but they had not received any training in relation to duty of candour.

Safety thermometer

- The NHS safety thermometer is a national initiative, with a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. It provides a monthly snapshot audit of avoidable harm that includes falls, new pressure ulcers, catheter related urinary tract infections (CUTI) and venous thromboembolisms (VTE) – these were monitored on a monthly basis at Hayward House. Between September 2014 and September 2015 Hayward House reported 32 pressure ulcers, one catheter related urinary tract infection, three new venous thromboembolisms and no falls.

Cleanliness, infection control and hygiene

- Patients receiving palliative and end of life care were cared for at Hayward House and on many of the wards throughout the City Hospital. Hayward House and the wards we inspected were visibly clean. We saw that hand washing facilities were available and that liquid soap and hand towel dispensers were adequately stocked. We observed staff following hand hygiene practice and 'bare below elbows' guidance.
- Infection control was monitored through the trust's nursing metrics. Information provided by the trust showed that between January 2015 and June 2015, Hayward House was 100% compliant for infection prevention and control.
- The trust had a policy for dealing with the body of a patient who had or was suspected of having an infectious disease.
- Nurses and porters followed correct procedures to ensure they were protected from the risk of infection when having contact with the deceased patient's body.

This included the use of personal protective equipment (PPE) by staff when dealing with the body and the use of a body bag for the movement and storage of the deceased patient.

- Staff who worked in the mortuary were aware of procedures for the prevention and control of infection, such as the management of clinical waste and environmental cleanliness.
- Mortuary staff had sufficient access to personal protective equipment (PPE) and there was adequate access to hand washing facilities.
- The mortuary had facilities to store the bodies of deceased patients who were deemed to be a high risk in relation to infection control and therefore required isolation.
- The mortuary was visibly clean; and we saw cleanliness audits took place on a bi-monthly basis. This meant that cleanliness within the mortuary was being monitored and where action was required clear directions had been given.

Environment and equipment

- There was sufficient equipment available to meet the needs of people receiving end of life care at Hayward House and on all of the wards we visited.
- The trust used syringe drivers for patients who required a continuous infusion to control their symptoms and these met the current NHS Patient Safety guidance. This meant that patients were protected from harm when a syringe driver was used to administer a continuous infusion of medication because the syringe drivers used were tamperproof and had the recommended alarm features. We reviewed the records of the last three services of four syringe drivers. In two cases, the servicing of the driver has not taken place within the required 12 month timeframe. We were told this was likely due to the driver being used in the community and not returned to the hospital within a timeframe that allowed an annual service to take place. The hospital had started to record when a driver had been issued to a patient; however these records only went back to the beginning of 2015. This meant it was not possible to see if the drivers had been in use or in the community at the time it should have received an annual service. As a result of these findings, we reviewed the service records of another four syringe drivers that had recently been issued to patients to verify if they had been serviced within the previous 12 months. In all four cases, the drivers were serviced within the previous 12 months. This meant appropriate action was taken to ensure syringe drivers remained safe to use.
- Equipment and facilities were fit for purpose. We looked at equipment used for resuscitation and found it to be visibly clean. Single-use items were sealed and in date, and emergency equipment was dated to indicate it had been serviced. We saw records showing equipment was checked daily by staff. This meant the equipment was safe and ready for use if required in an emergency.

Medicines

- The National Care of the Dying Audit 2014 showed the trust was in line with the England average for prescribing medication for the five key symptoms [pain, excessive respiratory secretions, breathlessness, nausea and vomiting, and agitation] at the end of life.
- We asked the trust for their standard operating procedure for anticipatory medicines (anticipatory medicines are medicines that are prescribed in case they are required) at the end of life. The trust did not provide this information. We could therefore not be assured the trust had a standard operating procedure for anticipatory prescribing. The trust had pre-printed end of life care medication administration charts for patients who required anticipatory medicines.
- Medicines were stored safely at Hayward House. We saw records showing staff had monitored and recorded the medicines fridge temperature every day.
- We reviewed the storage and administration of controlled drugs. [Controlled drugs are prescription medicines controlled under the Misuse of Drugs legislation, these require special storage arrangements]. We found them to be stored appropriately and records were accurately completed.

Records

- Information governance training for staff was included in the trust's mandatory training programme.
- Patient records were stored securely to minimise the risk of unauthorised access.

End of life care

- Records were paper based and records such as fluid balance charts, care plans and risk assessments were kept by each patient's bed space and so were easily accessible to staff.
- We reviewed the medical and nursing records for 14 patients who were receiving end of life care and were identified as being in the last days of their life. These records were mostly complete, accurate, legible and up-to-date. However, we saw isolated incidents where care interventions had taken place but records were not accurately completed. For example when patients were assisted to reposition or when a patient had received intravenous fluids (fluids administered directly into a vein). On one ward we saw a patient was receiving intravenous fluids and their documentation had not been completed for three hours.
- Although we saw patients received mouth care where this was required, there was nowhere to document that mouth care had taken place. We spoke with a nurse on Berman 1 ward about this and they told us they would document mouth care on the patient's fluid balance chart, but was aware that not all nurses did this. This meant that staff would not be certain when mouth care was last offered to patients or whether patients had received mouth care.
- Locked confidential waste bins were available to dispose of confidential records.

Safeguarding

- Nursing staff we spoke with had an understanding of how to protect patients from abuse. We spoke with staff who could describe what safeguarding was and the process to refer concerns. None of the staff we spoke with were able to recall any recent safeguarding incidents relating to end of life care.

Mandatory training

- End of life training was not included in the trust's mandatory training programme. However, specialist nurses raised an awareness of end of life care to all newly appointed staff and discussed how to contact the specialist nurses team when required.
- Nursing and medical staff we spoke with at Hayward House reported having good access to mandatory training. Mandatory training included safeguarding, infection control, resuscitation, moving and handling, health and safety and information governance.
- Portering staff were not employed by the trust. The head porter confirmed that all porters received training in manual handling and transporting deceased patients from Hayward House and the hospital's wards to the mortuary. Additional training was planned for porter team leaders regarding the placing of deceased patients into the mortuary fridges. This training would then be cascaded to other portering staff.

Assessing and responding to patient risk

- Nursing and medical handovers occurred at every shift change, during which staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients.
- Risk assessments for patients for venous thromboembolism (VTE), pressure ulcers and falls were undertaken appropriately and were reviewed at the required frequency. Risk assessments identified required actions to minimise any potential risk to patients.
- Patients who were identified at high risk of falling were included on a high risk care checklist. This required nurses to check patients for changes in condition every two hours. Patients who were at high risk of falling were also cared for in a cohort bay where a member of staff was required to supervise the bay at all times.
- On admission to the wards, all patients were assessed for their risk of developing pressure ulcers. This was done using a nationally recognised risk assessment tool. Where patients had understanding, they were given leaflets which explained about pressure ulcers and how they could be avoided. In addition, each ward had a tissue viability link nurse who was responsible for checked that risk assessments were completed and acted upon.
- All of the wards we visited used an electronic system to monitor patients' physiological observations, for example patients' temperature, blood pressure, pulse rate, respiratory rate and pain score. Each member of staff had a hand held electronic device to record the

observations. Each observation was given a score and this was used to calculate an early warning score which gave an indication of whether a patient was deteriorating. The system tracked the observations and triggered an alert to doctors and the critical care outreach team when there were significant changes in a patient's observations. The electronic system also gave the ward sisters an overview of all the patients on their ward. This enabled them to check that appropriate action was being taken should a patient's condition deteriorate. This system however was not used at Hayward House. Staff used an early warning system to record physiological observations which were recorded on a paper chart rather than a hand held device. This placed responsibility on nursing staff to alert medical staff if a patient's condition was deteriorating. We saw that medical staff were appropriately alerted when a patient's condition deteriorated and nursing staff demonstrated a good understanding of the circumstances under which medical staff might need to be alerted.

Nursing staffing

- Specialist palliative and end of life care was provided at Hayward House, on the grounds of the City Hospital site. Patients receiving end of life care were also cared for by general nursing staff throughout the trust.
- There were 7.8 full time equivalent specialist palliative care nurses who provided support to the wards at Nottingham University Hospital NHS Trust. The specialist palliative care nurses were employed by the trust.
- The planned staffing level for the inpatient area of Hayward House was five nurses and three healthcare assistants (HCA) during each morning shift. This went down to four nurses and three HCAs for the afternoon shift and three nurses and one or two HCAs for the night shift. One of the sisters at Hayward House told us that staffing levels were increased if required to meet patients' needs.
- There were staff vacancies at Hayward House for two nurses and four HCA. We were told recruitment was underway to fill these vacancies.
- Following our inspection visit, we received concerning information about the lack of a robust system to manage the staff rota at Hayward House. The staff rota was stored electronically but there were also paper versions and we were told none of them ever tallied. This had led to situations where there were not enough staff on duty. In light of this information, we included Hayward House as part of our unannounced inspection visit. We scrutinised the staff rota and found that staff were not always able to make changes to the electronic version, for example, if a member of staff was off sick. Staff could change the paper version but these changes were not always noted or acted on.
- We found that between April 2015 and August 2015 there were 11 reported incidents where the number of staff on duty at Hayward House did not meet the planned staffing level. One of these incident reports included information about three separate occasions when staffing was not adequate to provide safe care for patients. The incidents mostly related to staffing levels at night where shortages were reported to senior level staff in the daytime but shifts were not filled. Eight of these incidents identified that staff were not booked to provide supervision for those patients who required one to one support or who were supported in a cohort bay. Many of the incidents indicated senior staff were alerted to the staff shortage but no action was taken. The incidents reported the impact to patients, for example not being able to maintain adequate repositioning regimes and skin checks, delays in being able to administer pain relief and delays in providing personal care.
- Staff at Hayward House told us they were often moved to work on ward areas where there were shortfalls in staffing levels at the City Hospital site. This had happened the morning of our unannounced visit; however, staffing levels on the unit were still appropriate for the dependency of the patients.

Medical staffing

- There were 0.9 full time equivalent consultants in the SPCT who provided support to the wards at Queen's Medical Centre and City Hospital. An on call palliative care consultant provided telephone support out of hours.
- The Commissioning Guidance for Specialist Palliative Care recommends one whole time equivalent (WTE)

consultant for every 250 beds. There were 1,793 general and acute beds in total at Queen's Medical Centre and City Hospital and therefore the trust provision did not meet recommended guidance.

- Patient care, including patients receiving end of life care, was managed by a consultant in the specialty most relevant to the patient's condition.

Major incident awareness and training

- The trust had a major incident plan in place which included plans to increase storage capacity within the hospital's mortuary should it be required. Initially, all available mortuary storage capacity within the trust would be used across both the City Hospital and Queen's Medical Centre sites. If further storage was required, the trust had planned to use temporary storage units which would be brought on to the Queens Medical Campus site. Mortuary staff were familiar with the use of such temporary storage unit provision since it had been used in previous winters during periods of high demand for mortuary storage.

Are end of life care services effective?

Requires improvement

We judged the effectiveness of end of life care services required improvement.

In response to the 2013 review and withdrawal of the Liverpool Care Pathway (LCP). The trust had developed an individualised end of life care bundle. Evidence based assessment, care and treatment was mostly delivered in line with national guidance and the National Institute for Health and Care Excellence (NICE) quality standards and local guidelines were in place and followed for the effective management of the five key symptoms at the end of life. However, patients were unable to access a seven day face-to-face service from specialist palliative care staff in accordance with National Institute for Health and Care Excellence guidance (NICE). The specialist palliative care team attempted to see all referred patients regardless of diagnosis within 24 hours but owing to the lack of seven day cover this was not always possible.

The trust used the essence of care benchmarking tool to benchmark end of life care across the trust. There were 12 benchmarks and clinical teams scored each of the benchmarks to give an overall score of gold, green, amber or red, depending on how many of the indicators of best practice were achieved. Across the trust 79 areas submitted scores and the results of the 2014 benchmarking scores showed 44 (56%) areas scored gold, 29 (38%) areas scored green and six (6%) areas scored red. This meant 94% of areas scored green or gold. This was an improvement on the 2012 scores where approximately 68% of areas scored green or gold.

Do Not Attempt Cardio-Respiratory Resuscitation decisions (DNACPR), were not always written in line with the trust's policy. An audit of DNA CPR forms was completed but there were no recommendations or actions from the findings of the audit. We were therefore not assured that sufficient steps were taken to make further improvement in the completion of DNA CPR forms.

Evidence-based care and treatment

- Between January and December 2014 there were a total number of 3,344 deaths at the trust.
- Information provided by the trust indicated that between April 2013 and March 2014, 1,387 patients across the trust were referred to the specialist palliative care team; of these patients 18% had a diagnosis other than cancer. Between April 2014 and March 2015, 1,472 patients were referred. Of these patients, 1135 had a diagnosis of cancer, while 294 had a diagnosis other than cancer. 41 of these patients did not have a recorded diagnosis. Although there was a slight improvement in the referral rate of patients who did not have cancer, this meant that patients who had a diagnosis other than cancer were less likely to be referred to the specialist palliative care team if they required support. However, referral was always an option for those patients who had symptoms that were difficult to control.
- The trust had participated in the National Care of the Dying Audit 2014 and had performed better than the England average for nine out of the 10 clinical indicators but had not achieved five out of the seven organisational indicators including continued education, training and audit, trust board

representation and planning for care of the dying. A report submitted to the Quality Assurance Committee in October 2014 indicated they were now compliant with four out of the five indicators they had not achieved.

- The trust used the essence of care benchmarking tool to benchmark end of life care across the trust. The benchmark was not scored in 2013 due to changes required following the national withdrawal of the Liverpool Care Pathway (LCP). 79 areas across the trust submitted scores and the results of the 2014 benchmarking scores showed 44 (56%) areas scored gold, 29 (38%) areas scored green and six (6%) areas scored red. This meant 94% of areas scored green or gold. This was an improvement on the 2012 scores where approximately 68% of areas scored green or gold.
- The trust had responded to the national recommendations of the LCP review in 2013 by discontinuing the use of the LCP. Following the withdrawal of the LCP the end of life care group had developed an individualised end of life care plan. Staff piloted this at Hayward House and it was rolled out across the trust in September 2014.
- Patient needs were assessed, and care and treatment was delivered in line with National Institute for Health and Care Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness.
- A review of six sets of patient records showed symptom control for end of life patients was managed in accordance with the relevant NICE Quality Standard. The Quality Standards outline best practice for safe and effective prescribing of strong pain medication in end of life care of adults.
- End of life care at this trust mostly followed the National Institute for Health and Care Excellence (NICE) Quality Standards relating to best practice in end of life care for adults. However, the trust did not comply with Statement 10 of those standards: People approaching the end of life that may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night. The trust was aware of the requirement to provide a specialist hospital palliative care team seven days a week but had not developed an action plan to enable them to achieve this standard.
- The specialist palliative care team attempted to see all referred patients regardless of diagnosis within 24 hours but owing to the lack of seven day cover this was not always possible.
- The staff we spoke with confirmed most patients they referred to the specialist team were seen in a timely manner, although this was not possible over the weekend or at night.
- There were good relationships between ward staff and the specialist palliative care team, although patients with a diagnosis other than cancer were not always identified as requiring specialist input at the end of life.

