

# Nottingham University Hospitals NHS Trust

## Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Good 

Are services safe?

Requires improvement 

Are services effective?

Good 

Are services caring?

Outstanding 

Are services responsive?

Good 

Are services well-led?


Good 

Are resources used productively?

Requires improvement 

# Summary of findings

## Combined quality and resource rating

Good 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Background to the trust

Nottingham University Hospitals NHS Trust (NUH) was established in 2006 following the merger of Nottingham City Hospital and Queen's Medical Centre. NUH 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 surrounding counties. NUH has a budget of just under £1 billion.

The trust is based in the heart of Nottingham and operates acute hospital services from three main sites:

- Queen's Medical Centre (QMC)
- Nottingham City Hospital
- Ropewalk House.

QMC is the emergency care site where the emergency department, major trauma centre and the Nottingham Children's Hospital are located. QMC is also home to the University of Nottingham's School of Nursing and Medical School.

Nottingham City Hospital is the trust's planned care site, where the cancer centre, heart centre and stroke services are based.

Ropewalk House is where the trust provides a range of outpatient services, including hearing services.

The trust is also a provider of care at the National Centre for Sports and Exercise Medicine in Loughborough.

The trust has approximately 1,904 in-patient beds over 90 wards in addition to 116 children's beds. The trust operates 2148 outpatient's clinics per week.

With 16,000 staff, NUH is one of the biggest employers in the city of Nottingham with a central role in supporting the health and wellbeing of the local population. NUH play a leading role in research, education and innovation.

## Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as **Good**   

## What this trust does

NUH is the fourth largest acute trust in England and provides a full range of acute 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 surrounding counties. The trust operates the major trauma centre and the Nottingham Children's Hospital which are located on the QMC site. QMC is also home to the University of Nottingham's School of Nursing and Medical School. Nottingham City Hospital is the trust's planned care site, where the cancer centre, heart centre and stroke services are based. Ropewalk House provides a range of outpatient services, including hearing services. The trust is also a provider of care at the National Centre for Sports and Exercise Medicine in Loughborough.

# Summary of findings

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 20 November 2018 and 13 December 2018, we inspected a total of seven core services provided by the trust across two locations. We inspected urgent and emergency care, medical care (including older peoples care), critical care, maternity, children and young people and end of life care at the Queens medical centre. Urgent and emergency care and end of life care we rated as requires improvement. We returned to check on progress within these services. Medicine (including older peoples care), critical care, maternity, children and young people were rated as good at our last inspection; we inspected these services this time as some of our local intelligence indicated there may have been a decline in these services.

We inspected medical care (including older peoples care), maternity, neonatal services and end of life care at Nottingham City Hospital. At our last inspection end of life care was rated as requires improvement, we returned to check on progress within this service. Medical care (including older peoples care), maternity, neonatal services were rated as good at our last inspection; we inspected these services this time as some of our local intelligence indicated there may have been a decline in these services.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish. Our findings are in the section is this organisation well-led?. We inspected the well led question between 8 and 10 January 2019.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as good because:

We rated effective, responsive and well-led as good, caring as outstanding and safe as requires improvement.

We rated five of the trust's services as good and two as requires improvement. In rating the trust, we took into account the current ratings of the two services not inspected this time.

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. There was clear leadership of the trust to drive and improve the delivery of high quality person centred care.
- Leaders understood the challenges to quality and sustainability; they could identify actions needed to address these.

# Summary of findings

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Most managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust had a 'Best-of-Breed' Strategy to become a 'Paperless Hospital' by 2020 and had a mission to be a global digital exemplar. The trust was very digitally orientated.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- There was a strong culture of continuous improvement, driven through transformation work. The Institute of Nursing and Midwifery Care Excellence had seen the development of new knowledge, innovation and education.

However:

- Not all services had enough medical and nursing to keep people protected from avoidable harm and to provide the right care and treatment.
- Arrangements to admit, treat and discharge patients were not in line with national standards.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From October 2017 to September 2018 the trust failed to meet the standard and performed worse than the England average.
- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From September 2017 to August 2018, the trust did not meet the standard for 11 months over the 12-month period.
- In children's services, outpatient appointments did not always run on time. Children and their families were not informed about delays in outpatients and the service did not monitor or analyse delays to outpatients. The outpatient environment could become very crowded for certain clinics
- Lack of out of hours access to paediatric interventional radiology meant that some babies needed to be transferred to other hospitals.
- In maternity, although the trust had made improvements to the leadership and governance structures, the changes had not yet been fully embedded and there was still a lack of oversight and assurance in some areas.
- In maternity there was not a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – [www.cqc.org.uk/provider/RX1/reports](http://www.cqc.org.uk/provider/RX1/reports).

## Are services safe?

Our rating of safe stayed the same. We took into account the current ratings of services not inspected this time. We rated it as requires improvement because:

- Not all services had enough medical and nursing staff to keep people protected from avoidable harm and to provide the right care and treatment.
- Not all services controlled infection risk well. Staff did not always keep equipment and the premises clean.
- Staff did not always follow best practice when prescribing, giving, recording and storing medicines.

# Summary of findings

- Compliance with mandatory training was low for nursing and medical staff in some core services.

However:

- Staff understood how to protect patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- There were good patient risk assessments in place and completed by staff, this included the escalation of patients who displayed signs and symptoms of deteriorating health.
- Patient safety incidents were mostly managed well.

## Are services effective?

Our rating of effective stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- Staff delivered care and treatment based on national best practice, internal and external audits and research outcomes. This included evidence-based guidance such as that issued by the National Institute of Health and Care Excellence, World Health Organisation (WHO) and various royal colleges aligned with the specialty of each service.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

However:

- Mental Capacity assessments were not always reviewed as required.
- Staff did not always demonstrate awareness of the Mental Capacity Act and the Deprivation of Liberty safeguards (DoLs).

## Are services caring?

Our rating of caring improved. We took into account the current ratings of services not inspected this time. We rated it as outstanding because:

- Feedback from people who use the services was continually positive.
- There was a strong, visible person-centred culture.
- Staff were motivated and inspired to deliver care that was kind and promoted dignity.
- Staff were consistently compassionate about patient care and strived to go ‘above and beyond’ where they could.

## Are services responsive?

Our rating of responsive stayed the same. We took into account the current ratings of services not inspected this time. We rated it as good because:

- The service took account of patients’ individual needs.
- Concerns and complaints were treated seriously, investigated and lessons learned from the results.

However:

- People were not always seen or treated in a timely way.

# Summary of findings

- Services were not always planned to meet the needs of patients.

## Are services well-led?

We rated it as good because:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice at QMC in urgent and emergency care, medicine, critical care, children and young people services and end of life care. At Nottingham City Hospital we found examples in neonates and end of life care

For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including a breach in one regulation that the trust must put right.

We found 67 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.

## Action we have taken

We issued one requirement notice to the trust. That meant the trust had to send us a report saying what action it would take to meet this requirement.

For more information, see the Areas for improvement section.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

# Summary of findings

## Outstanding practice

We found the following outstanding practice:

### Overall Trust

- Shared governance councils were in operation. This was part of the NUH Nursing and Midwifery strategic plan – “Demonstrating Excellence”. The trust aimed to develop leadership at all levels. Shared governance worked to flatten the hierarchy and gave all levels of staff an equal voice in decision making. The trust through shared governance equipped staff with leadership skills and confidence.
- The trust had a unique Junior Doctor Liaison Officer (JDLO) role. Amongst many tasks they undertook to offer dedicated pastoral support to the junior doctor workforce – over 1000 trainees and trust grades. Junior doctors could contact the JDLO directly, or be referred by their educational supervisor.
- The trust created a bespoke e-coroner and mortality screening tool which supported screening of all adult inpatient deaths and identified cases that may warrant further review.
- We saw numerous examples of where engagement with the local population had brought a tangible value. For example, in development of the ‘Memory Menu’, this had brought about fundamental changes to patients’ meal choices at the trust, for example there was now a “finger food” menu which was particularly important to those patients living with dementia.
- The trust had a Chief Nurse Excellence in Care Junior Fellows’ programme across the hospital. Nurses, midwives and ODPs were recruited to the role and provided with the opportunity to work as a clinical academic, combining a clinical role and the opportunity to develop and deliver a quality improvement project.
- The trust was working to the American Nurses Credentialing Center (ANCC) Magnet Recognition Program®. The trust was aiming to be the first accredited centre in the UK. Magnet recognises healthcare organisations for quality patient care, nursing excellence, and innovations in professional nursing practices. The Magnet designation means a hospital has met rigorous criteria and delivers exceptional nursing care.
- The Institute of Nursing and Midwifery Care Excellence had seen the development of new knowledge, innovation and education. INMCE continued to expand its strategic role in spearheading and delivering trust-wide programmes including shared governance leadership, preceptorship, acute care skills and wider workforce development.

### Queens Medical Centre

#### Urgent and Emergency Care

- The senior sister in eye casualty had developed a bespoke competency and development programme for junior doctors, ophthalmologists, nurses and nurse practitioners. They designed this to be delivered in short bursts during shifts, which enabled staff to access intensive sessions whilst minimising impact on patient waiting times.
- A multidisciplinary, multi-professional team led the department of research and education in emergency medicine, acute medicine and major trauma (DREEAM). This team was dedicated to emergency and acute medicine and trauma care and provided a comprehensive, innovative nurse development and training programme based on the latest national and international practice research. DREEAM managed a cohort of 40 simulation-trained patients who took part as actors in simulated training exercises for staff, including for major trauma and social care scenarios. The team had been recognised nationally for their work in writing and implementing a curriculum for the first two years of the nurse role.



# Summary of findings

- The DREEAM team carried out a twice-daily 'roll call' in the ED that provided staff with the opportunity for flash training based on a case review of a patient in the department. For example, the process offered staff the ability to deliver flash training on managing sepsis or a mental health need. Staff spoke positively of this process and said 15-minute 'bursts' of training provided them with opportunities to plan care for individual needs whilst avoiding additional pressure during their shift.
- The senior ED team had significantly improved nurse recruitment and retention through a programme of support and facilitating the department as a supportive, rewarding place to work. This had resulted in the return of 13 staff who had undertaken rotational programmes outside of the department and the return of other staff who had previously left through the hospital transfer programme.