Pain relief

- Results from the National Care of the Dying Audit 2014 showed the trust had achieved the organisational key performance indicator relating to the prescription of medication for the five key symptoms at the end of life, (62% compared to the England average of 51%).
- Assessment and care planning for the control of pain formed part of the nursing metrics, [nursing metrics are a way of measuring the quality a service is providing. They look at many aspects of nursing including infection prevention and control, nutrition, patient observations and pain]. The metrics focussed on the assessment of pain and delivery of pain control. The nursing metrics for Hayward House were undertaken on a monthly basis. Between January 2015 and May 2015 the metric for the completion of pain assessment averaged at 95%.
- Pain assessment tools were used to assess patients' levels of pain. Nurses we spoke with were clear about how to assess for changes to a patient's condition and what medication would be required.
- Patients we spoke with were asked about their pain and given pain relief where appropriate at regular intervals. All staff we spoke with were pro-active in managing patients' pain. We reviewed the nursing records for four patients in the last days of life and saw where pain assessments were included in the end of life care bundle.

End of life care

- The end of life care bundle contained a guide for medical and nursing staff for pain management. Additional support could be gained from the specialist palliative care team. This aimed to minimise delays in responding to patients symptoms as they occurred.

Nutrition and hydration

- Patients we spoke with were satisfied with the quality and choice of food available to them. The food menu offered choice and food could be adapted to meet the needs of individuals who had special requirements, for example if they required a soft diet. The menu also offered food choices to meet people's cultural and religious needs.
- Patients had access to drinks and we saw they were able to reach them when they wanted to. Drinks were replenished throughout the day.
- The results of the National Care of the Dying Audit 2014 indicated the trust performed better than the England average for reviewing patients' nutritional and hydration requirements.
- We reviewed four sets of nursing records for patients in the last days of life. We saw patients were screened for malnutrition and the risk of malnutrition on admission to hospital using the malnutrition universal screening tool (MUST).
- Where necessary, a food diary was kept for each patient. This allowed staff to assess whether patients required a referral to the dietitian and enabled nursing staff to update family on their relative's food intake.
- A colour-coded tray and water jug system was used on all medical and care of elderly wards to identify patients who needed help with eating and drinking. Patients who were nutritionally at risk or required support with eating had their meals served on a red tray. Patients who were at risk of dehydration or required support with drinking had their water in a red water jug. This meant staff could easily identify these patients and offer assistance as it was required.

Patient outcomes

- The specialist palliative care team contributed data about palliative and end of life care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services within the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set.
- The trust had participated in the National Care of the Dying Audit 2014 and had performed better than the England average for nine out of the 10 clinical indicators. The trust scored particularly well for the assessment of the spiritual needs of the patient and their nominated relatives or friends (77% against the England average of 37%) and multidisciplinary recognition that the patient is dying (81% compared to the England average of 61%). The trust however did not achieve the key performance indicator (KPI) score for five out of the seven organisational indicators. A report submitted to the Quality Assurance Committee in October 2014 indicated they had reviewed the KPIs and were now compliant with four out of the five indicators they had not achieved.
- Trust wide between April 2013 and March 2014, 1387 referrals were made to the specialist palliative care team. 1137 of these were cancer related and 250 were non cancer related. Between April 2014 and March 2015, 1432 referrals were made to the specialist palliative care team, 1432 were cancer related and 360 were non cancer related. This meant that patients who had a diagnosis other than cancer were less likely to be referred to the SPCT if they required support.

Competent staff

- Information provided from the trust indicated that medical staff working in palliative care did not receive an annual appraisal and that between April 2014 and March 2015 86% of nursing staff received an annual appraisal against the trust's target of 95%. This figure had improved on the previous year where between April 2013 and March 2014 only 39% of nursing staff working in palliative care had received an annual appraisal.
- Most nursing staff we spoke with told us they had received training to enable them to safely administer

medication using a syringe driver. Training records received from the trust showed 92% of staff had been trained on the use of syringe drivers, which was above the trust's training target of 75%

- End of life training was not included in staff mandatory training, although we saw newly qualified nursing staff received a two hour session relating to end of life care during their introduction as part of the trust's seven day acute care skills foundation programme. The programme also included an introduction to pain management. A total of 177 nurses had completed the training since the course commenced in October 2013. Of those 177, 66 had undertaken the course from January to July 2015.
- The leads for the specialist palliative care team told us all new staff starting at the trust received some training on end of life care. Information provided by the trust gave a breakdown of teaching sessions delivered by the specialist palliative care team, but this only highlighted the groups of professionals that had received training, for example there were health care assistant sessions, student nurse sessions and acute skills sessions.
- The trust only kept estimated numbers of staff who attended end of life care training sessions because registers of attendance were not maintained. We were therefore unable to check if a formalised end of life care training programme existed in the trust.
- Role modelling in the form of shadowing was offered by the specialist palliative care team to members of staff throughout the trust. Information provided by the team showed there were 50 episodes of shadowing and 18 episodes that included medical students in 2013 / 14.
- There was a dedicated end of life care champion on each ward. The end of life care champions ranged from band two health care assistants to band seven nurses. End of life care champions were responsible for cascading end of life care training and raising the profile of end of life care within their clinical area. This included ensuring staff were familiar with the end of life care bundle and were using this appropriately. End of life care champions attended quarterly meetings at Hayward House and cascaded information from the meetings back to their clinical area. The role of end of life care champion was not one of the identified four core trust wide link roles. This meant the end of life care champions did not receive the same protected time to attend additional training days and keep their knowledge up-to-date as their other link role colleagues.

Multidisciplinary working

- The specialist palliative care team worked in a collaborative and multi-disciplinary manner. This was particularly noticeable at Hayward House. They shared information efficiently and were proactive in meeting people's needs. We saw that multidisciplinary team meetings took place on a weekly basis and that all communication was written and shared within patient records. There was a sticker which prompted staff to ensure all core aspects were considered throughout the meeting.
- We observed a multidisciplinary team meeting where each member of the team had the opportunity to speak and contribute to patients' treatment plans. The meeting included input from nurses, specialist palliative care doctors, chaplains, complementary therapy practitioners a GP and two doctors from the wards at the City Hospital. All disciplines we spoke with felt well respected and listened to by the team.
- Each ward had their own multidisciplinary team (MDT) meetings for their own specialities. End of life care was discussed at these meetings. Board rounds took place on a daily basis and patients who required a fast track discharge were also discussed.
- Staff at Hayward House told us that access to physiotherapy services for patients receiving day therapy services depended on which Clinical Commissioning Group (CCG) had commissioned the service. Patients who fell under the County CCG could access physiotherapy via the trust but patients who fell under the City CCG could not. This meant not all patients had equal access to physiotherapists.

Seven-day services

- Staff at Hayward House provided a 24 hour seven day service for patients admitted for palliative and end of life care.

End of life care

- The specialist palliative care nurses were available from 8am to 4pm Monday to Friday. The palliative care consultants were available to provide face to face support Monday to Friday and provided 24 hour telephone support seven days a week.
- Physiotherapy services were on-call out of hours and at weekends for the City Hospital. Nursing staff told us physiotherapists would come in to see patients who required acute treatment, for example chest physiotherapy.
- Day therapy was available between the hours of 10am and 3pm, four days a week at Hayward House.
- The mortuary provided a 24 hour service seven days a week to the City Hospital and to Hayward House.
- The bereavement office at the City Hospital was open between the hours of 10am and 4pm Monday to Friday, except bank holidays.

Access to information

- Information needed to deliver effective care and treatment was available to all staff in a timely and accessible way. For example, each ward had an end of life resource box, end of life care bundles were set up and there was good access to the specialist palliative care team.
- The trust had access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- Information relating to Hayward House and the palliative care services provided there was available on the trust's web site. There was an information booklet for patients and their carers on the website. We noticed the booklet referred to Hayward House as a specialist palliative cancer care unit. However, when we spoke with staff at Hayward House they confirmed they provided specialist palliative care for patients who had other conditions too. The information from the booklet could therefore be misleading as some people may believe they have to have a diagnosis of cancer to receive care and treatment there.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed 14 sets of medical and nursing records of patients receiving palliative care or in the last days of life. We saw consent to care and treatment was mostly obtained in line with legislation and guidance, including the Mental Capacity Act 2005 (MCA) and patients were supported to make decisions. [The MCA is a framework and a safeguard for anyone who is unable to make decisions for themselves to ensure they are at the heart of decision making when decisions are being made on their behalf].
- We saw the records for one patient who staff had assessed for capacity to make decisions. The first part of the assessment was completed which indicated the patient lacked capacity to make an informed decision. However, the second part of the assessment, which looked at the extent of the person's ability to make a decision, was not completed. This meant a full mental capacity assessment was not undertaken for this patient. We raised this with the senior nurse on the ward who told us they would seek further clarification.
- During our inspection we reviewed 14 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Our review showed 10 out of 14 DNACPR forms were completed by a registrar but were not signed by a consultant as required. Otherwise, the forms were correctly completed. Mental capacity assessments were undertaken where required and we saw where discussions had taken place with patients and their families. When a DNACPR form indicated discussions had not taken place it was clearly recorded that patients had opted not to enter into discussion about their prognosis and future decisions. DNACPR forms were filed at the front of the notes, allowing easy access in an emergency.
- There was a trust wide audit of 121 DNACPR forms dated January to April 2015. The data showed 73% had a documented summary of communication with the patient and 88% of relatives or friends had been involved in the DNACPR decision. 57% of the DNACPR forms were written out of normal working hours and 59% were reviewed and endorsed by the most senior health care professional. Of the 121 DNACPR forms, only 1.7% had a review date completed. 59% of the forms were completed under the speciality of acute medicine and 27% of the forms did not specify a speciality. There

were no recommendations or planned actions from the findings stated in the report. We were therefore not assured that sufficient steps were taken to make further improvement in the completion of DNACPR forms.

Are end of life care services caring?

Good

We judged the care provided to patients and relatives using this service as good.

Patients and their relatives were treated with compassion, dignity and respect. They were involved in discussions about their care and kept informed by staff. There were facilities for relatives to stay and visiting hours were flexible for those visiting patients who were receiving end of life care.

At Haywood House staff offered holistic therapies to patients and carers, with the aim of promoting relaxation and a sense of wellbeing.

Compassionate care

- The trust had participated in the National Care of the Dying Audit in May 2014. The results showed that the trust was identified as better than the national average in relation to the provision of care that promoted patient privacy, dignity and respect, before and after the death of the patient
- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Medical and nursing staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner.
- Staff offered holistic therapies to patients and carers, with the aim of promoting relaxation and a sense of wellbeing. Referrals were made by consultants at Hayward House, day care staff, Hayward House inpatient staff and community Macmillan nurses. Therapies were provided either in the purpose-built therapy unit or at the patient's bedside. Therapies offered included massage, aromatherapy, reflexology, hypnotherapy, Reiki and Indian head massage.
- Mortuary and bereavement staff described how they prepared and supported relatives before taking them to the viewing room to see their loved one.
- Portering staff saw end of life care as an important part of their role. They told us they recognised the importance of treating the deceased person with dignity and respect.
- The bereavement service supported the hospital to provide a sensitive and specialised service when a patient died. The bereavement service were involved in the immediate period following death and provided practical help and information to deceased relatives.
- Visiting hours were relaxed for visitors of patients identified as being at the end of their life. This ensured family and friends could spend unlimited time with their loved one.
- The trust did not undertake bereavement surveys to capture the experiences of people who had gone through the bereavement process with the trust.

Understanding and involvement of patients and those close to them

- The results of the National Care of the Dying Audit 2014 showed the trust was slightly better than the England average for staff discussions with both the patient and their relatives/friends regarding their recognition the patient was dying. The survey also identified the trust as being better than the England average for communication regarding the patient's plan of care during the dying phase.
- One patient we spoke with told us about their wishes for their end of life care. The patient was fully involved in decisions about their care. The patient had decided they wanted to go home and then return to the ward for the final days of their life. The patient said they did not want their grandchildren to see them die and they felt safe on the ward. This was documented in the patient's notes and we later learned the patient had died on the ward. This meant staff took opportunities to ensure patients and those close to them had choices at the end of their life.
- All of the patients and those close to them were supportive of the care and treatment they had received.

End of life care

- We spoke with a patient on one ward who told us they had been referred to the SPCT and had been given the opportunity to discuss where they wished to die. The patient had expressed a wish to go home but wanted to come back to the ward to die. The patient told us although they were given an option to go to Hayward House, they had declined because they knew the staff on the ward and the staff knew them. The patient wanted to be in an environment that was familiar to them. We spoke with staff about this patient and the plans were in place to ensure the patient's wishes were fulfilled.

Emotional support

- The National Care Of the Dying Audit 2014 results showed the trust was significantly above the national average in relation to the spiritual needs of the patient and their nominated relatives or friends.
- Staff at Hayward House developed trusting relationships with patients and their relatives by working in an open, honest and supportive way. Throughout our inspection, we saw that staff were responsive to the emotional needs of patients and their relatives.
- The specialist palliative care team had received training to enable them to have difficult discussions with patients and their families.
- Staff at ward level provided emotional support in addition to the specialist nurses. The trust also had chaplaincy service that could provide support for people of all faiths. We spoke with two relatives and three patients about emotional support. All the people we spoke with told us they felt emotionally supported by all the staff involved in their care.
- The chaplaincy worked closely with the specialist palliative care team and would attend, as necessary, with the team to see patients when there was a need to break bad news.
- Although not licensed to conduct weddings for end of life care patients, the chaplaincy team were able to facilitate this with a community registrar within four hours of a referral for an end of life care patient.
- The team used volunteers to escort patients to religious services in the hospital or sit with patients receiving end of life care as required.
- The chaplaincy worked with local faith leaders to ensure deceased patients were cared for in accordance with their cultural and religious requirements.
- The viewing of deceased patients was undertaken by appointment in a dedicated room just off the mortuary. The room was neutral of religion and people were afforded privacy to pay their respects to their loved ones.
- Debriefing sessions were held for staff at Hayward House if a death had been traumatic or had affected staff. Staff also had access to free counselling services through the trust.
- The trust had a chaplaincy service that was available for patients and their families or carers to use. There was a chapel within the City Hospital. The chaplain could access ministers and leaders from other faiths as they were required. There were separate dedicated prayer rooms for Muslim men and women.
- In the multidisciplinary team meeting we saw where a patient was referred to the chaplaincy team and another was referred to a counsellor. We saw three relatives were referred to day therapy for complementary therapy services.

Are end of life care services responsive?

Good

We judged the responsiveness of end of life care services as good.

People's needs were mostly met through the delivery and organisation of end of life care throughout Hayward House and the City Hospital.

The trust had dedicated beds for patients receiving palliative and end of life care. Out of hours telephone support was available, however the trust had yet to develop a 24 hour, seven day a week face to face end of life care service.

The needs and preferences of patients were central to the planning and delivery of care at Hayward House and most

people here achieved their preferred place of death. The wider trust however did not undertake audits to establish whether patients on ward areas achieved their preferred place of care or death.

The trust had discharge coordinators who had the ability to fast track patients; however, we were unable to establish whether patients were fast tracked in a timely manner because the trust had not monitored this.

Service planning and delivery to meet the needs of local people

- There were designated beds for patients receiving palliative care. Hayward House provided 20 specialist palliative care beds, four of which were single occupancy rooms. In addition to this, day therapy facilities were available.
- Patients with more complex needs who required regular daily specialist input could be transferred to Hayward House. However, there was sometimes a waiting list for admission which meant those patients were supported on general wards.
- Patients supported on the general wards at City Hospital could also be referred to the specialist palliative care team for symptom control or if their needs were complex. Patients known to the specialist team were visited as often as was required; this varied between every two or three days and those requiring input on a daily basis.
- In addition to bays, each ward at City Hospital had single rooms, and patients approaching the end of their life were given the opportunity to be nursed in a side room if one was available. However, if the patients wish was to be nursed in a bay this would also be accommodated.
- Patients were cared for and treated on specialist wards at City Hospital if they needed specific treatment, for example radiotherapy.
- At Hayward House we saw posters to inform and actively encourage relatives and carers to attend (with the patient's consent) consultant ward rounds.
- The trust did not audit information relating to the number of patients dying in their preferred location. However, the specialist palliative care team monitored patients preferred place of death for patients who were referred to them. These were reported each month through the Hayward House quality, risk and safety meetings.
- We spoke with a discharge coordinator at City Hospital as they were reviewing a patient for fast track discharge. They told us there were often problems achieving a timely discharge for patients at the end of their life. This was usually because of difficulties organising care for those who wished to die at home.
- The relatives or carers of those who were receiving end of life care could have free car parking at the hospital.
- The body storage fridges in the mortuary were segregated and provided dedicated storage areas for adult and child deceased patients. The City Hospital mortuary did not routinely receive bodies from the community, as these were usually taken straight to the mortuary at the Queen's Medical Centre. The mortuary also included storage facilities for deceased bariatric (heavier) patients. Deceased patients who could not be accommodated in the storage fridges at the City Hospital because of their size were transferred to the Queen's Medical Centre. This had a designated body storage area where larger people were accommodated on beds within the cold room.

Meeting people's individual needs

- Patients had their individual needs assessed by medical and nursing staff and, where required, other members of the multidisciplinary team. We saw where patients had input from the specialist palliative care team.
- The needs and preferences of patients and their relatives were central to the planning and delivery of care at Hayward House. The regime at Hayward House was flexible, providing choice and ensuring continuity of care.
- An 'About Me' document was used on the wards for patients who were cognitively impaired, for example if they were living with dementia or a learning disability. The aim of the 'About me' document was to capture essential information about the patient to ensure person-centred care was provided. This was completed by the patient's family or carer as soon after admission as possible. It included information about the person's life history; their likes, dislikes, hobbies and interests.

However, this document was not routinely used for patients who were receiving end of life care. The document could be useful for staff caring for patients who had lost the ability to communicate as they reached the end of their life.

- Staff told us they could access interpreter services. Staff could use a telephone or face to face service for patients who required an interpreter. Staff told us it was easy to obtain an interpreter when needed. Some staff spoke other languages and were able to interpret for patients. Patients who needed a British Sign Language interpreter were required to let staff at the trust know. Staff knew they could access this service but told us they had never needed to.
- Leaflets and posters were all written in English, but staff told us they could order leaflets in different languages if they were required. Bereavement packs included written information for bereaved family and friends and were available through the bereavement service. Staff informed us this information could be translated for people whose first language was not English.
- Patients were discussed at the weekly multidisciplinary team meetings where clinical staff from differing specialties reviewed their treatment and care needs. The trust had participated in the National Care of the Dying Audit 2014. The results showed the trust was better than the England average in relation to multi-disciplinary recognition that the patient is dying. The trust scored 81% and the England average was 61%.
- There were arrangements to ensure patients were cared for in single sex facilities and had access to single sex washing and toilet facilities.

Access and flow

- Patients were admitted to Hayward House from home or transferred from hospital. Admissions could occur seven days a week.
- Referral for admission was through the patient's GP if the patient was at home. If the patient was an inpatient at the Queen's Medical Centre or City Hospital referral was through the specialist palliative care team with the approval of the patient's consultant. Admission to Hayward House was determined by the patient's needs, and the needs of their family and carers.
- Bed occupancy at Hayward House was between 88% and 98% from January to May 2015. It is generally accepted that occupancy rates above 85% may affect the quality of care provided to patients.
- The trust had a discharge and transfer policy that included a fast track pathway for patients who were receiving end of life care. The aim of the fast track pathway was to allow a rapid transfer for patients in the last days of life who wished to be at home or in a nursing home. Patients were assessed by a fast track coordinator who assessed their care needs and coordinated the transfer for end of life care in the patient's chosen place. The information did not specify the timescales for completion of the discharge. A fast track coordinator told us they tried to transfer patients as quickly as possible, but this was sometimes difficult because the care and support needed by the patient were not available.
- Nursing staff told us fast track discharges usually took up to 48 hours to arrange but in some cases could take longer. The trust had audited fast track discharges in 2013-14 but did not share the outcome of the audit with us. We were therefore unable to identify if the trust had addressed any potential delays. However, at Hayward House fast track discharges were audited and we saw any delays were discussed and addressed at quality, risk and safety meetings.

Learning from complaints and concerns

- The trust had an up-to-date management of complaints, concerns, comments and compliments (4C's) policy. This set out the responsibilities of staff at all levels who handled concerns and complaints throughout the trust. The policy also set out the procedure for staff to follow to respond to the 4C's
- We saw posters explaining how to make a complaint within the ward areas throughout the trust. Patients and those close to them could give feedback using comment cards provided.
- Staff told us there were very few complaints relating to end of life care throughout the trust. Information from the trust showed there were two complaints relating to end of life care at Hayward House between 1 July 2014 and 30 June 2015. Following investigation, one was partially upheld and one was not upheld.

End of life care

Are end of life care services well-led?

Requires improvement

The leadership of this service required improvement.

There was clear leadership for specialist palliative care services and for Hayward House. However, there was a lack of visibility of the leadership for the wider end of life care provision across the trust.

Although there was a specialist palliative care annual plan for 2015/16, there was no written vision or strategy for end of life care or for palliative care. End of life care did not feature on the agenda of the trust board meetings.

There was a risk register for Hayward House and risks were discussed and reviewed at Hayward House quality, risk and safety meetings. Quality, risks and performance in palliative and end of life care were monitored through the clinical effectiveness committee.

All the staff we spoke with felt their line managers and senior managers were approachable and supportive. They reported good access to the specialist palliative care team and demonstrated a good awareness of developments within the service. The staff we spoke with were all aware of the specialist palliative care nursing team available to them as well as knowledge of the out-of-hours help they could access from Haywood House when required. Staff gave examples of various support mechanisms available to deliver good end of life care, including the chaplaincy team and the bereavement office.

Vision and strategy for this service

- There was no written vision or strategy for end of life care across the trust. The trust lead for end of life care said their vision for end of life care followed the trust's strategy for palliative care and National Institute for Health and Care Excellence (NICE) guidance. However, there was no written evidence to support this.
- Staff we spoke with were unaware of a vision or strategy for end of life services in the trust. However, they were able to demonstrate their commitment to ensuring patients and their relatives received the care and treatment they required.
- The trust had a specialist palliative care annual plan for 2015/16 which was in line with the trust's objectives. Actions were identified but outcomes were not always measurable. An accountable member of staff was assigned to each action and dates were set for review and for completion of actions. There were no detailed plans for each of the actions. Some of the planned dates for completion of actions had passed but there was no indication of whether or not the action was completed.

Governance, risk management and quality measurement

- There was a risk register for Hayward House and risks were discussed and reviewed at Hayward House quality, risk and safety meetings.
- The clinical effectiveness committee monitored quality, risks and performance in palliative and end of life care. The Medical Director chaired these meetings. The minutes of a meeting on 2 October 2014 recommended that end of life care should be an agenda item for the trust board meetings. We looked at minutes of the trust board meetings but did not see end of life care included on their agenda.
- An end of life care steering group was set up as a sub group of the clinical effectiveness committee. The group reported to the clinical effectiveness committee who fed any issues to the quality, risk and safety committee. However, the only minutes provided by the trust in relation to this group dated back to January 2014. It was not clear if these meetings took place on a regular basis.
- The service had not developed an action plan to monitor the actions required to meet the key performance indicators of the National Care of the Dying Audit 2014. We were unable to see if appropriate action was planned or taken to ensure these indicators were met.

Leadership of service

- There was strong leadership for specialist palliative care services at the trust. However, although the same professionals were identified as the leads for end of life care, this was less well known. Staff throughout the trust knew exactly who the specialist palliative care team was, however when asked who the leads for end of life

care were, staff were unable to tell us. This meant there was more focus on specialist palliative care services with a risk that wider end of life care services were not being monitored or fully developed. .

- The clinical lead for end of life care was a consultant who was enthusiastic and proactive in driving forward the end of life agenda for the trust. They told us they had good support from the chief nurse, the executive and non-executive directors of the board.
- All the staff we spoke with felt their line managers and senior managers were approachable and supportive.
- The staff we spoke with were all aware of the specialist palliative care nursing team available to them as well as knowledge of the out-of-hours help they could access from Haywood House when required. Staff gave examples of various support mechanisms available to deliver good end of life care, including the chaplaincy team and the bereavement office.

Culture within the service

- We saw effective team working at Hayward House and an obvious mutual respect amongst staff. All the staff we spoke with told us they felt proud of working for the trust and enjoyed working in palliative and end of life care. We observed staff working well together and could see staff were supportive of each other.
- Staff felt their line managers listened to their concerns and ideas and consistently told us of their commitment to provide good quality care. One nurse told us, “We have only one opportunity (to deliver end of life care) and we always need to do it well. That’s what I try to do”.

Public and staff engagement

- The trust did not undertake specific surveys of bereaved relatives and carers. There were opportunities for relatives and carers to give feedback using comment cards provided in all ward areas throughout the trust and in Hayward House.
- There was an end of life care champion on each ward. The champions were responsible for ensuring staff were familiar with the end of life care bundle and used this appropriately. These staff did not have the same protected time as their colleagues who had similar roles in areas such as nutrition or tissue viability.

Innovation, improvement and sustainability

- There was good evidence of learning from incidents. For example, a project was set up and led by a ward sister at Hayward House following a high rate of incidents related to falls. An independent falls expert was invited to look at the environment and the day to day culture of nursing practice on the ward at Hayward House. This review found a lack of focus on patients who were at high risk of falling. Steps were taken following the review to reduce the risk of falls on the ward. Two cohort bays were set up. [A cohort bay is for patients at high risk of falling to be cared for together in the same area so their needs are managed more efficiently and safely]. A cohort nurse was allocated to the cohort bay. The cohort nurse wore a brightly coloured tabard to reduce the risk of interruptions and diversions. Changes to the ward environment included a colour theme to make it easier for patients to find their way around and equipment clutter removed from corridors. A six month review in June 2015 showed these changes had led to a 43% reduction in total falls, a 38% reduction in unwitnessed falls and a 67% reduction in repeated falls.
- Although the trust was benchmarking end of life care services against the essence of care benchmarking tool, there was little evidence of audits in relation to the outcomes of care for the patient. For example, there was no auditing of preferred place of care and death and whether patients had achieved their preferred place.
- There was no structured training for staff in end of life care. Records of staff training did not include who had attended any end of life care training, or details of the content of the training. Patients were at risk of receiving poor quality end of life care from staff without adequate training.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

Nottingham City Hospital outpatient services had just over 420,000 patients attending between January and December 2014. The trust outpatient service is one of the largest in England.

Services at Nottingham City Hospital included urology, breast, chemotherapy, diabetes eye screening and foot clinics, neuro rehab, cardiology, general medical and renal. There were ad hoc emergency and drop in clinics to help meet demand. Most outpatient clinics were consultant led, with full time dedicated clinicians; others were nurse and technician led clinics with dedicated teams. In addition, there were diagnostic, clinical support and allied health practitioner clinics, including physiotherapy. Outpatient clinics were not managed by a single directorate but by several directorates including medicine, surgery, and cancer. The diagnostics and clinical services directorate managed the main outpatients department as well as imaging services.

Nottingham City Hospital radiology department was a large multi-disciplinary and multi-modality department. A modality is the way, or mode, in which scanning and imaging is done. Services included plain film computed radiography (CR) and direct radiography (DR), computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, mammography, interventional radiology, fluoroscopy, theatre imaging, nuclear medicine including Dexa scanning and dental specialities.

We visited a range of outpatient clinics and services: radiology departments, cardiology, diabetic foot clinics, ophthalmology, chemotherapy, burns and plastics, renal, medical and urology. We observed care and interactions between patients and staff. We spoke with 30 patients before and after their appointments and 79 staff including nurses, doctors, health care assistants, allied health professionals, technicians, radiographers, clinical scientists, clerical staff, porters, and managers. We looked at four sets of patient records and examined equipment. We reviewed performance information from and about the trust.

Outpatients and diagnostic imaging

Summary of findings

We rated the outpatients and diagnostic imaging service good overall.

Staff reported incidents appropriately and we saw evidence of incident investigation, actions and shared learning. Clinical areas were visibly clean with effective systems to ensure cleanliness was maintained. Medicines were stored appropriately and fridges and stock were checked regularly. Records were stored securely and were available on time for clinics. The service had safeguarding policies and procedures and staff knew their safeguarding leads. Staff were up to date with their mandatory training. Equipment and the environment was not always checked or maintained in line with trust policies and guidance. However, when we raised these issues these were dealt with quickly.

Outpatient and diagnostic imaging services worked to National Institute for Health and Care Excellence (NICE) and other national guidance. There were good examples of multi-disciplinary working. All staff we spoke with had received an annual appraisal, although outpatient and diagnostic imaging services fell just below the trust target of 90%. Radiology services offered a seven day service to hospital departments. Staff understood their role concerning the Mental Capacity Act 2005 and knew what to do when patients were unable to give consent for treatment.

Staff respected and maintained patients' privacy and dignity. Patients were positive about staff and the way they were cared for. Staff gave examples of when they had gone the extra mile to help patients. Staff involved patients in their care and treatment. In some areas, the environment had an adverse impact on the planning and implementation of outpatient and diagnostic imaging services. The trust had not met cancer waiting time targets, which meant some patients did not have timely access to treatment. There were targeted clinics for communities or groups of people who were at risk of particular conditions.

Interpreters and chaperones were available for patients who required them. There was limited information available in different languages. Staff knew about the trust complaints policy and described what they would do in the event of a patient making a complaint.

There was a well-defined strategy for outpatient and diagnostic imaging services with clear links to the overall trust strategy. Risks were discussed at directorate meetings with clear actions and accountability to respond to them. Leaders were approachable and visible and were aware of the issues and risks affecting their service. Staff were well motivated and felt supported by their leaders. There was a patient centred and supportive staff culture. There were examples of where services sought continuous improvement and innovation.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We found safety in outpatients and diagnostic imaging was good.

Incidents, including radiation related incidents, were reported appropriately and we saw evidence of incident investigation, actions and the sharing of learning. Clinical areas were visibly clean and staff used cleaning rotas and checklists. Equipment testing and maintenance programmes were in place and we saw risk assessments were used for imaging equipment. Medicines were stored appropriately and we saw fridges and stock were checked regularly.