## Medical Care (including older peoples care)

- The team on ward F18 had carried out research into the potential for improved health outcomes through structured, sustained efforts to help patients socialise. They used a family room on the ward for specific activities, such as mealtimes, and measured the outcomes over a period of time. The research contributed to improved practice on the ward and across the trust and was published in a peer-reviewed sociology journal.
- The integrated discharge team (IDT) engaged with patients who had previously had a poor experience of discharge from the hospital. They invited them to training days for excellence in discharge champions and encouraged staff to discuss what went wrong and identify strategies to avoid future recurrences. The IDT provided a digital forum for newly qualified nurses and used social media to discuss examples of good practice and learning. The team had recently introduced training for junior doctors on effective discharge. This was a key strategy to address the lack of discharge training student nurses received at university and the team were liaising with a local higher education provider to address this.
- The HCOP team had submitted business cases to significantly improve the capacity and scope of the service following mapping exercises to identify the current and future needs of their key population. For example, one business case had resulted in the introduction of bladder scanners connected to the electronic record system on every ward. Other work had resulted in the establishment of a new continence advisory service, whose staff trained hospital nurses and provided peer support. A senior holistic nurse, enhanced social worker support and an independent mental capacity advocate (IMCA) were also in post as a result of business development projects. The team had a pending case for a further eight advanced care practitioners and trust grade junior doctors to expand the frailty service.
- The team on ward B49 had identified a need for a link role in cultural diversity. This would be the first link role of its kind in the trust and the team was planning a frame of reference and aims for the role before opening it to applications for existing staff. This was in response to staff feedback on the diversity of patients and how the team could better meet individual needs.
- A pilot scheme on ward C25 had resulted in significantly improved experiences for patients. A clinical nurse specialist (CNS) in airway management had led a project to reduce the recovery time for patients with a tracheostomy following a laryngectomy. This enabled patients to be safely discharged home without the need for community inpatient care. For example, the CNS had escorted one patient to a family member's funeral, which had only been possible because of the more intensive recovery care provided.

## Critical Care

- The service was a lead in the development of national critical care best practice. For example, the service was active in making changes to critical care guidance through the national critical care network and the service was a lead in best practice relating to the NHS Blood and Transplant Organ Donation and Transplantation Directorate.
- The service held a critical care remembrance afternoon which took place in March 2018 at a local hotel. This enabled relatives and friends to remember their loved ones and share their experiences.



# Summary of findings

- Staff developed a moisture lesion prescription sticker as a guide for staff on moisture lesion management. The sticker was shared across the trust and was also presented at a critical care local network event and national events, including Wound UK and NHSI.
- The tissue viability link lead for critical care led on promoting an alternative nasogastric tube fixation device to prevent patients developing pressure ulcers and unintentional displacements of the naso gastric tube. The project reported a reduction in pressure ulcers and unintentional displacements.

## Children and Young People

- The service tried to make hospital fun for children. Around the wards and clinical areas, there were two ‘giggle doctors,’ and we observed a variety of volunteers entertaining children – including Spiderman, some musicians, a magician, and Millie the therapy dog.
- Shared governance was a driver for continuous improvement. The Children’s Assessment unit was the longest running model and had resulted in comfort packs for families, and investigated saturation probe reliability and whether it was better to have disposable or non-disposable probes. This resulted in a £9000 saving over three months. They identified that parents were struggling to leave their child to obtain refreshments. They implemented a comfort round which offered drinks and biscuits to parents. This was delivered predominantly by the house keeping/ reception staff at 6pm which was one of the busiest times on the ward.

## End of Life Care

- The implementation of the SWAN initiative had raised the profile and importance of EOLC across the trust and staff were without exception, motivated to ensuring the best possible care for patients at the end of their life, and their relatives.

## Nottingham City Hospital

### Neonates

- In 2016 the service initiated the quality improvement project “Neonatal Infections Near Zero (NINZ)” with the aim of reducing late onset sepsis. During 2018 the service had introduced new initiatives to reduce infection rates further. This included the ‘Time to rest, time to care’ visiting arrangements. Following an extensive parent/carer and staff consultation they identified challenges around undertaking optimal central line access for parenteral nutrition, footfall and visitor numbers on the unit, safe handover and mum’s missing evening meals. To address this a two-hour parent (and their children) only visiting window was adopted from 4-6pm. This coincided with central line access, medical handover, evening meal time for mums and allowed a period of relative quiet in the afternoon for the babies to rest with minimal activity from visitors. This initiative had been universally welcomed and seen as a very positive step for the care delivered.
- The service had been supported to appoint two Chief Nurse Excellence in Care Junior Fellows’ the role provides the opportunity to work as a clinical academic, combining a clinical role and the opportunity to develop and deliver a quality improvement project.’ As a result of this the Chief Nurse Fellows will work closely with Clinical Associate Professor in Children, Young People and Families, in conjunction with the Associate Professor. They will have a protected 1 day/week dedicated to QI projects such as the NINZ. This will include liaising with other units with low infection rates to identify any aspects of practice that could be improved on. We were told they would also be developing new procedures in parenteral nutrition and the case for supplementation to high risk infants for necrotising enterocolitis (NEC) and infection. (NEC is a medical condition where a portion of the bowel dies. It typically occurs in babies that are either premature or otherwise unwell.

## End of Life Care

# Summary of findings

- Hayward House had a viewing room known as the Swan Suite which had been newly refurbished in white and lilac. It was used to provide families of patients who had died with a quiet area where they were able to say good bye. As this was a cooled area, this allowed loved ones to spend an extended amount of time with the patient.
- The implementation of the SWAN initiative had raised the profile and importance of EOLC across the trust and staff were without exception, motivated to ensuring the best possible care for patients at the end of their life, and their relatives.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

### **Actions the trust MUST take**

#### **Queens Medical Centre**

##### **End of life care**

- The trust must ensure that Do Not Attempt Cardio-Respiratory Resuscitation (DNACPR) forms are documented fully and conversations with patients and relatives regarding DNACPR decisions are documented in patients' medical record.

### **Actions the trust SHOULD take**

#### **For the overall trust:**

- The trust should review the way in which scrutiny of the risks on the significant risk register takes place, to ensure a phased approach to risk reduction.
- The trust should ensure a regular review of the effectiveness of the mitigation actions of risks on the significant risk register are discussed and accurately recorded.

#### **Queens Medical Centre**

##### **Urgent and Emergency Care**

- The trust should ensure paediatric medical cover meets guidance from the Royal College of Paediatrics and Child Health.
- The trust should ensure consultant staffing cover in the ED aligns with guidance from the Royal College of Emergency Medicine.
- The trust should review the most recent audit from the laser protection advisor and ensure overdue and unaddressed actions are resolved urgently.
- The trust should address and resolve fire risks identified in 2017.
- The trust should ensure it improves access to paediatric radiology services overnight and at weekends.
- The trust should address the inconsistencies in staff knowledge and training in relation to the Mental Capacity Act (2005), the Deprivation of Liberty Safeguards (DoLS) and caring for people living with dementia.
- The trust should ensure the ED meets national performance targets in relation to the four-hour wait.

# Summary of findings

## Medical Care (including older peoples care)

- The trust should ensure they address the shortage of speech and language therapists so that patients have access to timely care and the existing team can safely prioritise workload.
- The trust should ensure it provides fire safety and evacuation training to all staff when they move wards and when a new ward is established.
- The trust should review the effectiveness of the fire warden system to ensure staff identify risks such as obstructed and blocked fire exits.
- The trust should review infection control systems to ensure they identify areas of poor performance in the management of sharps.
- The trust should work with the discharge lounge team to ensure they have equitable opportunities for engagement and development.

## Critical Care

- The trust should ensure that medical staff complete mandatory training required for their role in critical care.
- The trust should ensure that they continue to work towards 50% of critical care staff having post registration critical care module.
- The trust should continue to pursue the commencing of follow up clinics, to ensure these are provided for applicable patients following discharge from the critical care department
- The Trust should continue to improve rehabilitation post critical care discharge.
- The trust should review the need for the critical care outreach team in the evenings and weekends.
- The trust should ensure non-clinical transfers out of the unit are reduced to bring the service in line with national targets.
- The trust should ensure out of hours discharges to the ward from the adult intensive care unit are reduced.
- The trust should continue to provide resilience training for critical care staff.

## Maternity

- The trust should ensure that staff report all patient safety incidents and near misses so that they have a better understanding of the risks of their service.
- The trust should ensure there is sufficient midwifery staff to meet minimum safe staffing levels, carry out essential tasks and ensure staff get the breaks.
- The trust should ensure mandatory training compliance is in line with trust targets.
- The trust should ensure the environment and equipment is visibly clean always.
- The trust should ensure equipment checks are carried out in line with trust policy, ensuring that consumables are not out of date.
- The trust should ensure staff follow trust guidelines to ensure women are not having unnecessary caesarean sections.
- The trust should continue to improve their engagement with the clinical staff.
- The trust should ensure the culture supports the delivery of good care.
- The trust should ensure all risks are recorded on the divisional risk register.

# Summary of findings

## Children and Young People

- The trust should work towards there being at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service trained in advanced paediatric life support (APLS) or European paediatric life support (EPLS) depending on the need of the service.
- The trust should minimise delays to outpatients and inform children and their parents when there are delays. It should develop systems to record, monitor and take action on delays and causes of them.
- The trust should improve arrangements for children who need a general anaesthetic before their post tumour removal MRI scan so that scans can be booked on a more reliable basis.
- The trust should review capacity in children's theatre.
- The trust should take action to ensure children's operations cancelled for non-clinical reasons does not continue to increase. It should develop systems to record, monitor and take action on delays and causes of them.

## End of Life Care

- The trust should ensure that Mental Capacity Act assessments are completed for relevant patients when making DNACPR decisions.
- The trust should ensure that conversations about patient's mental health needs, spiritual and pastoral needs are documented in EOLC care plans.
- The trust should continue at pace to ensure there is a fully functioning hospital palliative care team providing a face to face service seven days a week by April 2019
- The trust should ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients.
- The trust should ensure there is a robust audit programme for end of life care to include but not limited to ratio of cancer to non-cancer patients treated by the service, fast track discharges, anticipatory medicines administration and prescribing and preferred place of death.

## Nottingham City Hospital

### Medical Care (including older peoples care)

- The trust should ensure that all staff attend training in the Mental Health Act and relevant trust policies.
- The trust should ensure all large yellow clinical waste bins are kept locked.
- The trust should ensure procedures and processes are in place to ensure patient medicines and potassium infusions are stored correctly.
- The trust should ensure staff are aware of correct monitoring of and recording of medicine fridge temperatures.
- The trust should consider introducing grand rounds to the city campus.
- The trust should consider inviting locum staff to training events.
- The trust should continue at pace to ensure it is compliant with the accessible information standard particularly for flagging vulnerable patients.
- The trust should ensure the David Evans Building is fit for purpose.