There were shortages in staff, however, outpatient and radiology departments still operated safely and recruitment processes were on-going. Records were available on time for clinics and electronic information and radiology patient records were stored securely on electronic systems. There were safeguarding policies and procedures in place and staff knew their safeguarding leads. Staff were up to date with their mandatory training. We saw examples of staff responding to patient risk and the radiology service demonstrated processes to protect patients from unnecessary exposure to radiation. Both outpatient and radiology services had clear roles and guidance in the event of a major incident.

However, there some issues with infection control and the environment; one clinic had no hot water and therefore presented an infection control risk to staff and patients. Some infection control audits were not up to trust standard. We saw equipment was not always checked and tested as required. However, when we raised these issues with the trust they responded quickly and carried out tests and checks on all identified equipment and closed the clinic. Patient records in outpatient clinics were not always managed safely, and this was not identified by the trust as a risk.

Incidents

- Between 1 March and 30 June 2015 there were 33 reportable patient safety incidents in outpatient departments. Most were categorised as causing no harm. There were 12 incidents categorised as causing low harm and two causing moderate harm to the patient involved. The most frequent were related to patient falls. Records showed these were managed and followed up appropriately.
- Incidents were reported using an electronic system. All staff we spoke to knew how to report incidents and the majority of staff could tell us when they last reported an incident. Incidents were added to an incident risk log and discussed at quarterly meetings. Incidents were investigated with actions and learning identified where necessary. Medical physics experts were an integral part of incident management. Diagnostic leads and radiographers at a senior level showed awareness of reportable radiation thresholds.
- Learning from incidents was shared through team meetings, staff notice boards and through other forms of communication such as newsletters or communication folder. There was no formal process for feeding back learning from incidents. Staff said feedback happened in a way which suited them.

  The duty of candour regulation applies to all NHS providers. It requires NHS staff to act in an open and transparent way with people using their service when things go wrong. The duty of candour was included in mandatory training for all staff along with briefing sessions and information available online. Staff knew about the duty of candour and described a culture of openness and honesty with patients. Managers discussed the duty of candour with staff in team meetings. Patients were kept informed of action taken under the duty of candour by telephone or by letter depending on their needs.

Never Events

- There was a never event within the last 12 months in the radiology service. Never events are serious, largely preventable patient safety incidents that should not happen if the available preventative measures are correctly implemented. On investigation, the never event was attributed to a surgical error during a procedure in the interventional radiology suite. In response to the never event, the World Health Organisation (WHO) checklist (a tool clinical teams use

to ensure surgery is safe) and the Interventional Radiology checklist was reviewed and revised. This enabled staff to strengthen the procedure to ensure it was a more proactive process.

Radiation incidents

- NHS trusts are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R). Diagnostic imaging services had procedures to report incidents to the correct organisations, including CQC, and ensured a review of practices when incidents occurred. We saw all incidents were recorded internally on the trust incident reporting system and there was timely notification of reportable incidents to the IR(ME)R inspectorate and the Health and Safety Executive (HSE) as appropriate.
- Staff knew how to report incidents and were encouraged to do so. Medical physics experts were an integral part of radiology incident management. Technical leads and senior radiographers were aware of reportable dose thresholds.

Cleanliness, infection control and hygiene

- Clinical staff had access to personal protective equipment as needed, such as disposable gloves and aprons, and they wore these when appropriate. We observed clinical staff were bare below the elbow, in keeping with trust policy to help prevent the spread of infection. Staff followed the trust's infection prevention and control policy
- All equipment, imaging departments and clinic areas were visibly clean and cleaned regularly. Cleaning checklists identified how regularly clinical areas were cleaned. However, there were concerns regarding the quality of the cleaning of some clinic areas.
- There were regular audits of staff hand hygiene for all departments in line with the trust's infection control monitoring guidance. Results of the audits were mixed with some departments scoring better than others. Results and learning from audits were discussed at team meetings and staff could access about hand hygiene.
- Where there were concerns around standards of cleanliness in outpatient clinics these were addressed quickly by the trust. Audits of clinic seven identified low standards of cleanliness. On the 8 September 2015 audit results showed clinic seven scored 63% compliance in cleaning standards. The following week the clinic scored 78%. In response, managers implemented weekly cleaning audits and re-training of domestic staff to ensure standards improved. We saw from cleaning audits dated 17 September 2015 compliance had improved to 95% and to acceptable standards.
- During our inspection we found clinic seven had no hot water available for the previous ten days. Staff working in the clinic told us they were concerned there was an infection control risk and the issue had not been addressed. Staff had to use cold water to wash their hands and to clean the clinic area. The issue had been escalated we were told a replacement part was needed. During our inspection clinic seven was closed after receiving further advice there was a risk to patient safety. Clinics operating there moved to other locations to ensure patient safety.
- Quality and performance information was displayed in public waiting areas, for example, infection control and hand hygiene audit results. Patients could see the performance of clinics and how they met standards around infection control and hygiene.
- There were issues raised by radiology and outpatient staff regarding the contracted logistics service. We were told of an occasion when there was a delay in removing radioactive waste because staff from the logistics service were not available to do this.

Environment and equipment

- At the last inspection CQC found the trust did not have an effective equipment maintenance programme and a large number of items of equipment had not been tested or checked. Since the last inspection in late 2013, the trust had embarked on a large equipment maintenance programme in which equipment was prioritised according to risk to patients.
- Throughout the radiology and main outpatients departments oxygen flow meters were out of date with the longest unchecked date identified as October 2010. Flow meters told staff how much oxygen a patient was receiving if they had breathing difficulties and required oxygen. In radiology it was not clear to staff who had the responsibility for checking and changing these. Staff in main outpatients had reported the issue and were told

it was a low priority as part of the on-going equipment maintenance programme. We checked seven flow meters across outpatient departments and found all were overdue to be tested.

- We saw from the outpatients asset register 14 patient couches had not been checked. We went into clinic rooms and checked five couches, all of which were overdue for testing by 12 months. Again, staff said these were low priority as part of the on-going maintenance programme. Patient couches did not necessarily present a safety risk, but could delay treatment of a patient if the couch was not fit to use. However, we saw by the end of our inspection all the couches had been tested and checked.
- There were issues with equipment used to support the rehabilitation of patients with neurological conditions. Staff said the beds and plinths they used did not meet patient safety needs. For example, lifting hoists could not be positioned properly to fully access the patient therefore putting patients and staff at risk of injury. There was a recorded incident of an injury to a staff member as a result of using a lifting hoist. As a result, risk assessments and mitigating actions were put in place.
- Clinics had emergency resuscitation equipment available. We checked five resuscitation trolleys and emergency equipment. The equipment was clean and was checked on a regular basis. The seals on resuscitation trolleys were intact and were dated to show when they were last checked. The guidelines for using the equipment were located with the equipment, or on the wall above it.
- The trust was well supported by the Medical Physics and Clinical Engineering service and had appointed radiation protection advisors (RPA) and radioactive waste advisors (RWA). The Medical Physics and Clinical Engineering service service had carried out a thorough 'mapping' exercise of radiation protection and regulatory requirements. This made sure the department was continually updated about the requirements for all relevant regulations. Protocols for each piece of equipment were available for staff in paper and electronic formats.
- There was regular and consistent quality assurance testing of imaging equipment. The standard of equipment testing was better than nationally required standards.
- Risk assessments for new equipment and procedures were carried out by imaging leads in conjunction with the Medical Physics and Clinical Engineering service. All risks were rated and populated on the trust risk register where required. Equipment specific protocols were available electronically.
- Some diagnostic imaging equipment was in need of replacement across the trust had implemented a replacement scheme. All new equipment was purchased through a procurement programme, taking advice from the Medical Physics and Clinical Engineering service. However, this had proved difficult at times due to lack of forward planning.

Medicines

- We checked five medicines stores in clinics and all medicines were stored securely with access limited to clinical staff. Staff carried out weekly medicines checks. We saw examples of accurate and up to date medicines checks and monitoring the temperature when medicines need to be stored at certain temperatures to maintain their effectiveness. Controlled drugs were stored appropriately in accordance with legal requirements.
- Nursing staff explained medication to patients and gave advice about how to take them and any likely side effects. Patients were given information leaflets to support this.

Records

- Records were available on time for clinics. Data from the trust showed one per cent of patients were seen in outpatient clinics without their notes being available. If records were not available, the consultant still had access to the letters, which were used to form emergency notes. The emergency notes were then merged with the original notes as soon as possible. This was in line with trust policy. This meant patients could be treated in a safe manner if their records were not immediately available.
- Patient records in outpatient clinics were not always managed safely, and this was not identified by the trust

as a risk. Records were managed differently across the clinics and therefore there was no consistency. In some clinics they were stored in locked cabinets to make sure patients' details were kept safe. In others they were placed in temporary boxes outside clinic rooms, with no means of security or monitoring. One member of staff expressed concerns the boxes did not have dividers and therefore it was possible for sections of notes to get mixed up with others.

- Radiology patients' records were held securely on the radiology information system (RIS) and picture archiving and communication system (PACS). They were protected through password access.
- Between March and June 2015 there were two reported incidents regarding records. One when letters relating to another patient were found in another patient's file, and another showing a delay in obtaining patient records.
- We looked at four sets of patient records. The records were complete with the correct information and patient details. The notes were easy to understand, legible and it was possible to follow the patient journey. Records were attached we saw no loose sets of notes. We saw actions were followed up in care plans meaning patients were receiving comprehensive treatment and care.

Safeguarding

- Clinical, support and administrative staff attended safeguarding training. Updates on safeguarding children and adults were part of a mandatory training DVD that staff watched annually. All managers we spoke with said their staff were up to date with this and this was confirmed by staff we spoke with.
- Services used policies and procedures to safeguard adults and children. Policies were available both electronically and in policy files located in staff rooms. Staff showed us where they were and demonstrated how they could access the online policy. Staff could tell us who their safeguarding leads were. The genito-urinary medicine clinic had processes for staff to follow if children presented at the clinic with sexual health problems.
- Appropriate information was displayed in clinical and waiting areas, including the processes to follow and contact details for relevant agencies. We saw safeguarding information and posters including key telephone numbers were available and visible in clinics. Clerical and reception staff referred to a guidance document for information about issues to raise and with whom.

Mandatory training

- The trust had developed a system where staff attended mandatory training each year in their birthday month. Mandatory training consisted of a two and half to three hour video for staff to watch. This system had contributed to improved mandatory training rates and staff awareness of the need to undertake the training. Managers had access to staff training records to ensure staff took the training as planned.
- Data from the trust showed the majority of outpatient services had met the trust target of 90% of staff having completed their mandatory training. All staff we spoke with said they had received and were up to date with their mandatory training. Data from the trust showed 93% of nursing staff and 90% of non-nursing staff had completed their mandatory training between July 2014 and June 2015. For the same period, 80% of medical staff had completed their mandatory training, which was below the trust standard.
- Mandatory training in radiology was up to date. However, due to a change in the delivery of training, there were some elements of mandatory training that could be difficult to carry out in future. Data from the trust showed on average 89% of radiology staff had received mandatory training between April 2014 and March 2015.

Assessing and responding to patient risk

- Clinical staff observed patients and recorded physiological observations such as blood pressure and heart rate. Staff knew the side effects of some tests and kept patients under close observation. Staff used early warning scores for both adults and children to ensure patients at risk were managed appropriately. Staff told us of incidents when patients were transferred to wards when their health deteriorated
- There were resuscitation trolleys in the majority of departments for cardiac emergencies. In the absence of a trolley, clinics had an emergency box and access to neighbouring wards. Staff had received training in emergency life support as part of their mandatory

training. Out of eight outpatient and radiology teams, 5 achieved the trust's 90% target; two were over 85% and one was 72%. All staff we spoke with confirmed they were up to date with resuscitation training. There were protocols in place for contacting the appropriate emergency team.

- Staff used the hospital's emergency call system to get help if a patient's health deteriorated. During our inspection a patient became seriously ill outside the outpatient department. We saw staff respond quickly to attend to the patient, undertake the necessary assessments and treatment. The patient was then admitted to an inpatient ward.
- The diagnostic imaging departments were well supported by the Medical Physics and Clinical Engineering service and had appointed radiation protection advisors and radiation protection supervisors to all imaging departments. There were radioactive waste advisors (RWA) and support from medical physics experts. This meant there was appropriate safety advice to help prevent harm and risk to patients.
- High dose procedures, such as those carried out in interventional radiology and CT scanning, were identified as requiring attention and priorities for these areas had been set by the radiation protection service. Plans included the implementation of a regional dose committee to ensure patient safety when receiving high doses of radiation.
- National diagnostic reference levels (NDRLS) were used. There was good dose awareness amongst radiologists across all grades and expected dose levels for routine examinations were known. This was in part due to the support of the medical physics and clinical engineering staff. This meant risks were managed with regards to patients not receiving higher doses of radiation than they should.
- Clinical staff in the inpatient and outpatient plain film departments demonstrated a lack of awareness of NDRL's or where to locate this data, despite an IR(ME)R procedure clearly stating the existence of the figures. The IR(ME)R practitioner told us this was a known issue and steps were being taken to address this. In CT and interventional radiology, radiation protection and regulatory knowledge was more apparent and dose awareness was discussed between staff.

Nursing staffing

- The majority of specialties with outpatient clinics had nursing vacancies. Where possible staff from inpatient wards or within the directorate would cover clinics, and so bank and agency usage was low. Between June 2014 and June 2015 agency and bank use remained at less than one per cent until March where it rose to five per cent, where it remained to June. This meant some departments had regular substantive staff who, were trained and able to give continuity of care patients.
- However, diabetic medicine, upper gastrointestinal, and rheumatology clinics all had higher use of bank and agency staff. From September 2014 to June 2015 bank and agency staff for upper gastrointestinal clinics varied between 15% and 35%, for rheumatology 12% to 30%, and diabetic medicine 16% to 29%. Recruitment for nursing staff was on-going by the trust and managers identified staffing levels as one of the biggest risks. Minutes of a directors group meetings stated there would be a review of nursing staff requirements as part of the on-going development of outpatient services.
- Sickness amongst nursing staff was low and most specialties had no more than six or seven per cent sickness rate between August 2014 and July 2015. During the same period, rheumatology clinics had higher sickness rates ranging from 17% to just under four per cent in July 2015. High sickness levels could explain the high bank and agency staff rates, and demonstrated sickness was being covered and staffing levels were safe.
- The main outpatients department had its own dedicated nursing staff who worked there on a daily basis. This ensured there was continuity and stability within the department. Staff knew how the clinics worked meaning there was consistency for patients. However, turnover of staff between April 2014 and March 2015 averaged at 17% causing vacancies. Recruitment was on-going and staff covered each other between Queen's Medical Centre and City Hospital. This sharing of resources, due to being managed by one directorate, meant bank and agency staff use was low, staff were appropriately trained (and therefore safe for patients).

Diagnostic imaging staffing

Outpatients and diagnostic imaging

- There was use of agency staff within radiology services. Agency training records were evident and the training agency staff received was in line with the training received by core staff at the trust.
- There were identified vacancies in the work force across the radiographer, radiologist and clinical scientist groups. In part, this was due to a national shortage and although this gap in the workforce impacted on the capacity of the department it did not compromise the safety of patients. Recruitment was under way and there had been appointments of overseas personnel in order to stabilise and sustain staffing levels.
- Staff turnover for radiology was nine per cent, which was the lowest it had been in the previous 12 month period and was below the trust average. Sickness levels remained below the trust average meaning the department was starting to see some continuity of staffing.
- The radiology service managers had undertaken an extensive workforce review and identified the skill mix needs of the department. Band 5 radiographers rotated across both City Hospital and Queen's Medical Centre with plans going forward to rotate all team leads and assistant practitioners. This meant staff could be shared and gaps in workforce filled in the event of sickness, maternity leave, and staff vacancies.
- Use of locums across outpatient and diagnostic specialties varied. Most specialties we visited had a less than 4% locum use between August 2014 and June 2015. Sickness rates amongst medical staff were low (below one per cent between August 2014 and July 2015), which explained the low use of locum doctors. This meant patients were seeing the same consultants and receiving continuity of care. Rheumatology and respiratory medicine clinics had fluctuating locum use over the same period, which rose to 19% and 26% respectively. Both had seen reductions in locum use by June 2014, which demonstrated the services were managing the staffing situation.
- There were shortages of radiologists, namely in paediatric, neurological, interventional and chest specialities, comprising six vacancies. Recruitment for these specialities had been unsuccessful, but the department managed to be flexible to meet demand. Recruitment was ongoing and the gap in staffing was identified as a risk. We saw radiologist staffing was on the trust risk register. Morning handovers between radiologists were effective.
- Job plans were an annual agreement between the trust and the doctor. Job plans set out what doctors do for the trust, when and where it is done including the time doctors are expected to be available for work. 75% of radiologists had job plans meaning most radiologists had clearly defined roles and expectations defined.

Medical staffing

- Medical staffing for outpatient clinics was arranged depending on the needs of the consultants running clinics. Consultants would let outpatient departments know how many junior doctors were required to support clinics. This meant clinicians were well supported and patients could get appropriate care and treatment.
- There was sufficient medical staffing for clinics with the majority of specialties having enough consultancy staff. This meant clinics would be able to operate as normal and reduce cancellations for patients. However, pain management and upper gastrointestinal specialties had a high vacancy rate of 71% and 82% respectively. This presented a risk of patients having to wait longer for clinics because there were not enough consultants to meet demand for clinics. We saw from patient waiting lists patients were waiting longer for gastrointestinal clinics and booking staff highlighted this as an issue.
- Outpatient clinics rarely ran out of hours (weekend and evenings).

Major incident awareness and training

- There was clear information available to patients and staff regarding fire procedures. Fire exits were clearly signposted and lit. Staff knew what to do in an emergency and the evacuation procedure.
- The trust had a major incident policy and plan. It identified roles and responsibilities of departments including imaging services and outpatient clinics. It identified how imaging services and certain clinics should respond including fracture clinics. The policy

identified the use of clinic space in the event of emergency, such as children's outpatients used as a press room. The policy planned for the cancellation and suspension of outpatient services.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatient and diagnostic imaging services are not rated.

Radiology services had practice based on national and local guidelines. Radiology departments conducted audits and used them to inform how services were delivered. We saw outpatient departments working to National Institute for Health and Care Excellence (NICE) or other national guidance. Some outpatient departments had nurse prescribers and clinics could refer patients to the pain team for management of pain. Patient outcomes were recorded and sent to directorates, although it was not clear how this information was used by clinicians. There were good examples of multi-disciplinary working for both outpatient and radiology services.

All staff we spoke with had received an appraisal and outpatient services had almost met the trust target of 90%. However, radiology had fallen short of the trust target despite showing improvement in appraisal rates. There were competency frameworks for new and existing staff. Staff described a culture of learning and development with opportunities to attend conferences and training. Staff in radiology used electronic systems for storing patient information and could access the information from any location. Outpatient services operated five days a week Monday to Friday with occasional weekend clinics to meet demand. Radiology services offered a seven day service to hospital departments. Staff understood their role concerning the Mental Capacity Act 2005 and knew what to do when patients were unable to give consent for treatment.

Evidence-based care and treatment

- Outpatient clinics had local procedures based on relevant professional guidance, national service frameworks and evidence based practice. Staff accessed guidance on the trust's staff internet, and clinics had their own resource rooms where they kept up to date protocols and journal articles. We saw guidance and practice guidelines on the walls of staff rooms. Information about relevant medical conditions and national treatment guidance was displayed in most clinic waiting areas for patients and their families.
- Local rules and Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R procedures were evidenced. There was a dedicated IR(ME)R practitioner who worked with Medical Physics and Clinical Engineering service, radiology management and clinical staff to write procedures, implement them, and ensure compliance. The Medical Physics and Clinical Engineering service had undertaken radiation protection and regulatory requirements mapping. This ensured the radiology department and the trust were informed of the requirements for compliance against all regulations.
- However, a number of areas demonstrated a lack awareness of radiation protection and regulatory requirements. We saw out of date paper copies of procedures and a number of radiographers were unsure of where to locate the electronic versions. There was confusion around core IR(ME)R procedures and a lack of understanding of terminology. The IR(ME)R practitioner spoke of issues surrounding staffing levels over the previous two years. They said there had been a great effort to construct, ratify and implement procedures. However, the training and education of clinical staff had been neglected as "all hands were at the pump" to assist with clinical demands. The department were aware of their requirement to continually educate radiographic staff and ensure the department remained clinically safe for both staff and patients.
- We spoke with the IR(ME)R practitioner who developed, in conjunction with one of the radiologists, a dedicated webpage on the trust intranet, where all policies and procedures for radiation protection were held. These were easily accessible to staff both within radiology and across the trust. We saw in-depth information relating to referrers and scopes of practice especially for non-medical referrers, and the system was of a high standard and gave confidence of the radiation protection from a managerial level.
- National diagnostic reference levels (NDRLS) were used and the absence of local diagnostic reference levels (LDRLS) were due in part to a lack of a regular dose audit

programme due to poor uptake by clinical staff. This was being addressed by Radiology, Medical Physics and Clinical Engineering in order to facilitate dose data collation through a third party dose management system. Going forward the aim was to collate data and have it analysed by the Medical Physics and Clinical Engineering service. This would enable the service to adopt LDRLS and aid in the on-going optimisation of radiation dose levels.

- There was an annual radiation protection audit. This was a rolling three year programme whereby each department was visited and assessed for compliance. Historically it was felt recommendations were not acted on in a timely manner and management teams needed to be assured they were compliant and had systematic monitoring in place.
- In line with NICE guidance for referral for suspected lung cancer, the radiology CT service offered GP direct referral for CT chest scans. There were referral criteria and all patients referred were assessed by a practitioner at the point of justification, to ensure they met the requirements prior to scanning. It was identified there were a group of non-attenders who may not accept an invitation for screening and this group were perhaps the highest risk group locally. Plans going forward were to provide a mobile CT scanning service for improved uptake of screening.
- Audits against IR(ME)R procedures were undertaken regularly and compliance was varied. There were concerns around recording documentation of pregnancy checks. It was identified through data analysis, recording of information on the radiology information system required improvement. All necessary supporting information should be scanned onto the patients records as per departmental procedures. These actions were highlighted in July 2015 and were being addressed at the time of our inspection.
- The Patient Tracking List (PTL) was a management tool, which provided information for operational staff, for example staff booking appointments or admissions for patients. The PTL provided crucial performance management information, which highlighted patients were approaching a breach in their waiting time for an appointment date. This allowed staff to manage appointments and treat patients in a timely manner.
- The burns clinics practiced in line with the national burns standard guidelines, for example photographs of injuries and swabs were undertaken in accordance with guidelines.

Pain relief

- Some clinics had nurse prescribers so patients could receive pain relief quickly.
- Outpatient departments could refer patients to the pain team who held outpatient clinics. Patients were referred to the team for long-term management of pain.
- If a patient attending a clinic was in pain staff told us they would use early warning scores and assess the level of pain. The patient would be referred to the appropriate individual and/or department, depending on the severity of the pain. Staff said they would do all they could to ensure patients were comfortable.

Patient outcomes

- Clinic managers told us they monitored procedures and patient outcomes. All patients had an outcome form which they took to reception at the end of their appointment. Information from the outcome forms was passed on to managers in each directorate and to the individual specialities. However, a senior manager told us, “I don’t know what they do with them”.
- In consultant led clinics, the doctor was notified if a patient did not attend and they would decide the next course of action for the patient. The patient could be asked to attend for another appointment or the patient could be discharged. This was recorded on the patient outcome forms.
- The trust finance team conducted an exercise to look at the cost implications if patient outcomes were not recorded after attendances to outpatient clinics. This work was conducted by speciality and identified where patient outcomes were missing. This was then fed back to consultants and directorates to ensure patient outcomes were recorded.
- The diabetes service amputation and healing rates were worse than the national average. Audits showed that problems could be identified sooner with early screening, and outcomes could be improved by using a heel safe mattress to help reduce nerve damage to patients.

- There were regular reviews of antibiotic use; as a result, types of antibiotic used were changed based on these reviews.

Competent staff

- The trust had a target to deliver appraisals to 90% of staff over a rolling 12 month period. Appraisal rates for staff across all outpatient areas averaged at 85% between April 2014 and March 2015 for nursing staff and non-nursing staff. This meant the majority of nursing staff had received an appraisal in the past year. All staff we spoke to said they had received appraisals on a yearly basis except where they were new in post. We saw managers kept accurate appraisal records and all staff appraisals were up to date. Objectives were set and there was input from line managers.
- The radiology department had an appraisal completion rate of 53% between April 2014 and March 2015. This percentage had improved by August 2015 where 63% of staff had received appraisals. This meant not all staff were receiving yearly appraisals including personal development reviews.
- However, data from the trust showed zero medical staff for outpatients and radiology had received appraisals between April 2014 and March 2015. The figures remained the same from April until September 2015. Information received from Health Education East Midlands before the inspection identified concerns by trainee medical staff about regular support. There was a risk medical staff were not receiving appropriate support and reviews in their performance. Our inspection team clarified issues raised in the report with the trust and saw actions had been taken to ensure medical staff receive appropriate support.
- Staff could access psychological support where required. A member of staff said they could have clinical supervisions or debriefs with a psychologist if required to support staff mental wellbeing.
- Continuous professional development was encouraged throughout the hospital. There was space on appraisal forms to offer suggestions regarding learning, for example, attending staff service conferences. Role extension was evidenced especially around reporting radiographers. However, there were concerns within the breast screening service. Staff told us staff shortages hindered their ability to attend training courses as part of their professional development. We saw evidence of continual training plans for nursing staff.
- The majority of staff we spoke with said they could shadow other roles and take on more responsibility and training so they could develop. Three managers we spoke with talked to the inspection team about training band five nurses into band six roles and up-skilling their staff. Managers recognised continuous development of staff led to staff retention and a stable workforce.
- Staff had a competency framework they completed as part of their induction and on-going development reviews. Staff had to demonstrate they met these competencies and they were signed off by managers. This contributed to assessing whether staff were continuously capable of performing their roles.
- At the time of inspection, the outpatient plain film department consisted of junior radiographers with no senior oversight. This was attributed to current departmental sickness and to staff leaving at 4pm at the end of a shift.
- Medical Physics and Clinical Engineering were International Standardization Organisation (ISO) accredited with the last visit in spring 2015. Medical Physics and Clinical Engineering were actively engaged with the radiology department plans to receive Imaging Services Accreditation Scheme (ISAS) accreditation. ISAS accreditation is a patient-focussed assessment and accreditation is designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- Diagnostic services had equipment training records for operators of all staff groups entitled to operate medical devices for the delivery of medical exposures. These were comprehensive, well managed and regularly reviewed to ensure staff competencies were up to date.

Multidisciplinary working

- Most clinics we visited were run by multi-disciplinary teams (MDT) including a mix of staffing skills, roles, and levels. These included doctors, physiotherapists, nurses, care assistants, and radiographers. Where required all MDT's were attended by imaging staff.

Outpatients and diagnostic imaging

- We saw evidence of MDT working in patient records. There was evidence of MDT discussion and planning around patient care.
- There were some good examples of MDT working at City Hospital. For example, the diabetes service met every week to discuss patient needs and complex cases and attended a radiology MDT meeting every two weeks. Medical staff, nursing, podiatry, and care assistants attended the meeting. Patients were discussed, their needs and opinions were taken into account before clear actions and responsibilities were identified.
- The urology service was working with Notts County Football Club in a community project to raise awareness of prostatic and breast cancer. The service provided expert advice for people with cancer and 12 free exercise sessions.
- The chemotherapy team worked with GPs and provided an advice service GPs could access. The team worked with community matrons and provided training on renal management.
- We spoke to the lead radiographer of advanced practice radiographer reporting. There were seven reporting radiographers. They covered reporting in the Musculo-Skeletal directorate in the inpatient, emergency department, and outpatient rheumatology groups. This meant they worked with a variety of different teams and settings. The work was regularly peer reviewed and self-audited to maintain its effectiveness. However, there was no GP reporting undertaken in radiology.
- The radiology service worked well with the stroke service as part of the stroke patient pathway. There was effective communication when a patient with a suspected stroke arrived at the hospital so the patient could have a scan as soon as possible to help with diagnosis. The service provided to stroke services was monitored and reviewed by managers regarding the time taken for patients to receive scans.
- The interventional radiology teams were multi-disciplinary. Interventional radiology was an independent medical specialty which used minimally invasive image-guided procedures to diagnose and treat diseases. The teams included medical, nursing and technician staff had a good skill mix and a cohesive approach to work.

Seven-day services

- Radiology provided a seven-day service for emergency and inpatients in all relevant modalities. It was in the process of developing outpatient imaging services in those areas such as MRI where there was high demand.
- A seven day service was offered by the MRI department with an on call service for spinal cord compression and neurological patient emergencies. Saturdays were assigned for inpatients and Sundays relied on radiographers to volunteer to undertake outpatient work.
- The pathology service offered a seven day service for emergency services across the hospital.
- Almost all of the outpatient services were provided Monday to Friday during 'working hours'. None of the outpatient services were provided seven days a week. Some services provided occasional clinics on Saturdays and evenings to help meet demand. Many departments had plans to add evening and weekend clinics to help reduce the number of non-attendances.
- The urology service had a 24 hour helpline, seven days a week where patients could call and receive help and advice.

Access to information

- System facilitators were responsible for setting up and preparing clinics. Reception staff monitored the availability of patients' notes. If patient notes did not arrive, the supervisor would search for them and if they could not find them they would make up a temporary set for clinic. The temporary notes included paper versions of electronic letters and test results. This was in line with the trust policy. All administrative staff we spoke to where aware of this procedure.
- Across the trust in 2014/15, 1% of patients were seen in outpatients without their full medical record being available. Between March and June 2015 there was one reported incident at the City Hospital of patient records not being available for clinic. This meant that majority of patients were seen at clinics with their full medical records.
- Patients' records were held securely on the radiology information system (RIS) and picture archiving and

communication system (PACS) and protected through password access. These were electronic systems and allowed clinicians to view patient images from any location securely and easily.