## Maternity

# Summary of findings

- The trust should ensure that staff report all patient safety incidents and near misses so that they have a better understanding of the risks in their service.
- The trust should ensure there is sufficient midwifery staff to meet minimum safe staffing levels, carry out essential tasks and ensure staff get the breaks.
- The trust should ensure the environment and equipment is visibly clean at all times.
- The trust should ensure equipment checks are carried out in line with trust policy, ensuring that consumables are not out of date.
- The trust should ensure staff follow trust guidelines to ensure women are not having unnecessary caesarean sections.
- The trust should continue to improve their engagement with the clinical staff.
- The trust should ensure mandatory training compliance is in line with trust targets.
- The trust should ensure the culture supports the delivery of good care.
- The trust should ensure all risks are recorded on the divisional risk register

## Neonates

- The trust should ensure continued recruitment and development of neonatal nurses to meet the service plan for achieving national standards.
- The trust should consider timely review of a cross site service in view of the infection control risks highlighted by root cause analysis post MRSA colonisation on the Unit.

## End of life care

- The trust should continue at pace to ensure there is a fully functioning hospital palliative care team providing a face to face service seven days a week by April 2019
- The trust should ensure patient outcomes are regularly monitored and reviewed to ensure the end of life care service is meeting the needs of patients.
- The trust should ensure there is a robust audit programme for end of life care to include but not limited to ratio of cancer to non-cancer patients treated by the service, fast track discharges, anticipatory medicines administration and prescribing and preferred place of death.
- The trust should ensure the internal ambulance is fit for purpose and that access to Hayward House is improved so that the deceased can be removed in a timely manner.

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This was the first trust-wide well-led inspection under our next phase methodology.

We rated well-led at the trust as good because:

# Summary of findings

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. There was clear leadership of the trust to drive and improve the delivery of high quality person centred care.
- The trust executives presented as an exceptionally cohesive and collaborative team who were well supported, and appropriately challenged, by a range of NEDs. There was clear leadership from the chair and chief executive.
- Leaders understood the challenges to quality and sustainability; they could identify actions needed to address these. Executive board members were capable, they had been both open and responsive to challenges and had strived for improvement throughout the organisation.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust had become key partners in the Integrated Care System (ICS) and worked with partners to better co-ordinate the Nottinghamshire health and care system through strong system leadership. The trust was fully involved in all elements of governance and leadership of the ICS. The trust played a lead role within the Integrated Care Partnerships (ICP) in greater Nottingham, demonstrating collaborative system leadership and actively developing a programme plan for ICP in Greater Nottingham.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff were in general motivated and wanted to provide the best possible care for patients and were proud to work for the trust. Staff articulated the contributions made by themselves and their teams. We saw there were co-operative, supportive and appreciative relationships among staff and within teams, despite the challenges of staffing levels and increasing capacity and demand issues and a challenging estate.
- Without exception the executive directors, directors and NEDs described a workforce focused on doing their best and striving to deliver. The chief executive told us “passion was palpable in the organisation”.
- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The trust had made some changes to strengthen the committee structure since our last inspection. Structures, processes and systems of accountability, including governance and management of partnership arrangements were clearly set out, understood and effective.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The trust had invested in innovative and best practice systems and processes to support the delivery of care, for example an e-coroner and mortality screening tool which supported screening of all adult inpatient deaths and identified cases that may warrant further review and an electronic sepsis screening tool.
- The trust had a ‘Best-of-Breed’ Strategy to become a ‘Paperless Hospital’ by 2020 and had a mission to be a global digital exemplar. The trust was very digital orientated.
- There was holistic understanding of performance. Integrated reporting supported effective decision making.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

# Summary of findings

- We saw numerous examples of where engagement with the local population had brought a tangible value. For example, in development of the 'Memory Menu', this had brought about fundamental changes to patients' meal choices at the trust, for example there was now a "finger food" menu which was particularly important to those patients living with dementia
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- There was a strong culture of continuous improvement, driven through transformation work. The Institute of Nursing and Midwifery Care Excellence had seen the development of new knowledge, innovation and education.
- There was a strong focus on research and innovation which supported local, national and international best practice. The trust had significantly improved its recruitment activity and were ranked 12th in terms of overall recruitment activity to clinical trials among all trusts in England. Commercial research performance in the trust had improved significantly (18.75% year on year growth) with the trust being in the top 5 in the country for improvement in commercial research activity.

However:

- We were not assured that full scrutiny of the risks was taking place. There was no assurance that the current mitigating actions were sufficient to get the risk to its residual score as there did not appear to be a phased approach to risk reduction and a regular review of the effectiveness of the mitigation actions.
- At the time of our inspection the trust did not have a fit and proper person (FPPR) procedure in place; it formed part of the recruitment policy. The trust planned to create a specific FPPR procedure by March 2019, to enhance their current process.
- Leaders recognised the trust hadn't yet met its full potential. There were more opportunities for the trust to promote the research, teaching and innovation elements of the trust.

## Use of resources

Please see the separate use of resources report for details of the assessment and the combined rating. Please see the separate use of resources report for details of the assessment and the combined rating. The report is published on our website at [www.cqc.org.uk/provider/RX1/Reports](http://www.cqc.org.uk/provider/RX1/Reports).



## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Mar 2019	Good ↔ Mar 2019	Outstanding ↑ Mar 2019	Good ↔ Mar 2019	Good Mar 2019	Good ↔ Mar 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

## Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Queen's Medical Centre	Requires improvement ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Requires improvement ↓ Mar 2019	Good ↔ Mar 2019	Requires improvement ↓ Mar 2019
Nottingham City Hospital	Good ↑ Mar 2019	Good ↔ Mar 2019	Outstanding ↑ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019
Ropewalk House	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
<b>Overall trust</b>	Requires improvement ↔ Mar 2019	Good ↔ Mar 2019	Outstanding ↑ Mar 2019	Good ↔ Mar 2019	Good Mar 2019	Good ↔ Mar 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Queen's Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Requires improvement ↔ Mar 2019	Good ↔ Mar 2019	Requires improvement ↔ Mar 2019
Medical care (including older people's care)	Good ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Outstanding ↑ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019
Surgery	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016
Critical care	Good ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Outstanding ↔ Mar 2019	Good ↔ Mar 2019
Maternity	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Services for children and young people	Good ↑ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Requires improvement ↓ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019
End of life care	Good ↔ Mar 2019	Requires improvement ↔ Mar 2019	Good ↔ Mar 2019	Good ↔ Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019
Outpatients and diagnostic imaging	Good Mar 2016	N/A	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

### Ratings for Nottingham City Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good ↑ Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019
Surgery	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016
Critical care	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Outstanding Mar 2016	Outstanding Mar 2016
Maternity	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Neonatal services	Good ↑ Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019
End of life care	Good ↑ Mar 2019	Requires improvement →← Mar 2019	Outstanding ↑ Mar 2019	Good →← Mar 2019	Good ↑ Mar 2019	Good ↑ Mar 2019
Outpatients and diagnostic imaging	Good Mar 2016	N/A	Good Mar 2016	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016
<b>Overall*</b>	Good ↑ Mar 2019	Good →← Mar 2019	Outstanding ↑ Mar 2019	Good →← Mar 2019	Good →← Mar 2019	Good →← Mar 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

### Ratings for Ropewalk House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
<b>Overall*</b>	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Queen's Medical Centre

Derby Road  
Nottingham  
Nottinghamshire  
NG7 2UH  
Tel: 01159249944  
www.nuh.nhs.uk

## Key facts and figures

Nottingham University Hospitals NHS Trust (NUH) was established in 2006 following the merger of Nottingham City Hospital and Queen's Medical Centre. NUH 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 surrounding counties. NUH have a budget of just under £1 billion.

The trust operates the major trauma centre and the Nottingham Children's Hospital are located on the QMC site. QMC is also home to the University of Nottingham's School of Nursing and Medical School.

## Summary of services at Queen's Medical Centre

**Requires improvement** ● ↓

Our rating of services went down. We rated it them as requires improvement because:

- Not all services had enough medical and nursing to keep people protected from avoidable harm and to provide the right care and treatment.
- Not all services controlled infection risk well. Staff did not always keep equipment and the premises clean.
- We were not assured of appropriate safety processes at service level for laser equipment in eye casualty. There were discrepancies between the services the trust believed were offered in the laser service and the services offered in practice. The most recent annual laser protection audit identified areas in need of significant improvement
- Arrangements to admit, treat and discharge patients were not in line with national standards.
- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From October 2017 to September 2018 the trust failed to meet the standard and performed worse than the England average.
- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From September 2017 to August 2018, the trust did not meet the standard for 11 months over the 12-month period.
- In children's services, outpatient appointments did not always run on time. Children and their families were not informed about delays in outpatients and the service did not monitor or analyse delays to outpatients. The outpatient environment could become very crowded for certain clinics

# Summary of findings

- Lack of out of hours access to paediatric interventional radiology meant that some babies needed to be transferred to other hospitals.
- In maternity, although the trust had made improvements to the leadership and governance structures, the changes had not yet been fully embedded and there was still a lack of oversight and assurance in some areas.
- In maternity there was not a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However:

- Staff understood how to protect patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service provided care and treatment based on national guidance and monitored patient outcome to monitor for the effectiveness.
- Staff worked together as a team to benefit patients.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The trust planned and provided services in a way that met the needs of local people.
- The services took account of patients' individual needs.
- Most of the services had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff patients, and key groups representing the local community.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

# Urgent and emergency services

Requires improvement   

## Key facts and figures

The emergency department (ED) is located at the Queens Medical Centre site, with the associated major trauma centre. The service has an urgent primary care provider, which is open seven days a week and commissioned on separate arrangements directly to the Commissioning Partnership.

Nottingham University Hospital (NUH) has a separate paediatrics and adult emergency department, neighbouring each other, with patient care for all ages combined in the resus area. The emergency department is staffed 24/7 by consultants supported by a multidisciplinary team of advanced clinical practitioners, junior doctors, nurses, ED assistants and other supporting members of the team.

A short stay unit, Lynn Jarrett unit (LJU), is located in close proximity to the department and will accommodate short stay admissions both under the ED team and the acute medical team. A non-bedded frailty unit is co-located with ED and led by health care of the elderly.

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

### Activity and patient throughput

#### **Total number of urgent and emergency care attendances at Nottingham University Hospitals NHS Trust compared to all acute trusts in England, July 2017 to June 2018**

From July 2017 to June 2018 there were 203,374 attendances at the trust's urgent and emergency care services.

*(Source: Hospital Episode Statistics)*

#### **Urgent and emergency care attendances resulting in an admission**

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2017/18 compared to 2016/17. In both years, the proportions were higher than the England averages.