- Staff handovers occurred in outpatient departments. Some clinics had a team huddle at the beginning of each day and during the day if there were shift changes. Key information about patients and what doctors were working that day were shared. We saw there were separate handover sheets for qualified and unqualified staff. The handover sheet was printed late morning and contained details of patient medication, patients who required transport and patients who had specific requirements. The nurse in charge led handovers. There were verbal handovers between individual members of staff who were part time and crossing shifts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of the Mental Capacity Act 2005 and their roles and duties around consent. Mental Capacity Act training formed part of the staff yearly mandatory training programme. We saw paperwork and electronic records included staff confirming the patient had given consent to examination and treatment.
- Clinical staff asked patients for their consent as part of their initial assessment at the clinic. Patients we spoke with told us staff asked for their consent and kept them fully informed about any procedures and treatments. Consent was recorded in patients' notes.
- Staff gave examples of when patients were not able to give consent. One member of staff told us about a time when staff refused to treat a patient because the patient could not give their consent.

Are outpatient and diagnostic imaging services caring?

Good

Overall, we rated caring for outpatients and diagnostic imaging services as good.

Patient dignity and privacy was respected and maintained by staff and there were private areas for patients to change and wait for appointments and scans. However, it was possible to hear some confidential patient information in the DEXA scanning rooms. Patients were positive about staff and the way they were cared for. We saw positive interactions between patients and staff. Staff gave examples of when they had gone the extra mile to help patients.

Staff involved patients in their care and treatment. We saw staff talk to patients about what to expect in their treatment. Some clinics used patient interviews to understand their needs and as part of the involvement process. Some clinics had nurse specialists to support the emotional needs of patients and we saw plenty of guidance and information regarding support for patients. Counselling and chaplaincy services were available to support patients who had received bad news or needed emotional support.

Compassionate care

- The NHS Friends and Family Test (FFT) gives every patient the opportunity to feed back on the quality of services they receive. Patient surveys and the FFT were regularly carried out in outpatient and diagnostic imaging services and scores were positive. Between October 2014 and February 2015 outpatient services scored consistently above 95%.The most recent result was 97% of patients stating they would recommend the service to friends and family.
- Dignity and privacy were maintained at all times in communal booking and reception areas as well as in x-ray rooms. Due to the layout and building constraints in the DEXA scanning room there were two scanners in one room separated only by a screen. It was possible patients in this room would be able to hear information and personal details about each other.
- Gowns were readily available and changing rooms were available for patients to ensure privacy. Where possible male and female patients were seated separately when changed. In the inpatient and outpatient plain film department patients who were changed and ready for their examination were seated away from the main reception area and the view of the main corridor.
- Patients told us staff were friendly and caring. We saw caring interactions between staff and patients. One patient we spoke with said, “I love this hospital, they are really caring and look after you, you are treated like a

person and not a number, the staff listen to us and offer good explanations". We saw patient comment boards in clinic areas had many compliments from patients on them.

- One patient spoke about how they felt their health had been completely turned around by staff at City Hospital after being treated elsewhere. They said, "All the team are great".
- The service used volunteers to support patients and help guide them around hospital. One volunteer told us volunteers helped to reduce patient anxiety when coming to outpatient appointments. Volunteers talked to patients, were friendly, smiled and reassured patients in waiting areas.
- The inspection team spoke to a receptionist in urology who had been nominated for a trust award. The receptionist had gone above and beyond for patients by ordering lunch bags and drinks for older patients so they could eat and drink while they attended clinic.
- Services in the breast institute demonstrated good compassionate care. Patients' privacy and dignity were preserved with separate areas for routine and symptomatic breast screening. This included separate waiting areas so patients could sit and wait with patients attending for similar reasons. Patients were not asked to return to the waiting area after their screening when partially clothed in gowns. Staff described patients' dignity as being important.
- Staff gave us examples of when they had gone the extra mile. A member of staff in the chemotherapy service told us about a patient had become homeless and had nowhere to sleep. Staff contacted social services and placed the patient in the patient hotel on the City Hospital site. The patient stayed there until social services had found the patient somewhere to live. This demonstrated staff commitment and compassion for patients. The chemotherapy team had been nominated for an award in the NUH honours for staying late in their own time to allow patients to finish their chemotherapy treatment.

Understanding and involvement of patients and those close to them

- Patients were well informed about the examinations they were undergoing and about onward care and results availability. We observed patients were choices in appointments and staff listened to what patients wanted.
- Chemotherapy and renal outpatients used a patient interview for new patients. This enabled staff to get to know the patient, understand them and discuss practical issues with them. This involved a group presentation, what to expect and a question and answer session to find out if there were any patient concerns. Patient needs were then documented in the care plan. We saw an example of this in patient notes where a patient chose not to have dialysis and was commenced an end of life pathway.
- We observed staff involving patients in their care and treatment. We saw staff explaining what was going to happen and ensuring patients understood what they were told. Patients told us they felt involved with care and treatment and staff had explained things to them. One patient said, "The staff are brilliant and they explain things".

Emotional support

- There was information available to patients about support services and about various medical conditions. Information was visible on walls and in leaflet racks. For example, we saw information for patients on limb protection and emotional wellbeing in the diabetic clinics. There was lifestyle information giving advice on smoking, driving, alcohol consumption and salt reduction.
- Counselling services were available to patients. In urology outpatients there were two rooms available for staff to use if patients had to be given bad news. This meant patients could be given bad news in private and away from other patients.
- Volunteers worked with the chaplaincy service to provide emotional support, spiritual and pastoral care to patients. Volunteers provided patients with information and referred them to other support services.
- Nurse specialists were available for some services to support patients especially when they received bad

news. Staff told us wherever possible they would provide support to patients and would ensure if patients wanted a quiet area to reflect then they would make this possible.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsiveness for outpatient and diagnostic imaging services as requires improvement.

The environment affected the planning and implementation of outpatient and diagnostic imaging services. This led to the closure of some clinic areas. The physical environment provided challenges in nuclear medicine and patients receiving different treatments were sat together, which was not good practice. There were issues with temperature control issues in both radiology and outpatient clinic areas. The trust follow up to new appointment ratio was worse than the England average. Cancer waiting time targets were not met so some patients were not accessing treatment in a timely manner. The process of booking appointments was inconsistent across specialties leading to some clinics having longer appointment waiting times. There was limited availability of patient information in different languages.

However, there was positive work to meet patient needs. There were targeted clinics for communities or groups of people who were at risk of particular conditions including outreach services. Interpreters and chaperones were available for patients who required them. A red alert system identified patients at risk of falls in radiology. There were practices and procedures to meet needs of vulnerable people and patients with complex needs. Learning from complaints and concerns was share and Staff knew what to do if a patient complained. Patients knew how to make complains and could access information about making a complaint.

Service planning and delivery to meet the needs of local people

- Some clinics ran outreach services to meet the needs of the wider population. The burns unit at City Hospital was commissioned to deliver services across the East Midlands. This included clinics at City Hospital and an outreach service providing clinics elsewhere. This meant patients did not have to travel to Nottingham and could be assessed nearer to where they live. The genito-urinary (GU) clinic ran outreach clinics, which provided testing, diagnosis and support for patients.
- The trust worked with commissioners to provide services to meet the needs of the local population. Commissioners provided demographic details so the trust could design services reflect them. For example heart and diabetes clinics were amongst the biggest and most frequent clinics, which reflected the demands of the local population.
- Staff highlighted the environment in clinic seven, nuclear medicine and burns and plastics as problem areas. The inspection team saw concerns highlighted by staff. Problems included physical space, an ageing building, and a lack of basic requirements such as temperature control and hot water.
- Risk assessments identified issues with the environment that potentially impacted on the delivery of services. The issues were mainly due to the age of the building. However, there were some concerns regarding the responsiveness of the privately contracted estates provider to fix issues.
- Due to environmental concerns, some clinic areas were closed. Clinic one was closed prior to our inspection and clinic seven was closed during the inspection. Both were closed due to concerns over the environment and safety to patients. This impacted on the location of clinics and planning where and how services were delivered. With regards to clinic seven we saw the main outpatients service redistributed clinics into clinic rooms and areas were not being used meaning no clinics had to be cancelled. There was information available to patients with volunteers and PALS staff on hand to deal with any patient questions or concerns. The service handled the closure efficiently and without disruption. This presented concerns about the longer term issue of how appropriate the environment was for outpatient services. Staff working in the burns and plastics clinic told us space was limited and due to a lack of availability of rooms this sometimes led to delays in clinics.
- There was an issue with temperature control in some clinic areas. In one clinic in the winter it was recorded

patients were having scans in temperatures as low as 12 degrees Celsius. Staff in clinic seven told us heating was inadequate in the winter. This meant patients were uncomfortable while attending scans. Staff in burns and plastics clinics said it was quite often too hot in clinic areas and patients had fainted. Rooms were too hot sometimes to close doors so curtains were used to protect and patients privacy and dignity.

- The breast institute was one of five national training centres. The facilities and environment were modern, surrounded by trees and sweeping lawns. It was a pleasant and supportive environment for patients accessing services such as breast screening. Inside the institute was well decorated, had a coffee shop, and a modern reception area. The building was designed to provide a logical patient flow depending upon why patients were attending the clinics. Staff demonstrated this to the inspection team. We saw different patients accessing different areas of the building including different waiting areas.

Diagnostic and Imaging environment

- Staff in nuclear medicine and outpatient departments told us the estates department did not respond in a timely way. Although not impacting on the day to day safety of the patients, there was a delay in the provision of minor new works. Issues were escalated to managers, but the response was slow.
- We saw temperature issues were included on the risk register for outpatients. There were actions identified to try and control temperatures in clinics, but no actions planned to permanently resolve the problem.
- Some of the physical environment provided challenges to diagnostic and imaging services. There was an issue with asbestos in the walls, which prevented refurbishment of some areas. Therefore the nuclear medicine waiting areas and trolley access into gamma camera rooms was limited. The provision of a new positron emission tomography (PET) CT scanner was put on hold due to lack of space requirements.
- The nuclear medicine department was adjacent to the ultrasound department and they share a waiting area. The specific waiting section for nuclear medicine patients was small, which meant patients who received different treatment and scans were seated together. For example, it was seen as good practice to separate patients who have been injected with radiopharmaceuticals from other patients to keep doses as low as reasonably practicable, in line with Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R. The department required restructuring and refurbishment but due to delays with estates assessment and asbestos issues this work was yet to be undertaken.
- There was a lack of space in nuclear medicine to carry out patient treatment. This meant rooms were not always available when needed.

Access and flow

- City Hospital had just over 420,000 outpatient appointments between January and December 2014. This was nearly half of all outpatient appointments across the trust in the same period.
- The percentage of new appointments was 16% at City Hospital compared to the trust (28%) and England average (25%).However, the percentage of follow up appointments was 55% (January to December 2014), which was more than the trust average (44%) and in line with the national average.
- The number of follow up appointments compared with first appointments influences how many newly referred patients can be seen and meet the waiting times standards. A lower ratio improves patient flow. The ratio depends on the type of service being offered. The follow up to new ratio for services at City Hospital was worse than the England average. The hospital average was between 3.4 and 3.6 (January and December 2014) with an England average of 2.4. Therefore, patients were receiving and having to attend more appointments compared to other areas of the country.
- Patients who did not attend appointments (DNA) rates for City Hospital stood at 6% between January and December 2014 and were slightly better than the England average of 7% for the same period. There was a DNA policy included in the patient access management policy. We saw clinics had their own processes for patients who did not attend appointments and therefore used the policy in a flexible manner depending on the specialty and type of patient.

Reminders were sent to patients by way of letters and some clinics telephoned patients, especially when some patients may have had memory problems and forgotten to attend.

- To help keep DNA rates low, patients were sent text and email reminders for their appointments to work towards making sure patients attended.
- The number of hospital cancelled appointments was worse than the England average. Thirteen per cent of appointments were cancelled by the hospital between January and December 2014 compared to the England average of seven per cent for the same Period. Between May and June 2015 three per cent of clinics were cancelled by the trust. This demonstrated an improvement in hospital cancelled appointments. The main reason for trust cancellation of clinics was consultant holiday. Consultants had to give six to eight weeks' notice of holiday so appointments and clinics could be managed and rescheduled.This was trust policy.
- Patients should start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral. The trust were better than the national standard and England average for referral to treatment. Between June 2013 and April 2015 97% and 99% of patients received consultant led treatment within 18 weeks.
- The NHS constitution states patients have the right to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. The national standard for two week waits was 93% of patients seeing a specialist within two weeks of a GP referral. Between April 2014 and March 2015 the trust were seeing 91% of patients within the two week standard. Data from NHS England showed the trust fell below the England average of 96% and national standard in early 2014 and as of April 2015 were still not meeting the standard for most cancer specialties. Commissioners prior to the inspection had expressed concerns about the trust performance over the two week wait standard.
- The trust had consistently performed below the national average against the 31 and 62 day standards. These standards state patients should be waiting less than 31 days from diagnosis to first definitive treatment and less than 62 days from urgent GP referral to first definitive treatment. The trust had seen a decline in the numbers of patients who were seen within 31 and 62 in line with national trends. This meant there had been a decrease in the number of patients receiving quick and timely care and treatment compared to two years ago.
- The 31 day wait performance had fluctuated between 98% and 95% from April to 2013 to March 2015 with 96% of patients receiving definitive treatment within 31 days in early 2015. The national standard set by NHS England was 94% therefore the trust were meeting these standards. .
- The 62 day wait standard had fallen from 86% to 79% of patients seen from urgent GP referral to first definitive treatment between April 2013 and March 2015. The national standard for 62 day referral to treatment standard was 85%.The trust was 6% worse than the national standard.
- The trust said work was on-going to improve the cancer waiting times performance. There was an action plan, which had clinical oversight and the approval of the commissioners. This included finding extra clinic slots, weekend clinics, and business case to improve staffing, and daily monitoring of the two week wait waiting list.
- Patients could book in for clinics electronically through a check in kiosk. This was a touch screen device, on which patients could change the language settings. Therefore patients whose first language was not English could book in easily and quickly. The kiosks allowed patients to book in without queuing at reception and having to disclose personal information out loud. However, there were no screens around kiosks and, depending on their position in clinics, it meant patient confidentiality might be at risk as patients passing by could see the information on the screen.
- Services at City Hospital measured how long people were waiting for appointments. If patients were waiting longer than 15 minutes for their appointment they would be told by a member of staff. We observed staff informing patients and waiting times displayed on boards in clinic areas. Data from the trust showed nearly 13% of patients were waiting longer than 30 minutes for

an appointment. However, waiting times after arrival into radiology were observed at the time of the inspection to be less than 10 minutes from booking to examination.