*(Source: NHS England)*

The eye casualty offers emergency care from 8am to 10pm seven days a week and treats approximately 80 to 120 patients daily, including approximately 20 children. A rapid access clinic (RAC) and an emergency observation bay in ward C25, a head and neck ward, provides additional capacity. The service sees approximately 27,000 patients per year including 4000 patients for laser treatment and 600 patients for the RAC. Outside of these times the ED team provides emergency care and treatment. Three laser rooms are co-located in casualty for procedures such as emergency retinal treatment. We included the eye casualty department in our inspection and our ratings and evidence reflect this service.

The minor injury and illness service operates 24-hours, seven days a week and is primarily nurse led by emergency nurse practitioners (ENPs). ENPs are unavailable from 2am to 7am, during which time junior doctors lead the service.

We previously inspected this service in December 2016 and rated it as requires improvement overall. These reflected ratings of good in effective, caring and well led and ratings of requires improvement in safe and responsive. After the inspection we told the trust it SHOULD:

- Consider measures to reduce overcrowding in ED.
- Install call bells for patients in the majors' area of ED.

# Urgent and emergency services

- Ensure the safety of patients waiting to be seen in minors.
- Ensure there is a robust system for reporting faulty or damaged equipment.
- Provide surfaces for staff to use for notes, clinical equipment and refreshments that do not present an infection control risk.
- Provide sufficient seating for patients waiting to be streamed.
- Ensure leaders in the ED have access to real time information to help them target areas for improvement.
- Ensure all staff understand how to support patients living with dementia.
- Provide patient information leaflets in the ED in languages to meet the local population.
- Consider how patient information can be displayed on the computer system to speed up review.

At this inspection we found the trust had addressed some of these areas, including improved patient supervision in minors and improved access to electronic patient records. However, the trust had not addressed all areas with some significant areas for improvement still to be resolved. This included the installation of call bells, unmitigated overcrowding in the resuscitation area and highly inconsistent access to training for staff in dementia.

During our inspection we carried out the following activities:

- Inspected the ED, RAC, eye casualty and LJU.
- Spoke with 53 members of staff representing a range of roles, grades and levels of responsibilities. This included staff who provided specialist services in emergency care areas but were not part of the local teams.
- Reviewed 19 patients' medical records.
- Reviewed over 90 additional items of evidence including audits, quality improvement exercises, national data and documentation relating to governance and risk management.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The ED performed consistently poorly in national measures of performance, including in the time from arrival to treatment and the time from arrival to transfer or discharge.
- We were not assured of appropriate safety processes at service level for laser equipment in eye casualty. There were discrepancies between the services the trust believed were offered in the laser service and the services offered in practice. The most recent annual laser protection audit identified areas in need of significant improvement.
- Staff training and care pathways did not consistently meet the needs of patients with mental health conditions or challenges.
- Performance against national averages was variable and the hospital performed worse in measures relating to time from arrival in ED to initial assessment, which was 41 minutes compared with seven minutes nationally.
- There were significant unmitigated risks in eye casualty caused by inadequate staffing levels and the failure of the division and trust to address long-standing concerns raised by staff. This reflected embedded disconnections between senior staff in the trust and the team in eye casualty who delivered clinical care.



# Urgent and emergency services

- Results in national Royal College of Emergency Medicine audits were highly variable, including poor results in the acute severe asthma audit, the consultant sign-off audit and the severe sepsis and septic shock audit.
- Risk management governance in some areas was variable with sporadic representation from some teams and inconsistent evidence of risk reduction and safety improvement.

However:

- The department of research and education in emergency medicine, acute medicine and major trauma (DREEM) team had implemented training and development programmes for nurses in the ED that contributed to retention and recruitment. This led to an over-establishment of nurses and a significant reduction in turnover and was part of a range of initiatives led by multiple staff and teams to ensure the service could meet demand and remained sustainable.
- Major incident and emergency planning had been significantly improved through simulated exercises and more advanced training.
- From 2016 to 2018 the number of patients attending ED who required an inpatient admission decreased from 23% to 19%.
- Broad improvements were needed in mental health provision across all emergency care services. This included environmental modifications to the paediatric ED and more accessible and advanced training for staff.
- A wide-ranging transformation plan was underway to increase capacity and improve patient flow, experience and care. This was planned to be implemented from December 2018 and would address a number of issues we previously highlighted to the trust.
- A dedicated, multidisciplinary patient safety team worked across urgent and emergency services to support staff skills and improve practice and patient outcomes.
- Medical staff, nursing staff and the psychiatric liaison team and the security team used joint risk assessment tools to support patients at risk of self-harm or absconding due to mental health needs. This was an effective system that promoted patient safety and reduced the need for restraint.
- Care was demonstrably multidisciplinary and staff from a range of specialist clinical, non-clinical and research worked together to benchmark standards and improve patient outcomes and experience. Audits and research demonstrably improved standards of care and treatment and promoted skill development amongst staff.
- Staff had developed clinical care to meet the specific needs of the local population, including the elderly, students and those experiencing mental health problems.

## Is the service safe?

**Requires improvement** ● → ←

Our rating of safe stayed the same. We rated it as requires improvement because:

- Although completion of mandatory training had significantly improved from May 2018 to November 2018 in the ED, 44 of 45 staff members with expired training did not have courses booked or a recovery plan in place.
- Results from bi-monthly hand hygiene audits were highly variable and demonstrated compliance scores as low as 38% in some areas. There was limited evidence of consistent improvement because of audits and not all departments submitted consistent audit data. We did however see staff performing good hand hygiene practices during our inspection.

# Urgent and emergency services

- Some areas of the ED had been fitted with patient call bells following our inspection in December 2016. However, this did not include all patient care areas and there were no patient alarm bells in the mental health assessment room.
- Fire safety risks dating to July 2017 had not been addressed in the ED and we did not find adequate levels of oversight.
- Medical staffing levels in ED and eye casualty fell short of requirements and this impacted patient safety and timely care.
- We found some shifts in eye casualty operating without a single doctor in the unit at a given time.
- Completion rates of life support training varied from 12% to 82%.
- We found varying standards of completion of medical records and staff used multiple overlapping systems. The most recent records audit had taken place nine months previously without a representative sample in any of the urgent and emergency care areas.

However:

- The clinical lead for emergency planning had worked with their team to significantly improve training, staff skills and collaborative multi-agency working in major incident planning.
- The eye casualty team maintained mandatory training completion at 95%.
- Appropriate local safety processes were in place for staff using laser equipment in eye casualty, including in relation to infection control, training and contingency plans for equipment failure. However, there was a need for significant improvement highlighted in the most recent laser protection audit, which had not been fully addressed.
- Safeguarding training was mandatory and staff demonstrated understanding of the resources available to them, including the trust specialist safeguarding team and online tracking system to identify patients known to be at risk.
- An assessment room adapted for patients with mental health needs and accredited by the Royal College of Psychiatrists Psychiatric Accreditation Liaison Network was available in the ED.
- Standards of monitoring patients for deterioration had improved, with better oversight from the patient safety team and more consistent electronic observation tools available to staff. Staff had implemented new ways of working that ensured they had clear accountability for specific patients, which reflected an improvement since our last inspection.
- Staff met or exceeded national standards in sepsis screening and treatment and the ED team were working to improve screening out of hours.
- Nurse staffing levels in the ED had significantly improved and stabilised, with a highly successful recruitment drive completed in July 2018.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Staff delivered care and treatment based on national best practice, internal and external audits and research outcomes. This included evidence-based guidance such as that issued by the National Institute of Health and Care Excellence, World Health Organisation (WHO) and various royal colleges aligned with the specialty of each service.

# Urgent and emergency services

- The emergency department (ED) physiotherapy team had completed a substantive piece of work to better understand the demand and capacity in the service, which had resulted in improved staffing at key times.
- Processes were in place to manage patients' nutritional needs and staff were proactive in avoiding dehydration.
- Staff consistently measured and monitored pain in adult patients and the Lynn Jarrett Unit had a track record of good audit results in relation to pain management.
- The eye casualty teams had developed a range of service strategies to improve patient outcomes in relation to presentations for suspected cancer and patients who returned following eye surgery.
- Appraisal completion rates were consistently high and typically met, or were within 0.5%, of trust standards.
- The department of research and education in emergency medicine, acute medicine and major trauma (DREEM) led a range of innovative education and development programmes designed to support new nurses and develop their skills. The senior sister in eye casualty had addressed a lack of trust training provision with a new education and teaching strategy. This reflected the focus of each team on ensuring they developed clinical competencies.
- A psychiatric liaison team provided a 24-hour on-demand referral service for adult patients with mental health needs.

However:

- There was a lack of assurance, audit and accountability for the laser service in eye casualty. The most recent hospital-wide audit to assess standards against WHO safety checklists had not included the laser service.
- An audit into standards against national Royal College of Paediatrics and Child Health standards found 74% compliance, with a need for significant improvements in some areas. This was reflective of the specific challenges to the paediatric ED unit and team.
- The ED performed poorly in some areas of national Royal College of Emergency Medicine audits, including the pain in children audit, which included scores as low as 0% in some measures against a national standard of 100%.
- Services for younger people with mental health needs were limited and staff described considerable challenges in obtaining specialist input.

## Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- From May 2018 to November 2018 the emergency department (ED), Lynn Jarrett Unit (LJU) and eye casualty performed better than the national average in Friends and Family Test recommendation scores. Against a national average of 88%, the LJU achieved 97% and the ED and eye casualty achieved 92%.
- Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.
- We spoke with 13 adult patients, three paediatric patients and six relatives. All the feedback we received was positive, with specific comments about the caring and approachable manner of staff.
- Staff provided emotional support to patients during difficult discussions and additional resources were available through the 24-hour chaplaincy service and local counselling services.

# Urgent and emergency services

- Staff routinely involved patients in discussions about their care and treatment and took the time to explain decision-making.

However:

- Staff had access to communication aids to help patients become partners in their care and treatment. However, not all staff we spoke with were aware of these communication aids.
- During our last inspection in 2015 we stated the majors' cubicle had no call-bells in use for patients to attract attention if they felt unwell or needed attention in any way. This issue had still not been addressed.
- The ED scored poorly in the privacy measure of the 2018 patient-led assessment of the care environment (PLACE), with a score of 50%. This was a significant deterioration, of 25%, from the 2017 result.

## Is the service responsive?

**Requires improvement** ● → ←

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From October 2017 to September 2018 the trust failed to meet the standard and performed worse than the England average.
- The Royal College of Emergency Medicine (RCEM) recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. From September 2017 to August 2018, the trust did not meet the standard for 11 months over the 12-month period.
- From September 2017 to August 2018, 8% of patients left the ED before being seen for treatment, which was worse than the England average of 2%.
- The trust took an average of 86 days to investigate and close complaints and did not provide evidence of appropriate reasons for this.
- The ED had two mental health assessment rooms that were accredited by the Psychiatric Liaison Accreditation Network (PLAN).
- The ED scored poorly in the dementia and disability measures of the patient-led assessment of the care environment (PLACE). In 2018 the department scored 40% for dementia and 53% for disability. Both scores had deteriorated significantly from the 2017 results, in which the ED scored 73% for dementia and 68% for disability.

However:

- Staff had developed and adjusted services to meet the needs of the local population. This included implementing new care pathways for urgent laser eye treatment, providing care in the Lynn Jarrett Unit for acute and emergency patients and developing health interventions for local prisoners.
- Physiotherapists worked with emergency nurse practitioners to ensure each patient with an injury or physiotherapy need was followed-up by phone if they presented out of hours. This was part of an extended service offered by emergency physiotherapy practitioners that included a drop-in service. The team had a significant impact on admission-avoidance.
- The emergency department (ED) team was making positive progress with a project to reduce attendances amongst known patients with mental health needs.

# Urgent and emergency services

- Acute and specialist medicine teams provided cover to ED patients through both in-reach and outreach arrangements, including for respiratory medicine and cardiology.
- A dedicated frailty team was based in the ED and provided immediate review and care for patients who attended from care homes or where they needed input from older people specialists.
- Patients and staff were supported by a range of specialists, including a learning disability team, a social worker, a drug and alcohol liaison team and a play specialist nurse.
- Services had appropriate discharge arrangements for people with complex health and social care needs.
- ED staff demonstrated good working relationships with paramedics to facilitate faster handovers.
- The rapid access clinic offered urgent ophthalmological care as an alternative to eye casualty, which helped reduce pressure on that service. The clinic offered 10 sessions per week with access to three laser treatment rooms.
- Communications staff and clinical teams had made significant progress in meeting the requirements of the NHS Accessible Information Standard, including provided adapted information resources.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- The emergency department (ED) leadership team was demonstrably involved in teaching, training and the development of the department. The local leadership team in eye casualty was similarly supportive of staff development but was restricted by persistent short staffing and lack of senior support.
- The ED team were preparing for the completion of a major transformation project that had engaged staff and patients in development and reconfiguration. This would result in an expanded and safer environment for patients and staff.
- The department of research and education in emergency medicine, acute medicine and major trauma (DREEAM) team actively fostered a vision of integrated research and academic activity with clinical practice and a philosophy of delivering education and research together.
- Most staff we spoke with said local working relationships were positive and supportive. Staff in a broad cross-section of roles and responsibilities said they had access to timely support from their line manager or more senior colleagues.
- Clinical governance and quality performance processes were well established and demonstrably led to improved safety, standards of care and learning from incidents.
- A range of strategies were underway to improve information management, including live auditing and more consistent governance.
- There was a range of staff engagement strategies and fora, including specialty, professional and operational groups and listening events.

However:

- There was limited oversight from senior divisional staff of the eye casualty service. Staff did not feel listened to and their ability to improve the service was limited because of a lack of senior support. Although the service provided urgent and emergency care, there were only tenuous links between the department and other services in the hospital.

# Urgent and emergency services

- Although staff spoke highly of local relationships and support, staff in eye casualty and paediatric ED felt less positive about their influence on practice and service improvement.
- In some cases, governance, risk management and performance processes were sporadically attended with limited or no representation from some staff groups in 2018.
- Fire risk assessments in the ED and LJU indicated a need for more consistent oversight of environmental risk management and governance.
- Acute medicine did not have a clinical effectiveness lead and there had been no recent clinical effectiveness quarterly reports submitted.

## Outstanding practice

We found four areas of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found eight areas of improvement. See areas for improvement section above.

# Medical care (including older people's care)

Good   

## Key facts and figures

Medical services are located at the Queens Medical Centre (QMC) across 17 wards.

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

The QMC site supports a large proportion of the emergency medical admissions for health care of the elderly, rheumatology, diabetes, acute medicine, gastroenterology and neurology including level one admissions for these specialties.

The trust's City Hospital campus accommodates respiratory, cardiology, stroke, infectious diseases as well as oncology and haematology. A number of these services operate as tertiary centres with associated specialised commissioning arrangements, more common with the City campus specialties where the QMC arrangements are largely commissioned by the Clinical Commissioning Partnership.

A number of acute admissions units are in operation for medical patients. At QMC these are in the acute medicine and health care of older people (HCOP) specialties; At City, cardiology operates an acute coronary unit for direct primary percutaneous coronary intervention (PPCI) admissions, a specialist receiving unit which accommodates largely oncology and haematology admissions, a hyper-acute stroke unit for direct stroke admissions and a respiratory assessment unit for direct respiratory admissions and transfers from QMC.

Medical services are spread across three divisions, predominantly medicine division and cancer and associated specialties division with a smaller proportion in the surgical division.

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

The trust had 105,278 medical admissions from July 2017 to June 2018, a 36% increase from July 2016 to June 2017. Emergency admissions accounted for 48,247 (45.8%), 2,347 (2.2%) were elective, and the remaining 54,684 (51.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 25,719
- Clinical oncology: 20,680
- Gastroenterology: 14,108

*(Source: Hospital Episode Statistics)*

The acute medical receiving unit (AMRU) accepts adult medical patients referred by GPs or directly from the emergency department for ambulatory care assessment or acute medical admission. We included AMRU in our inspection of medical care services in addition to inpatient general and specialty wards, endoscopy and the discharge lounge.

We last inspected medical care services in September 2015 and rated the service as good overall and good in each domain. We told the trust they should:

- Ensure patients on ward B49 are consistently screened for malnutrition and dehydration.
- Ensure all staff are aware of their responsibilities in relation to infection prevention and control.



# Medical care (including older people's care)

- Ensure patients on healthcare of older people (HCOP) wards have equal access to meaningful activities.
- Ensure care plans are consistently personalised to each individual's needs.
- Ensure care plans reflect how staff should support patients who present with complex and challenging behaviour.
- Consider extending the learning disability liaison service to include weekends.
- Regulate ward temperatures and ensure equipment is checked in a timely manner.

At this inspection we found the trust had addressed all of these issues and that improvements were consistent and sustained. Although the learning disability liaison service did not operate seven days a week, staff had access to resources and support tools to help them deliver care.

To come to our ratings, we inspected every inpatient medical ward, including assessment units and acute short-stay units, the discharge lounge and endoscopy. We spoke with 73 members of staff representing a wide range of roles and levels of responsibility. We spoke to staff who provided services to hospital patients but were employed by other organisations as well as student nurses and volunteers. We reviewed the medical records of 12 patients and looked at over 120 other items of evidence, including governance records and training documentation.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Clinical and operational staff used an effective system to ensure medical patients cared for as outliers on surgical wards received regular medical reviews and individualised care. This included multidisciplinary care and reviews from specialist teams such as allied health professionals and the rapid response psychiatry team.
- The safeguarding team were working with regional partners to standardise safeguarding training in line with new intercollegiate guidance. This would ensure local practice was benchmarked against national standards.
- The patient safety team had a key role in maintaining and improving safety standards, including through benchmarking and acting on local risks. The team used the human factors analysis and classification system as a tool during the root cause analysis of serious incidents to ensure they fully understood the actions and thought processes of staff.
- Multidisciplinary staff had introduced a range of initiatives to improve nutrition and hydration, including of older patients, in addition to standard use of the malnutrition universal scoring tool. This included a gold standard programme to ensure patients had access to nutritious food that was culturally appropriate and served during facilitated mealtimes to promote social contact.
- Professional development and education were clear priorities for medical care. Patient outcomes had demonstrably been improved as a result and staff were able to pursue more advanced qualifications and training.
- Multidisciplinary working was embedded in care services and a diverse range of specialist teams had established links with each other to address gaps in care provision and to improve patient outcomes and experience, including when patients transitioned to community care.
- The integrated discharge team worked across the hospital to improve access and flow through a more robust, patient-centred model of discharge planning and delivery. This was a multidisciplinary team that supported ward teams to establish more advanced understanding of discharges and had established a team of trained discharge coordinators.

# Medical care (including older people's care)

- Staff routinely went above and beyond their responsibilities to provide additional care for patients that demonstrated the culture of compassion and kindness. This included setting up a clothes bank for patients with limited means to buy new clothes, fundraising for blankets for patients going home in the winter and liaising with the British Red Cross to support a patient at the end of their life.
- Specialist teams were increasingly aware of population-based health models and explored the needs and demographics of their target population to shape care and treatment, including health promotion interventions.
- A range of work had been completed to assess and improve accessibility to all elements of the service. This included improved access to mental health and drug and alcohol dependency care, language support and strict standards for information access. NHS England had certified the communications team as meeting The Information Standard, a national standard for health and social care information.
- The integrated discharge team and specialist services had developed discharge improvement projects based on the needs of their patients. The frailty service had experienced significant improvements, including a 5% increase in the pre-noon discharge rate and a 25% increase in use of the discharge lounge.
- Staff spoke positively of the trust's vision and strategy and had adapted local variations to meet the trust's objectives and reflect the needs of their patients. This included specialist teams not based on specific wards and reflected the enthusiasm of staff to deliver sustainable care.
- Governance processes and structures were well-established with clinical and operational oversight and assurance provided by a series of committees and multidisciplinary groups. Governance, risk and quality management processes demonstrably led to improved practice.

However:

- The overall nurse vacancy rate was 19%, which reflected wide variations between specialties including one ward with a 50% vacancy rate.
- There was a lack of assurance around fire safety risk, including staff understanding of evacuation processes and training.
- From June 2017 to May 2018, patients at Queen's Medical Centre had a higher than expected risk of readmission for elective admissions and a higher than expected risk of readmission for non-elective admissions when compared to the England average.
- Some teams did not feel part of the broad improvements and innovative projects taking place in the hospital and did not feel they were valued by the trust or their colleagues.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The safeguarding team worked across medical inpatient areas and provided on-demand patient reviews and coordinated care with other specialist teams.
- Standards of infection control were consistently good and staff based practice on national and international standards, including from the Department of Health and Social Care and the World Health Organisation.