- Patient appointment waiting times were not reported or monitored formally within their directorates. Staff told us this used to happen and a new dashboard was being developed but for the time being waiting times were only being monitored at clinic level. This meant managers and leads for the service were not able to identify problem areas or services and provide direction to staff on reducing waiting times.
- Booking rules for appointment slots affected patient clinic waiting times. Consultants set their own booking rules so there was no standard process for appointment slots and how patients were booked in. For example, booking slots could be individualised or several patients could be block booked in for a single time and then have to wait. Staff described the computer system used for booking patients as "confusing" because different staff roles could book appointments for the same clinic. This could lead to overbooking clinics and long waiting times for patients. We were assured by the trust this was part of on-going work to reshape outpatient services.
- Some clinics at City Hospital used or had trialled a partial booking system for follow up appointments. Partial booking is when a patient receives a target date for the appointment and is then contacted nearer the time of the appointment to arrange the exact date and time. This helped to reduce DNA rates because the time and date of clinics were booked to suit the patient and acted as a reminder to the patient about their appointment. Partial booking allowed clinics to be flexibly managed and reduced numbers of patients having clinics cancelled.
- Other clinics were still fully booking follow up appointments for patients and providing them with an appointments date upon leaving the clinic. While this gave the patient a date, this system was inflexible and did not take into account consultant sickness and leave meaning a greater number of patients would potentially have appointments cancelled and rearranged.
- The urology clinic had dedicated slots for patients who required results of blood tests. This meant patients who required blood test results were not having to wait to receive them. Urology had emergency slots every afternoon were reserved for patients who needed to be seen urgently.
- There were good pathways for patients with diabetes. Outpatient clinics had admission pathways onto dedicated wards if patients attended clinic and needed to be admitted. For example there was a dedicated foot ulcer ward. Patients could choose to have their eyes screened on the same day as the foot clinic so patients could access a one-stop clinic rather than attend different appointments on different days and at different venues.

Access and flow- Diagnostic Imaging

- GP plain film requests were placed onto the electronic requesting system. GP's could refer directly to trust for a variety of scans including CT chest scans, MRI scans of knees, and spines. The system contacted the patient who was requested to ring into a centralised booking centre in order for an appointment to be offered. However, for acute or emergency requests the department offered a walk in service
- The radiology department utilised the e-requesting system for referrals but not all referrals were presented to the department in electronic format. This mixed referral system was in part due to implementation but to clinicians in certain departments not engaging with the electronic requesting process. This led to duplicate referrals in some cases, and contributed to inappropriate requesting with no audit trails. This issue had been highlighted to the clinical director who was currently working with the radiology service managers and the lead radiologist in order to ensure this was rectified.
- There were no perceived delays to discharge due to radiology. To allow the department to stay in line with targets for waiting times and reporting there was a drive to sustain the workforce and to ensure it was stable in the long term. Radiology outsourced reporting, extended the working week and working day, and contracted third party CT and MRI services where required.
- Staff working in radiology told us there were on-going issues around the porter service. Although individual porters were caring, approachable and hardworking,

outsourced contracting had led to service disruption and major delays in patients being brought down and returned to wards. This had an impact on patient care as they were often waiting in departments for hours at a time. Staff in radiology said they had to wait out of hours in order to scan patients who were delayed in reaching the department. We saw from directorate governance meetings the issue of portering had been discussed with actions identified to increase the portering staff.

- The escalation time for patients not collected by porters was set at 45 minutes post examination.Staff told us that even following escalation an additional 30 minutes could at times be expected before a porter arrived. Data indicated five per cent of patients waited in excess of 60 minutes and 75% waited 35 to 45 minutes. During our observation, one job was not assigned until 34 minutes post request.
- One porter informed us at times they were assigned patients in different locations of the hospital. This contributed to patient delays and disrupted communication between porters, wards, and radiology.
- Local radiology targets were set for examination attendances to verified reports being available. The aim was to reach 90% compliance against these targets. The targets were one day turnaround times for the emergency department and inpatients, 10 days for outpatients, and three days for GP's. There was 75% compliance against most of the targets except inpatient turnaround times which sat at 35%. Radiology service managers indicated inpatient reporting was a continued issue but they had been concentrating on reducing reporting times on GP examinations and outpatients. It was identified greater work around job planning was required for plain film reporting and sustainability of the current workforce to manage this.

Meeting people's individual needs

- Patients living with dementia were highlighted on the referral from GPs meaning services could provide dedicated support to patients. All staff we spoke to had received training about dementia and how to care for people living with dementia.
- Chaperones were available for vulnerable patients where required. There were posters highlighting to patients chaperones were available and could be requested if required.
- Following a patient who fell in the outpatients department and broke their wrist, a red alert system was adopted by plain film radiology for patients who were over the age of 65. Patients who had more than two falls in a twelve month period were highlighted on the system. This ensured patients requests were identified with a red flag, and patients were highlighted as requiring additional support whilst in the department. It was anticipated this would be adopted by other departments.
- Interpretation services were available for patients at City Hospital. Services used telephone or face to face interpreters. Reception staff said interpreters, including British Sign Language interpreters, were normally pre-booked through GPs. However, they could be booked on the same day if required. Staff told us they had never had any problems in booking interpreters when required and the service was quick. There were posters on clinic walls informing patients about interpreters, including signers for patients who were deaf, were available.
- There were limited materials for patients in other languages available at outpatient clinics. The signs around departments were only in English and we saw a sign in English stating that materials could be translated to other languages. One member of staff said, "I wish there was more multi-cultural information in waiting areas". This meant there was a risk of patients not accessing important information or being able to find their way to the appropriate department at the hospital. A senior manager said there was, "No current way of identifying patients whose first language isn't English".
- The genito urinary medicine service ran specific commissioned outreach clinics for specific groups in society. For example, the clinic ran outreach sessions for students and sex workers and ran clinics in the local prisons so prisoners could gain access to the service if required. This demonstrated a service, which aimed to meet the needs of different people.
- Patients attending the chemotherapy suite had to bring their own food while they waited for and received treatment. There were no facilities for the service to provide food or arrangements to provide food for patients. The service had been negotiating with the food contractor. However, a recent change in the food provider meant negotiations for the contractor to

provide food had to start again. This meant the chemotherapy service was not able to respond to requests for food or dietary needs of patients who may have been spending all day in the clinic.

- The urology service targeted prostatic cancer awareness in afro Caribbean communities in Nottingham. There was a large community in Nottingham and research suggested they were at higher risk of prostatic cancer than the general population. The service was in the progress of setting up drop in clinics and had already set up a referral system through local afro Caribbean community centres.
- Vulnerable patients attending chemotherapy clinics were given a rapid response alert card. The card had an urgent helpline number for if patients were feeling unwell and information for health providers advising them of the patient's condition.
- Outpatient services had access to the learning disability liaison team. The learning disability team supported patients while they attended hospital clinics. They ensured patients arrived to appointments and arrived home safely by organising transport. They provided a chaperone service to patients who required it.
- The radiology CT service offered GP direct referral for CT chest scans. It was identified there were a group of non-attenders who may not accept invitation for screening and this group were perhaps the highest risk group locally. As a result there were plans going forward to provide a mobile CT scanning service for improved uptake of screening.

Learning from complaints and concerns

- Information for patients and their families about making a complaint was displayed in all areas of City Hospital. There were posters and leaflets available to patients about the patient advice and liaison service (PALS). Patients told us they knew how to make a complaint and were aware of the PALS service. Patients said they felt comfortable making complaints and expressing concerns to staff.
- There were clear processes for handling complaints. The complaint team liaised with the investigators for evidence and agreed actions were completed. These were saved on the incident reporting system. Examples of learning from complaints were presented from the patient view and were available on the intranet and internet. Examples of learning were collated circulated to directorate management meetings. Case studies from complaints were used in training for group discussion in terms of investigation and learning.
- Staff were aware of the trust complaints policy and described what they would do in the event of a patient making a complaint. Staff highlighted they would try and support the patient to resolve the issue immediately at a local level. In the event of a complaint staff were aware of information they could provide the patient to help them making a complaint including knowledge of the PALS service.
- Learning from complaints and concerns was shared at team meetings. Staff gave examples of learning from complaints. We asked the trust for minutes of team meetings but they were unable to provide us with copies.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led for outpatient and diagnostic imaging services as good.

There was a well-defined strategy for outpatient and diagnostic imaging services with clear links to the overall trust strategy. Most staff were aware of the strategy for their services. Staff could identify key risks for their service which were reflected on risk registers. Risks were discussed at directorate meetings with clear actions to respond to them. Performance dashboards were being piloted to improve how outpatient clinics were performance managed. Radiology had weekly dashboard figures, which allowed them to communicate internally and with the trust board regarding waiting times and reporting issues.

Leaders were approachable and visible and were aware of the issues and risks affecting their service. Staff were well motivated and felt supported by their leaders. There was a patient centred and supportive staff culture. We saw examples of where patient engagement had changed or improved services through patient forums. Staff felt

engaged by the trust especially on key issues. Staff were communicated with in a variety of ways by managers in ways suited staff. We saw numerous examples of where services sought continuous improvement and innovation.

Vision and strategy for this service

- The trust had developed a new five year strategy based on a vision of "working together to be the best for patients." None of the staff we spoke with told us about the strategy although most spoke about the local vision and priorities for their services. Staff knew about how their service was developing.
- Staff told us about the values of the trust and the importance of attitudes and behaviours.
- The strategy for all outpatient services involved the development of governance and performance frameworks for outpatients. This included radiology services. At the last CQC inspection, we found there was no clear governance framework or responsibility for outpatient services. The trust had responded to this by developing a governance strategy for outpatients and radiology. The strategy was led by the diagnostics and clinical support directorate management team and had project managers responsible for developing and implementing the strategy. We saw from meeting minutes this was linked into the overall emerging trust strategy for 2016 to 2021.
- We saw there was information about the vision for outpatients situated on clinic walls so staff and patients could see the plans for outpatient departments.
- At senior management level there was positive inter-directorate work on formulating strategies. For example, the leads on the trust strategy attended the radiology strategy meetings to ensure connectivity between services and the trust as a whole. Other directorates attended these meetings due to the impact radiology had on services across the hospital. This meant there was communication across the trust as well as up and down.
- There was good strategic vision within the radiology department with forward thinking and clear direction. Staff were aware of the vision and strategy of the department and described how they contributed to it. For example, staff described their awareness of the trust financial constraints and therefore wanted to contribute by ensuring services were cost effective whilst delivering high quality care.

Governance, risk management and quality measurement

- There was no overall governance of outpatient services. The diagnostics and support directorate managed the main outpatients departments at QMC and City Hospital. However, there were many other outpatient clinics run by other directorates such as cancer, surgery and general medicine. This meant there was no overall oversight, strategic and performance management of outpatient services.
- We saw from governance meetings between June and September 2015 risks were discussed at directorate level. Higher level risks were reviewed and discussed in turn and new risks were added to the risk register. Actions were identified where necessary as a result of learning. We saw actions in governance meetings were followed up and progress fed back at the next meeting.
- The trust were in the process of several large projects to address this issue, which included work to bring all outpatient departments under one location and one directorate. We saw actions plans and managers talked about their ambition for outpatient services to be more cohesive. The diagnostics and support directorate attended other directorate management team meetings as well as staff from other directorates attending theirs. This meant there was some attempt at communication and information sharing between outpatient services at a senior level.
- As part of this work new performance dashboard was being piloted at the time of our inspection. This was part of the ongoing work to develop outpatient services. The performance dashboard included patient waiting times, DNA rates, cancellation rates which would assess the quality of services. The dashboard included other information which would influence financial measures and contractual arrangements with commissioners. This included friends and family test scores and planned versus actual activity. The implementation of the dashboard would allow managers to have a better overview of how outpatient services were performing and be more responsive to risk.

- Trust board papers showed these new initiatives were reported to the board and highlighted there was communication between the directorate, project team and the board. This meant there were clear lines of accountability for the project and a structured governance arrangement.
- There were developments regarding governance and quality measurement around key risks. One of the key risks for outpatient services was the delivery of cancer waiting time targets, in particular two week waits. There was an action plan with key strands of work, specific roles and ownership of key issues both operations and strategic. Two week wait data and 18 week referral to treatment times were to be included on a new quality dashboard. This would allow more responsive management of risks of this nature. This demonstrated senior managers' thorough approach to addressing risks and quality.
- Risk assessments were carried out within the diagnostic and clinical support directorate on clinical areas to identify possible risks. We viewed three risk assessments and saw actions had been identified regarding the environment. The physical environment of outpatient clinics was included in the risk register. This corresponded with risks identified by staff working in the clinics.
- During the inspection, we saw some risks were not assessed, such as the issues with a lack of hot water on clinic seven and oxygen flow meters not being checked and tested. We were told these issues had been escalated and we saw evidence they had. No formal risk assessments meant risks were not appropriately managed and the true risks to patients and staff were not identified.
- There were concerns from staff regarding the timeliness of addressing issues and risks. We saw some issues were not resolved in a timely manner and there was very little feedback for staff.
- While there was no overall directorate responsible for outpatient services, there was clear accountability within directorates for them. We saw there were allocated roles to address access issues, capacity planning, and patient experience. A quality assurance lead was appointed in Medical Physics and Clinical Engineering who oversaw all medical physics scanning.This meant management structures and accountable staff were clear for outpatient and diagnostic services.
- All clinics we visited had team meetings. All staff we spoke to had attended team meetings however, team meetings were not regular. Managers tried to hold monthly meetings but due to early clinic starts and rotas not all staff were available to attend. Staff felt informed and communicated with by their managers and did not see the lack of regular meetings as an issue. Some staff meetings were formal with minutes taken, some were informal and in some instances the discussion had been turned into a newsletter for staff.

Diagnostic and Imaging governance, risk management and quality measurement

- Radiology services were well led. Operational management arrangements were robust and well received with clear lines of accountability with each modality group assigned a radiologist for support.
- The radiology department was incorporated into the trust wide management and governance structure within the Diagnostics and Clinical Support Directorate. Managers and modality leads cross-covered between sites and the majority of radiologists and radiographers rotated through both hospitals. The majority of policies and procedures spanned across all three hospital sites including radiation safety and governance arrangements.
- The radiation safety committee (RSC) met regularly and there were clear governance arrangements within radiology with regular meetings and a dedicated radiology governance lead radiographer and radiologist. Regular radiation reports from the head of Medical Physics and Clinical Engineering, and radiation protection services were escalated to board level. We saw minutes from governance and RSC meetings, which discussed quality and improvement.
- There was a full quality assurance programme for diagnostic imaging. This included key performance indicators for tolerance levels, testing times and performance parameters set by Medical Physics and Clinical Engineering. The head of service attended a

monthly governance meeting where the performance of the department was presented. Constant performance monitoring was clearly evident and made available to the clinical director and the board

- Where directorates other than radiology referred radiation incidents we saw there was poor management of incidents. Directorates did not actively close off incidents despite escalation by the radiology governance lead and the trust radiation protection adviser (RPA).At the time of the inspection there were 68 open incidents. Open incidents required frequent chasing up, often in response to CQC requirements. Some incidents reported by directorates were closed off prior to actions being undertaken and assurances being given to the radiation protection service and the CQC. This led to the RPA reopening incidents and further escalation to prompt responses required.
- Radiology had weekly dashboard figures, which allowed them to communicate internally and with the trust board regarding waiting times and reporting issues. We were told some of the data was not correct due to reporting methods, but this was being addressed.