# Medical care (including older people's care)

- Staff used a range of processes for risk assessments to plan and deliver care, including an electronic observation system to manage modified early warning scores (MEWS) system. These were audited and improvement plans put in place when performance fell short of trust and national standards.
- Turnover and sickness rates of medical staff were better than trust targets and from August 2017 to July 2018 there were no uncovered planned medical shifts.
- Ward managers explored and trialled strategies to address gaps in core medical cover, such as through care led by advanced care practitioners, support from medical team assistants and pharmacy prescribers.
- Care for patients being accommodated as outliers was well coordinated, including regular consultant-led reviews and risk management.
- Standards of patient records completion was consistent and in line with General Medical Council standards.
- There was a positive culture of incident reporting and learning. Specialist teams worked with wards to act on themes and trends and to implement improvement strategies.

However:

- Completion rates of mandatory training were variable in general and specialty medicine. Nurses had a 70% overall completion rate and doctors had a 50% overall completion rate. In acute medicine 82% of staff had up to date mandatory training.
- We did not see consistent documentation of mental health assessments for patients who presented with a risk of self-harm or suicide.
- Fire safety was not always consistent. We found there was a lack of processes to ensure fire escape routes were kept free from obstruction and gaps in staff training and knowledge in some areas.
- There were inconsistencies in adherence to the Control of Substances Hazardous to Health Regulations (2002) and the Sharps Instruments in Healthcare Regulations (2013) in relation to the safe management of sharps and contaminated waste.
- Storage of medicines in some areas was inconsistent and required greater assurance to ensure safe practice. This included in restricted access and safe storage temperatures.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Each team based their care and treatment on trust policies and national standards, including that issued by the Royal College of Physicians, the National Institute of Health and Care Excellence (NICE), the British Thoracic Society and National Safety Standards for Invasive Procedures.
- Staff had carried out audits and reviews of the needs of their local population to ensure care was evidence-based and supported good health outcomes. For example, the healthcare of older people (HCOP) staff had audited patients over the age of 75 and modified the service they provided for this population group.

# Medical care (including older people's care)

- The speech and language therapy team had established multidisciplinary links with community colleagues as part of a strategy to standardise care in line with National Osteoporosis Society standards. This was one example of a wide range of multidisciplinary initiatives to better serve patients through closer working between different specialist teams, including those based in the community.
- Specialist teams worked to implement care standards across medical wards that adhered to best practice guidance from organisations such as the European Pressure Ulcer Advisory Panel.
- Ward teams and dieticians had implemented a range of strategies to promote consistent nutrition and hydration amongst patients. This was part of a gold standards programme to ensure each patient had access to supported mealtimes that promoted socialisation.
- In the national lung cancer audit the trust improved performance from 2016 to 2017, including an increase in the proportion of patients who saw a cancer nurse specialist.
- Work carried out by the frailty team to improve the use of care pathways resulted in a 75% reduction in HCOP patients cared for as outliers and a 41% admission avoidance rate.
- Overall medical care services met the trust standard of a 90% completion rate for appraisals.
- Staff had access to a range of continuing professional development opportunities both in their wards and through the clinical practice educator team. This had led to patient improvements in a number of specialties such as more advanced dietician supervision and more advanced dementia care. A ward manager in HCOP had implemented a rotation system for nurses to build their skills across acute medicine and elderly care and the tissue viability team delivered regular study days.
- The diabetes and endocrinology team had developed a range of health promotion strategies to encourage patients to manage their condition through healthy lifestyle choices.

However:

- Trainee cardiac advanced care practitioners did not have protected time for training and learning due to pressures on the service, which impacted their ability to progress.

## Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- From July 2017 to June 2018 medical care wards performed consistently well in the NHS Friends and Family Test, with an overall recommendation rate of 97%.
- We observed consistently compassionate, kind and caring attitudes from staff who demonstrated their ability to adapt communication and level of empathy to the person they were speaking with.
- Staff went above and beyond their duties to provide care for patients in addition to their clinical needs. For example, the team on ward F20 had established a clothes bank and staff on ward D58 provided fleece blankets for patients going home in cold weather.
- Healthcare assistants played a key role in providing patients and relatives with emotional support and a 24-hour chaplaincy team were always on call.

# Medical care (including older people's care)

- Most patients we spoke with said staff involved them in their care planning and delivery and we saw this reflected in patient's documentation.
- Staff promoted independence for each patient and worked with each individual to identify their level of support need for daily routines and activities.

However:

- Staff were very limited in how they could deliver care with dignity and privacy in the acute medical receiving unit (AMRU). The unit had been designed as an outpatient clinic, which meant patients did not have the usual standards of privacy when being cared for there for extended periods.
- Not all patients felt discussions around end of life and do not resuscitate (DNAR) considerations were appropriate. One patient said they felt pressured to sign a DNAR authorisation and felt information displays about dying were upsetting.

## Is the service responsive?

**Outstanding** ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

- Specialist services provided care across the trust. This meant clinical specialists visited patients wherever they were receiving care.
- Clinical teams worked to understand the needs of the local population and to interrogate patient presentations to better understand how to plan and deliver care. For example, the diabetes and endocrinology team had substantially restructured the service, which resulted in more consultant-led care and health interventions. Healthcare of older people services had carried out work to better understand the needs of patients living with dementia, which led to fundraising and investment to provide more activities support staff.
- A therapist-led ward provided patients with inpatient rehabilitation prior to discharge when they were medically fit. This reduced pressure on medical services and provided opportunities for staff in professional development.
- The management of patients cared for as medical outliers on surgical wards was well-coordinated and clearly placed patient care and needs at the centre of planning.
- A specialist dementia ward had been established following a pilot and research project to address the complex needs of patients with both an acute diagnosis and a dementia diagnosis. The ward was jointly staffed by mental health nurses from another provider and trust medical nurses.
- The rapid response psychiatric liaison team and the drug and alcohol liaison team provided care to patients on referral across the hospital. Both teams demonstrated embedded partnership working and prepared long-term care plans for patients who needed to receive continual care after discharge.
- Divisional teams and the IT team were working with the supplier of the patient administration system (PAS) to improve adherence to the NHS Accessible Information Standard.
- Staff used adapted communication tools, including pictorial signs, to help patients understand their care and to carry out conversations.
- Systems were in place to manage access and flow. This included an electronic patient record system that flagged delays in referrals and diagnostics of over 24 hours to the senior divisional team. This meant they could chase up tests, reviews and results to reduce delays on inpatient wards.

# Medical care (including older people's care)

- The integrated discharge team had worked with specialist teams to significantly improve discharge rates and processes, without an associated increase in readmission rates. This included a Saturday discharge process established through a new relationship with a community provider.

However:

- The service took an average of 83.0 working days to investigate and close complaints. This was not in line with their complaints policy, which stated complaints should be completed within 25-80 days.
- Speech and language therapists had a target of 95 % response time within 24 hours from referral for a first review during week days. However, the team had a 50% vacancy rate and achieved the December performance was 91.2% overall with 250/274 referrals being seen within the target.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Leadership structures and teams were well embedded and staff spoke positively of these in most areas.
- The trust had an overarching five-point vision that focused on patient outcomes and experience and staff development. The vision was based on the principles of multidisciplinary, collaborative working and the values and behaviours of all staff to deliver it.
- Healthcare for older people (HCOP) services had completed a restructure and relocation to place the whole speciality in a single building. The senior team planned for this to improve aspects of care such as time to consultant review, a reduction of out of hours bed moves and sharing of speciality teams, such as therapies, because the wards would be co-located.
- On each ward we inspected the team had developed their own vision and strategy for the year ahead. Teams used the trust's overarching goals as context and established local plans and objectives designed to meet the needs of their patients and the professional needs of their team.
- There was a noticeable drive in the hospital to support and develop new and unqualified staff.
- A culture of openness and honesty empowered staff to discuss errors and we found consistent compliance with the requirements of the duty of candour.
- Staff at all levels were involved in effective governance processes, which led to improved practice and quality standards.
- The medicine safety committee tracked and addressed incidents and safety across medical care specialties.
- Senior divisional staff worked on the basis that every member of staff should have a point of escalation and someone to contact for help, at any time of day and in any circumstance. This was a key element of the clinical governance and risk management systems and staff told us they felt confident and supported as a result.
- Risk registers were in place to identify and track risks to services. Senior staff addressed areas with limited assurance through governance and risk management processes.

However:

- Our discussions with staff indicated most individuals did not know what the trust's whistleblowing policy was or who the Freedom to Speak-Up Guardian was and how to contact them.

# Medical care (including older people's care)

- The discharge lounge team provided very negative feedback on the lack of involvement they had with a hospital-wide project to increase the use of their service. They said they felt left out and forgotten by the improvement work.
- Governance meetings for acute medicine were attended sporadically with no or limited representation from key staff groups, including advanced nurse practitioners, audit nurses and junior doctors.

## Outstanding practice

We found five areas of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found six areas for improvement. See areas for improvement section above.



# Critical care

Good   

## Key facts and figures

The trust had 124 critical care beds as reported to NHS England. The trust reported that it has three critical care areas with 58 level two and level three beds across two campuses (Nottingham City Hospital and Queen's Medical Centre). The trust has a critical care outreach service which is provided from 8am to 10pm, seven days a week.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected Queens Medical Centre which had 21 Level 3 beds and 20 Level 2 beds.

During our inspection:

- We visited the adult intensive care unit (AICU) and the high dependency unit (HDU).
- spoke with three relatives and two patients.
- spoke with 20 members of staff including ward managers, nurses, domestic staff, family liaison nurse, anaesthetists, a physiotherapist, consultants and junior doctors, a clinical educator and a bed manager.
- looked at four sets of medical and nursing records.
- observed a ward handover and interactions between patients, relatives and staff.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- The service had innovative and leading practices that improved the experience and outcomes for patients and their families.
- The service was a national lead in critical care practice and guidance.
- The service had enough staff, who had completed required training. Staff were supported by managers and had annual appraisals.
- On both units the environment was clean, tidy and equipment was readily available, clean and well maintained.
- The service stored and administered medicines well.
- Staff worked well in multidisciplinary teams and provided compassionate, appropriate and individualised care to ensure good outcomes for patients.
- Staff provided emotional support to patients and relatives to help them to manage through a traumatic experience.
- The service responded where there was a need for improvement. For example, staff carried out many local audits, compared results to national target and set actions to improve the service.
- Managers supported staff, promoted learning from incidents, concerns and complaints and used available information to improve to the service.