Leadership of service

- Leaders in radiology were visible and approachable. Some staff we spoke to said despite being well respected the lead radiologist did not face elements of departmental and trust conflict. Team leaders appeared cohesive and enthusiastic and staff felt well supported. The radiology service manager had a shop floor presence and once a month worked in the clinical environment with staff.
- Leaders were visible in outpatient departments. Staff and managers gave examples of when senior managers including the chief executive had 'walked the floor' and visited services. All staff we spoke to said local leaders were visible and matrons were often seen in clinics and supporting staff.
- Staff told us managers were sensitive to their concerns and were held in high regard. For example in radiology there were recent changes to the structure of the department. There were workforce issues and concerns with the trusts financial constraints. Staff said they felt managers handled these situations well.
- Managers were aware of ongoing issues relating to the radiology service. For example, the number of open radiation incidents. There were plans for a more focused approach ensuring there was a regular systematic overview of all incidents, especially those not escalated and addressed in external departments. Managers were aware of the advice and the radiation protection service at the trust had given assurances their plans would fall in line with recommendations.
- Leaders in outpatient services were aware of the issues affecting their services. They identified what needed to improve and how their services could develop.
- Leaders promoted a culture improvement and openness. A senior sister in chemotherapy said, "If staff suggest it, we will try it". There was an ethos across outpatient departments of encouraging all staff to give their views on how departments could be improved and work better.

Culture within the service

- All staff and volunteers we spoke with felt part of a team and described their own services as friendly and supportive. Volunteers said they were "looked after" in clinic settings and administrators felt just as much part of the team as clinical staff. We observed interactions between staff and saw it was respectful and friendly with everyone valuing each other's contribution.
- There was a patient centred culture at City Hospital. All staff and volunteers were passionate about good patient care. We saw examples of staff putting the needs of patients first through systems and processes and through patient interaction in and around clinics. Staff described their passion for getting to know patients and establishing patient relationships. We saw examples of staff going above and beyond for patients.
- Staff felt supported by their managers. They said they felt respected and valued by their managers and the trust. However, a small number of administrative staff said they did not feel valued by the trust due to a lack of engagement regarding the administration redesign project.
- The radiology department was completely restructured in 2012 and this had "turned around" the perception of

radiology, which was now much more positive. The clinical director told us radiology provided a quality service and the service was working constructively with other hospital departments.

- A preceptorship lead was responsible for new core and agency staff commencing employment in the radiology department. The programme for new staff was thorough and robust. Trust and departmental structures, policies and procedures were well laid out with a holistic and supportive approach to new team members, especially newly qualified radiographers.
- Radiology staff were motivated and focussed on providing a good service to patients. They were supportive of one another. Consultant radiologists described very good relationships between colleagues within radiology and consultants in other specialities. We observed the department were a good team who communicated and supported each other.

Public engagement

- Patients used comment cards to give feedback about their care and treatment. Patients could comment anonymously if they wished. There were comment cards in an 'easy read' format for patients who might prefer this.
- There were 'you said we did' posters on all clinic walls, which gave examples of where services had listened to patient feedback. We saw examples of where services had responded to patient feedback and changes the way they delivered services. Some were small changes and some were whole process changes for services. The majority of staff we spoke to gave us examples of when they had listened to patients and changed things as a result.
- Outpatient services conducted a '15 step' challenge with patient representatives. This was to assess the patient experience of outpatient departments. Services sent fake appointment letters to volunteers who then used the letters to see if they could find their way to clinics. As a result of this exercise services developed a patient letters group. The patient letters group made changes to patient directions, the map of the hospital, and simplified the language in letters so patients could better understand them. Work was ongoing at the time of the inspection and the work had not been evaluated yet.

Staff engagement

- At the time of our inspection a project to redesign and centralise administration services was in progress. This affected receptionists, secretaries, booking clerks, and staff who prepared records for clinics. There was a clear process of communication and consultation with staff. The majority of staff said they were kept informed through attending meetings and one to one discussions with their manager.
- Administrative staff told us despite being talked to about the process; they felt the trust were not listening to them. The staff were specifically concerned about loss of experience and patient relationships if staff were moved around. We raised this issue with project leads who were aware of it. The project leads told us they would ensure there was clear communication to staff and assured us the majority of staff would remain within the specialties where they worked.
- The majority of staff we spoke with felt they were involved and could have a say about what was happening in the trust. Staff told us how they were involved in discussions about the way services were delivered and felt they had an influence.
- Staff were communicated with through team meetings, emails and newsletters. Some clinic managers created their own newsletters to ensure staff had messages and communication from senior managers. Managers realised at times it was not possible to have whole team meetings and therefore they ensured staff were engaged in a number of different ways. Staff said they felt communicated with and accessed information in a way suitable to them.
- There were regular radiation protection, clinical governance and departmental staff meetings with good communication to junior staff by email and on the shared computer drives.

Innovation, improvement and sustainability

- The trust was undertaking several projects to improve services to ensure their sustainability. This included a project to centralise administrative services, a move to digitalised health records, a new performance dashboard, and an outpatient services redesign project. These projects were linked at a strategic level and were to improve patient access to services, consistency

regarding access to records and appointments, and patient experience. These projects were at an advanced stage and due to be implemented late 2015 and early 2016.

- In addition to the above, work was under way to centralise all outpatient services under one building and potentially under one directorate. This included the services delivered at Ropewalk House. An exercise was underway to establish how much space would be required to deliver all clinics from one location. This would benefit patients because they would be able to access several services in one location.
- The chemotherapy department demonstrated numerous examples of improvement and development. The service had developed projects to help the service run quicker and smoother for staff and patients. For example, the service had developed a purple bags initiative. This allowed patients to access treatment quicker after having their blood tested and authorised. Another initiative improved the flow of patients through the clinic by introducing a system for staff to quickly and easily see when a chair was available for patients to start their treatment.
- All new diagnostic and imaging equipment was purchased through a procurement programme and advice was sought from Medical Physics and Clinical Engineering prior to purchasing. However, due to the lack of forward vision of the capital rolling replacement programme, at times Medical Physics and Clinical Engineering could not offer full support with the short notice they were given. This led to delays at times in replacing and improving equipment levels.
- The radiology department performed a gap analysis and were working towards applying for ISAS accreditation. This included the appointment of a practice development coordinator. There were numerous project groups with one overarching steering group collating evidence across all of the accreditation domains. Gaps in compliance against the standards were being addressed as they were highlighted.
- Check-in kiosks were installed last year to reduce patient waiting times. Patients could check-in without standing in line at the front desk using new self-service kiosks. The trust sent us data for one clinic, which showed less than one fifth of patients used the kiosk to check in. We saw a small number of patients using these kiosks during the inspection.

Outstanding practice and areas for improvement

Outstanding practice

Medical care (including older people's care)

- We saw examples of innovative practice in order to reduce risks to patients. On Southwell Ward we saw patients wore a coloured wrist band when they required oxygen to ensure they received the correct rate. This ensured staff could easily identify the patient's required rate and dangerous levels of oxygen would not be administered.
- Patients receiving oxygen through a nasal cannula were at risk of developing pressure ulcers where plastic tubing went over the tops of their ears. Sponge covers were placed over the tubing to prevent this from happening. (A nasal cannula is a lightweight tube which splits into two prongs placed in the nostrils and from which a mixture of air and oxygen flows).

Surgery

- Theatres benchmarked activities against their own standards and compared their practices with external organisations. For example, they had compared some of their processes with neighbouring hospitals and as a result asked a trained band six nurse to do a specific eye procedure instead of a consultant.

Critical Care

- A critical care consultant at the trust was developing a tool to support the complex decision making process for critically ill patients. The tool was based on an ethical and balanced approach to selecting a suitable treatment plan for patients and act as a base for further clinical decisions. The tool would then be used as a tracking system so that clinicians understood previous treatment choices and clinical outcomes. This was supported by colleagues and was considered to be an innovative development in tracking the decision making process in treating critical care patients.
- The use of the trust's simulation centre had helped staff in developing advanced communication skills.
- Innovative approaches were used to gather feedback from people who used the service. One example was that patients and carers were invited to the opening of a new bed area to get their views on patient privacy.

End of life services

- A project was set up and led by a ward sister at Hayward House following a high rate of incidents related to falls. An independent falls expert was invited to look at the environment and the day to day culture of nursing practice on the ward at Hayward House. This review found a lack of focus on patients who were at high risk of falling. Steps were taken following the review to reduce the risk of falls on the ward. Two cohort bays were set up. [A cohort bay is for patients at high risk of falling to be cared for together in the same area so their needs are managed more efficiently and safely]. A cohort nurse was allocated to the cohort bay. The cohort nurse wore a brightly coloured tabard to reduce the risk of interruptions and diversions. Changes to the ward environment included a colour theme to make it easier for patients to find their way around and equipment clutter removed from corridors. A six month review in June 2015 showed these changes had led to a 43% reduction in total falls, a 38% reduction in unwitnessed falls and a 67% reduction in repeated falls.

Maternity and gynaecology services

- A member of staff designed an electronic application specifically for women using the trust's services called the 'Pocket Midwife'. It was free to download and anyone could access it. It had information about each stage of pregnancy, and all of the maternity leaflets and maternity guidelines could be accessed easily. The service could add news flash information to the application for women to see, such as sending a reminder to women about flu vaccinations.

Outpatients and diagnostic imaging

- The chemotherapy department demonstrated numerous examples of improvement and

Outstanding practice and areas for improvement

development. The service had developed projects to help the service run quicker and smoother for staff and patients. For example, the service had developed a purple bags initiative. This allowed patients to access treatment quicker after having their blood tested and authorised. Another initiative improved the flow of patients through the clinic by introducing a system for staff to quickly and easily see when a chair was available for patients to start their treatment.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The trust must ensure consultant cover in the maternity service for the labour suite meets national recommendations and guidance.
- The trust must ensure that there are sufficient numbers of suitably qualified, competent, skilled and experienced nurses working in the critical care service. The Core Standards for Intensive Care Units minimum requirement is for 50% of nurses in intensive care units to have a post-registration award in critical care nursing. There were 26% of nurses with this qualification at the time of our inspection.
- The trust must ensure there are sufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of patients on the inpatient ward at Hayward House.

Action the hospital SHOULD take to improve

- The trust should ensure patients' fluid and food charts are completed accurately.
- The trust should ensure oxygen is prescribed in line with the trust's policy for patients who require it.
- The trust should ensure immunosuppressed patients are not nursed in the same area as those with infections.
- The trust should consider the installation of air conditioning in the Wolfson Cystic Fibrosis Unit to reduce distress for patients in warm weather.
- The trust should ensure clinical waste bins awaiting collection are secure.
- The trust should review the security arrangements to the maternity unit and ensure the site is secure at night.
- The trust should ensure all equipment, including electrical, has been appropriately serviced and received portable appliance testing when necessary.
- The trust should ensure fire alarm break glass points have the necessary equipment so they can be activated.
- The trust should ensure the proper and safe management of medicines by staff following the correct procedures for checking and administering medication to patients.
- The trust should ensure assistance given to patients with oral hygiene is documented correctly and consistently by staff.
- The trust should ensure staff have feedback on the auditing of fluid charts.
- The trust should ensure adequate training is available for all staff using the inpatient adult risk assessment booklet NUH01873S in relation to pages 13, 14 and 15.
- The trust must ensure all staff in the Family Health division receive up to date training in the safe operation of medical equipment.
- The trust should ensure all complaints and the outcome of the investigations are shared with the area concerned and the wider directorates.
- The trust should ensure, as good practice, that prescription charts have the name of the prescriber written in capital letters with their contact number for identification purposes.
- In the trust's Family Health division 67% of staff had not completed training in the safe use of medical equipment. The trust should ensure staff are trained and competent to use equipment safely.
- The trust should ensure that workforce requirements in the maternity service are analysed in terms of what women using the service need, rather than what midwives do.
- The trust should ensure up to date guidance is available for staff in the maternity service regarding criteria for admission to the midwifery led unit.
- The trust should ensure a home from home philosophy and environment for women giving birth in the midwifery led unit.

Outstanding practice and areas for improvement

- The trust should ensure there are operating theatre facilities and time dedicated for planned caesarean section operations.
- The trust should ensure maternity service actively recruit user representatives.
- The trust should ensure all senior and specialist staff in maternity services are visible on the wards and participate with clinical activities.
- The trust should ensure women and their families using the maternity service have clear and accessible information about how to make a complaint.
- The trust should ensure the maternity service meets the national neonatal audit programme standards for temperature taken at birth, and mothers receiving steroid medication in the antenatal period.
- The trust should ensure confidentiality of information about women using the maternity service. Women's names and details of their treatment should not be displayed where they may be seen by visitors.
- The trust should ensure that all staff receive feedback about incidents.
- The trust should ensure that nursing assessments are fully completed and babies care plans are reviewed regularly.
- The trust should ensure that a complete record is kept for each baby, which includes appropriate information and documents the care and treatment provided.
- The trust should ensure that each staff member has an annual appraisal.
- The trust should ensure that each staff member attends mandatory training.
- The trust should ensure that medical cover in the critical care service meets the Core Standards for Intensive Care Units recommendations at all times.
- The trust should ensure all 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms are completed in line with the trust's DNACPR policy.
- The trust should have an end of life care strategy to ensure patients receive end of life care in line with national guidance and research based good practice.
- The trust should increase the number of consultants in the specialist palliative care team to reflect the recommendations of the Association for Palliative Medicine of Great Britain and Ireland and the National Council of Palliative Care.
- The trust should increase the specialist palliative care nursing team to ensure patients can access specialist palliative care services and receive a face-to-face consultation seven days a week, in line with National Institute for Health and Care Excellence (NICE) Quality Standard number 10 published in 2011 for end of life care for adults.
- The trust should ensure end of life care champions are allocated protected time each week for carrying out their role.
- The trust should consider updating their end of life care bundle to ensure staff record patients' preference for involvement of the pastoral care team.
- The trust should provide a structured programme of end of life care training for all staff to ensure patients receive appropriate care at the end of their life.
- The trust should ensure effective monitoring of 'fast-track' discharges and compliance with patients' wishes regarding preferred place of care and preferred place of death. Good practice in these areas should be shared across the trust and appropriate action taken to address any issues.
- The trust should provide a structured programme of end of life care training for all staff to ensure patients receive appropriate care at the end of their life.
- The trust should ensure the system for maintaining and testing clinical equipment is timely, effective and consistent to ensure it is safe to use.
- The trust should ensure risk assessments are carried out where environmental issues may have an impact on outpatient services.
- The trust should ensure there is a sufficient and effective portering service for patients attending outpatient clinics from the wards and when required to transport deceased patients to the mortuary.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise. How the regulation was not being met: Regulation 18(2)(a) The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units. The trust must ensure midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic. The trust must ensure midwives have appropriate training to provide safe care for high dependency women in an appropriate environment. Ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support. In the maternity service, the consultant cover did not meet national guidance. There were 68 hours per week of dedicated consultant cover for the labour suite. For the number of babies born in the maternity service each year there should be 168 hours per week of consultant cover.

This section is primarily information for the provider

Requirement notices

Ensure that trained nurse presence on the neonatal unit meets the 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM).

Ensure that there is sufficient neonatal consultant cover during the out of hour's period so that both hospital sites can access their own individual on call consultant. This is in line with the BAPM standards (3rd edition – section 5.1.4).

At Hayward House, there were 11 reported incidents between April and August 2015 where the number of staff on duty did not meet the planned staffing level on the inpatient ward. The incidents reported the impact to patients, for example not being able to maintain adequate repositioning regimes and skin checks, delays in being able to administer pain relief and delays in providing personal care. The trust must ensure staffing levels at Haywood House are sufficient to meet the assessed needs of patients.