However:

# Critical care

- The service had become accredited to deliver the post registration critical care module and 37% of staff were due to complete the course by March 2019. However, there was a risk that the course would not be funded after March 2019 and the service would not be able to ensure that 50% of staff had completed the course.
- Follow up clinics were not available for patients discharged from critical care. Managers planned to create follow up clinics and had created a new coordinating specialist nurse for continuing care role. Follow up clinics for critical care patients had not received support from commissioners.
- Discharge summaries did not include personalised rehabilitation goals and were not consistently sent to patient's GPs at the time of discharge.
- The lack of a critical outreach team service overnight had put a strain on the capacity in the adult intensive care unit and higher demand on the critical care consultant.
- Training completion rates for medical staff were lower than expected.
- The service had higher than expected numbers for patients transferred out of the unit for non-clinical reasons and out of hours discharge to the ward from the adult intensive care unit due to activity and continual high number of admissions to the unit.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The service provided mandatory training in key skills to all staff. The service ensured that nursing staff completed mandatory training but completion rates for medical staff were lower than expected.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The critical care outreach team played a vital role in the assessing and responding to patient risk across the hospital.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. Managers used this to improve the service.

# Critical care

## Is the service effective?

Good  → ←

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The service ensured people received appropriate care and treatment seven days a week.
- Staff provided information and support to patients to promote their health and mental wellbeing.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

## Is the service caring?

Good  → ←

Our rating of caring stayed the same. We rated it as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff paid attention to patients' privacy and dignity and ensured this was maintained when patients were vulnerable due to being sedated or on a ventilator.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff spoke to patients to explain what they were doing even when patients were sedated. This also benefited family members who could understand what staff were doing.
- Staff provided emotional support to patients and their families to minimise their distress. Staff spent time with family members to talk and encouraged them to have breaks and regain their strength.

# Critical care

## Is the service responsive?

**Good** ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The trust mostly planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs. Staff helped patients with communication and cultural support.
- People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The service had higher than expected numbers for patients transferred out of the unit for non-clinical reasons. Staff explained that this was due to transfers to the City Hospital critical care unit due to lack of capacity at Queens Medical Centre.
- The service was worse than expected for out of hours discharge to the ward from the adult intensive care unit. Due to activity and continual high number of admissions to the unit.
- The critical care outreach team was available between 8am and 10pm seven days a week. The lack of the outreach team in the overnight had put a strain on the capacity of the adult intensive care unit and a greater demand on the critical care consultants.
- The service had raised a risk due to lack of commissioning support for a critical care rehabilitation support service (follow-up clinics for patients). Providing follow up clinics is best practice as stated in the National Institute for Health and Care Excellence (NICE) guidelines.

## Is the service well-led?

**Outstanding** ☆ → ←

Our rating of well-led stayed the same. We rated it as outstanding because:

- Leaders of the critical care service were open, transparent and maintained a culture of support and quality. Staff were highly positive of the leadership team.
- There was a systematic approach whereby leaders promoted staff to lead on innovative projects to promote improvement to the service to benefit patients and their families.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients and relatives.

# Critical care

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was without exception a positive morale and an enthusiasm to deliver high quality care.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. We saw a number of innovative projects in this service. We also heard how leaders were leading on national projects.

## Outstanding practice

We found four areas of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found nine areas of improvement. See areas for improvement section above.

# Maternity

**Requires improvement** ●

## Key facts and figures

The trust's maternity service sits within the division of family health and provides a range of services from pregnancy, birth and post-natal care and is based across two campuses and Nottinghamshire community.

The trust provides inpatient antenatal, intrapartum and postnatal beds on Nottingham University Hospital (NUH) City campus and Queen's Medical Centre (QMC) campus for both high and low risk women. Both labour suites have alongside them midwifery led units and the trust provides a homebirth service.

From April 2017 to March 2018 there were 8,885 deliveries at the trust

The trust has maternity services across two sites therefore there will be some similarities within the two reports.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection visit, we reviewed information that we held about these services and information requested from the trust.

During this inspection we:

- Spoke with 39 staff members; including service leads, matrons, midwives, medical staff, maternity care support workers, housekeeping and administrative staff.
- Spoke with ten women and four partners who were using the service.
- Examined 19 pieces of equipment.
- Reviewed seven medical records.
- Reviewed ten prescription charts

## Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated safe and well-led as requires improvement and effective, caring and responsive as good because:

- The service had enough midwifery staff with the right qualifications, skills, training and experience, however, low staffing levels were affecting staff morale and reducing their ability to complete tasks such as cleaning and mandatory training.
- The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.
- The service had suitable premises and equipment, however. checking of emergency equipment was inconsistent.
- Staff did not always recognise, report and grade incidents appropriately, however managers shared lessons learned with the whole team and the wider service.
- Although women could access the service when they needed it, sometimes women had to wait for long periods to be seen in outpatient areas.

# Maternity

- Although the trust had made improvements to the leadership and governance structures, the changes had not yet been fully embedded and there was still a lack of oversight and assurance in some areas.
- There was not a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Managers had not effectively engaged with all junior staff, who did not fully understand the new structure, however we saw managers were trying to implement change.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Managers monitored the effectiveness of some care and treatment provided and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.
- The service took account of women's individual needs.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from women, and key groups representing the local community. The trust engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively

## Is the service safe?

### Requires improvement



We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

- The service had enough midwifery staff with the right qualifications, skills, training and experience, however, low staffing levels were affecting staff morale and reducing their ability to complete tasks such as cleaning and mandatory training.
- The service provided mandatory training in key skills to all staff but did not always make sure everyone completed it.
- The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.
- The service had suitable premises and equipment, however, checking of emergency equipment was inconsistent.
- Staff did not always recognise, report and grade incidents appropriately, however managers shared lessons learned with the whole team and the wider service.

However:

- Staff understood how to protect women and babies from abuse, staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of women's assessments, care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

# Maternity

- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service followed best practice when prescribing, giving, recording and storing medicines and women received the right medication at the right dose and at the right time

## Is the service effective?

**Good** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave women enough food and drink to meet their needs and monitored women regularly to see if they were in pain. They gave additional pain relief to ease pain.
- Managers monitored the effectiveness of some care and treatment provided and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff worked together as a team to benefit women. Doctors, midwives and other healthcare professionals supported each other to provide good care.

However:

- Whilst managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service, the service did not always make sure staff were competent for their roles.

## Is the service caring?

**Good** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.
- Staff provided emotional support to women to minimise their distress.
- Staff involved women and those close to them in decisions about their care and treatment.

## Is the service responsive?

**Good** ●



# Maternity

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated responsive as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The service took account of women's individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However:

- Although women could access the service when they needed it, sometimes women had to wait for long periods to be seen in outpatient areas.

## Is the service well-led?

**Requires improvement** 

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated well-led as requires improvement because:

- Although the trust had made improvements to the leadership and governance structures, the changes had not yet been fully embedded and there was still a lack of oversight and assurance in some areas.
- There was not a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Managers had not effectively engaged with all junior staff, who did not fully understand the new structure, however we saw managers were trying to implement change.
- The approach to continually improving the quality of its services and safeguard high standards of care was not fully robust, however we saw plans in place to make improvements.
- Some staff told us they did not always feel supported and valued by the senior leadership team.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from women, and key groups representing the local community. The trust engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

## Areas for improvement

We found nine areas for improvement. See areas for improvement section above.

# Services for children and young people

Good   

## Key facts and figures

Nottingham Children's Hospital is a 110-bedded acute service provided on Queen's Medical Centre (QMC) campus within Nottingham University Hospitals. There are eight inpatient wards, a critical care unit, two operating theatres specifically for children and two ambulatory care areas for day case surgery. The neonatal unit at QMC is a level three unit with 17 cots - 11 ITU/HDU and 6 special care. There are 39 cots across the whole trust.

Paediatric surgery is based at the QMC campus, having clinics and operating sessions at King's Mill Hospital and Derby Children's Hospital, Chesterfield, Lincoln & Boston. Children and young people's and neonatal services were divided into surgical and medical services. The department covers both secondary and tertiary referrals in paediatric surgery and paediatric urology. It also provides emergency and planned general surgery and supports specialist surgery provided by ear, nose and throat, maxillofacial, ophthalmology, spinal, trauma and orthopaedics and plastic surgery. It is an important national centre for scoliosis and cleft palate surgery. It has a children's cancer ward and a teenage cancer facility supported by the teenage cancer trust.

The children's outpatient department is based in two separate clinic areas on the ground floor of QMC. Community paediatric service sees children and young people in health centres and community clinics held at the child development centre on Nottingham City Campus.

Many specialities are regional or supra-regional e.g. renal, burns and oncology. It provides surgical neonatal care, as well as preterm sick newborn care. It includes a 14-bedded paediatric critical care and high dependency unit and supports the independent critical care transport team which is hosted by Leicester Royal Infirmary. QMC also has a level three neonatal unit which specialises in treating and caring for premature and sick newborn babies.

Paediatric emergency care was inspected as part of our inspection of emergency and urgent care and is not included in the children and young people's report.

Our last inspection of Children and Young People's services at Queens Medical Centre (QMC), published in 2016, stated that:

- The trust must take action to ensure that nursing staff working in the eye casualty receive training in the recognition and treatment of sick children. (progress on this is covered in our Emergency Department report)
- The trust must be consistent in the documentation of checking of emergency equipment and ensure that the resuscitation trolleys, neonatal transport systems and resuscitation equipment are checked, properly maintained and fit for purpose in all clinical areas.
- The inspection also found that:
- The trust should consider the appropriateness of the environment and facilities in the eye casualty waiting area for children and young people. (progress is covered in our Emergency Department report)
- The trust should consider the availability of hospital play specialists in the children's emergency department. (progress is covered in our Emergency Department report)
- The trust should work towards there being 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 (APLS) or European paediatric life support (EPLS).

# Services for children and young people

- A lack of specialist radiology cover out of hours meant that babies had to be transferred to another hospital to receive this service. The trust should consider how the service can be improved to ensure radiology care could be delivered on site.
- The trust should ensure that staffing within the neonatal unit follows the British Association of Perinatal Medicine (BAPM) standards
- The trust should ensure that an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- The trust should ensure that they have written formal arrangements in place with the children and adolescent mental health team so that the needs of children and young people with mental health problems are met.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During this inspection:

- We visited the surgical day case units, wards D33, D34, D35, E37, E38, E39 and E40 the neonatal unit, ambulatory care unit, outpatient department, paediatric intensive care unit, paediatric theatres and x-ray and diagnostic facilities.
- We met senior managers, four paediatric matrons, nine ward managers or sisters, five clinicians.
- We spoke with six patients and their families.
- We reviewed other information such as medical records, observations charts, policies and procedures.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Children's and neonatal services had appropriate arrangements for investigating incidents and shared the learning from them.
- The services had a well-developed approach to assessing and responding to risk. Staff used a paediatric early warning system to take action on any deterioration in child health. There was a well-established and understood approach to managing and escalating suspected sepsis. Mental health risks were recognised and the service worked well with mental health professionals.
- People's care and treatment was focused on achieving good outcomes, and this was supported by learning from clinical audit, and initiatives to improve clinical pathways.
- Parents and children told us that nurses and doctors were kind and took time to talk to them and explain care arrangements. The services did as much as possible to ensure that children were comfortable and they responded quickly if a child or young person was in pain. The services helped young children feel settled through play specialists and a variety of volunteers who entertained them, such as Spiderman, a magician, and a therapy dog.
- The services took a holistic approach to childhood and teenage cancer treatment and offered emotional support and arranged relevant social activities for them.
- Children generally had access to timely initial assessment, test results, diagnoses and treatment. Waiting list performance for the service was better than the national target of 92% of patients being definitively treated within 18 weeks (incomplete pathway). The cancer service was responsive and timely.

# Services for children and young people

- Senior leadership capacity for children's and neonatal services was improving and the leadership team was starting to address significant strategic risks and issues, for example how to ensure staffing and skills levels long term.

However:

- Some beds on wards were not open to children because there were insufficient staff to manage them safely.
- Vacancy rates and turnover figures were high for doctors in neonatal services. The service was advertising for three new neonatologists to give the services some resilience across City and QMC sites in 2019.
- Outpatient appointments did not always run on time and the service did not inform families or display wait times publicly. The outpatient waiting area was very crowded.
- Not all services were available 24/7 and outpatient and day surgery appointments were predominantly during the week between 9am and 5pm.
- Lack of out of hours access to paediatric interventional radiology meant that some babies needed to be transferred to other hospitals, and this had been on the service's risk register for three years.
- Arrangements for MRI scans 48 hour after tumour removal were not sufficiently formalised for children who needed a general anaesthetic.
- Children and young people's matters did not have a strong profile at Board level and lacked specific non-executive director representation.
- Processes around monitoring that products were kept at a safe temperature in fridges were not robust.

## Is the service safe?

**Good** ● ↑

Our rating of safe improved. We rated it as good because:

- Children's and neonatal services had appropriate arrangements for investigating incidents and shared the learning from them.
- The services had a well-developed approach to assessing and responding to risk. Staff used a paediatric early warning system to act on any deterioration in child health. There was a well-established and understood approach to managing and escalating suspected sepsis. Mental health risks were recognised and the service worked well with mental health professionals.
- The services used a safety thermometer approach to measure the quality of service and act on any potential harms.
- The services had good infection control and cleanliness procedures, and audited hand washing.
- Without exception, staff told us that safeguarding was given the highest priority. All the staff we interviewed were very knowledgeable about their patients and could identify any children who were on a child protection plan or who had been assessed as a child in need.
- 

However:

- Nurse staffing in children's services was not at a sustainable level and certain areas of the children's hospital occasionally had to ask staff from other clinical areas within the Children's Hospital to move to provide cover.

# Services for children and young people

- There were pockets of shortages of medical staff in children's services. Not all specialties could ensure that children were seen by a consultant within 14 hours of arrival, although they would be seen by a middle grade doctor within four hours.
- Fridge temperature control was inconsistent. Maximum and minimum temperatures were not always recorded, and records were not entered on some days for certain wards.
- Environmental audits showed some risks in outpatient areas and day surgery which had not been addressed.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- People's care and treatment was focused on achieving good outcomes, and this was supported by learning from clinical audit, and initiatives to improve clinical pathways.
- The service assessed patients nutritional and pain control needs using specific tools and standardised approaches.
- Good outcomes were evident in many of the paediatric services. Patient outcomes in QMC for paediatric diabetes were the best in England and Wales for 2016/2017, and the nephrology service was nationally recognised. Readmission rates for babies under one following emergency admission compared well to the national average.
- There was a policy in place for the transition to adulthood and arrangements were patient centred.
- Staff, teams and services worked well together to deliver the most effective care for children and the multidisciplinary approach was tailored to the needs of individual patients.
- Services were supported by a team of play specialists and a range of clinical nurse specialists. The services promoted healthy lifestyles through noticeboards and leaflets.

However:

- Outcomes for some specialties were below average, for example epilepsy readmissions.
- The neonatal service did not meet all the standards of the national neonatal audit programme.
- Not all services were available 24 hours a day, seven days a week.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Parents and children told us that nurses and doctors were kind and took time to talk to them and explain care arrangements.
- The services did as much as possible to ensure that children were comfortable and they responded quickly if a child or young person was in pain.
- The services took a holistic approach to childhood and teenage cancer treatment and offered emotional support and arranged relevant social activities for them.

# Services for children and young people

- Parents and children were supported at times of difficult news through the child bereavement service and a child psychologist.
- Staff provided support and information to parents when their child was discharged from hospital. In many areas clinical nurse specialists advised families before discharge.

## Is the service responsive?

**Requires improvement** ● ↓

Our rating of responsive went down. We rated it as requires improvement because:

- Outpatient appointments did not always run on time. Children and their families were not informed about delays in outpatients and the service did not monitor or analyse delays to outpatients. The outpatient environment could become very crowded for certain clinics
- Lack of out of hours access to paediatric interventional radiology meant that some babies needed to be transferred to other hospitals, and this had been on the service's risk register for three years.
- Lack of availability of theatre lists sometimes meant that the service struggled to meet demand.
- The number of children's operations cancelled for non-clinical reasons was increasing
- Day surgery and outpatient clinics worked on weekdays only, which would be difficult for working parents.
- There was no transition ward for teenagers.
- Arrangements for MRI scans 48 hour after tumour removal were not sufficiently formalised for children who needed a general anaesthetic.

However:

- Children generally had access to timely initial assessment, test results, diagnoses and treatment. Waiting list performance for the service was better than the national target of 92% of patients being definitively treated within 18 weeks (incomplete pathway). The cancer service was responsive and timely.
- The service responded to the needs of local children and young people and their families and was an important regional centre for some specialties. Medical teams were proactive in developing new pathways to improve the patient experience.
- Children and young people were seen in areas exclusive to them and did not mix with adults in wards or clinical areas. Facilities were tailored to the needs of children and young people and their families. Parents of babies cared for by the neonatal service could stay overnight in an eight-bed parent hotel in the hospital.
- The service had arrangements to help children with mental health needs, behavioural difficulties or sensory needs. It had access to expertise on learning difficulties.
- The service followed up if a child was not brought to the hospital for appointment and took safeguarding action if a child was repeatedly not brought to appointments.
- The service was responsive to complainants and received many compliments.

# Services for children and young people

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Senior leadership capacity for children's and neonatal services was improving and the leadership team was starting to address significant strategic risks and issues, for example how to ensure staffing and skills levels long term.
- The division had a strategy which was being refreshed and developed by the new management team in place. It aimed to deliver good quality care, and work was under way on a staffing strategy to make this sustainable.
- The culture was open and patient centred. Staff were willing to report concerns and there was a formal process for the duty of candour.
- The governance framework was developing. The senior leadership team were implementing the trust model of governance when we inspected. Effective arrangements were in place for accountability and to enable management action where needed, and there was a robust approach to identifying managing and monitoring risk.
- Performance issues were escalated through effective meetings and processes. There was a holistic view of performance which include finance and data. Performance on children's waiting list times was generally well managed.
- The services engaged well with parents and children, the public and staff, and this gave risk to service improvement. Shared governance was also a driver for continuous improvement.

However:

- Children and young people's matters did not have a strong profile at Board level and lacked specific non-executive director representation.
- The policy and governance framework were still being developed.
- Staff shortages were beginning to have an adverse effect on the positive working culture in neonatal and children and young people's services.

## Outstanding practice

We found two areas of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found five areas for improvement. See areas for improvement section above.

# End of life care

Good  

## Key facts and figures

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

From July 2017 to June 2018, the trust had 3,530 deaths.

End of life care services were provided at Queens Medical Centre (QMC) on any ward or service as there is no specialist palliative care provision at this site. Staff had access to the support and advice of the hospital palliative care team (HPCT) who worked across both sites.

NUH has a lead end of life nurse & consultant, who work within the HPCT. A network of EOL champions that are ward and division based across the trust, raise the profile of end of life care and assist in local education and are supported by the team.

The trust report that when someone is recognised as dying, a medical and nursing care plan is used to facilitate care, alongside an end of life care drug card, to ensure anticipatory medications are available. All clinical areas are trained to use the T34 syringe driver.

The SWAN model of care is being used at NUH, raising the profile of end of life care for all staff regardless of role, enabling staff to support patients in achieving what is important to them in their final days and supporting families and significant others into their bereavement. The Swan model of care is process of end of life and bereavement care which is used to support and guide the care of patients and their loved ones at the end of life and after they have died. The aim of the SWAN is to promote, dignity, respect and compassion at the end of life. We saw patient's records where staff were using the SWAN individualised care plans for the dying patient. This gave clear guidance for staff on how to meet the patient's needs in respect of repositioning, food and fluid intake, communication needs and pain relief.

We found the trust's end of life-individualised SWAN care plans were being used consistently throughout the hospital where patients were identified as end of life to ensure they received evidence based end of life care. Staff were also able to tell us about the current NICE guidance relating to end of life care.

Using 'nerve-centre' the trust has a mechanism in place to identify patients who have been identified as EOL and fast track them at NUH. All families are offered the opportunity to give feedback through completion of the Care of the Dying Evaluation Tool (CODE). There is a multi-professional end of life steering group with support from the bereavement, mortuary & chaplaincy teams.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected the whole core service for end of life care for adults over 18 years.

During our inspection;

- we visited the emergency department, the critical care unit (ICU) the mortuary viewing area, the bereavement office, the chaplaincy service, and medical and surgical wards where patients were being cared for at the end of their life



# End of life care

- We spoke with two relatives and two patients,
- We spoke with 29 members of staff including clinical nurse specialists, hospital porters, ward managers, nurses, the hospital palliative care team (HPCT) healthcare assistants, doctors, chaplaincy team and mortuary staff. We looked at eight sets of medical and nursing records and reviewed 26 Do not attempt cardio-pulmonary resuscitation orders.
- We observed part of a ward handover and interactions between patients, relatives and staff

## Summary of this service

Our rating of this service improved. We rated it as good overall because:

- The trust had taken steps to improve consistency in completion of patient's nutritional screening and the completion of nutrition and fluid charts.
- Improvements had been made to the availability of patient information leaflets, including those in other languages and accessible formats.
- Staff followed policies and procedures to ensure medicines were administered appropriately to make sure people are safe.
- The trust had implemented care plan documentation specific to end of life care.
- The Trust had increased their number of palliative care consultants to improve availability of a senior end of life care clinician.

However:

- Do Not Attempt Cardio-Respiratory Resuscitation (DNACPR) forms were not always completed correctly.
- Conversations with patients and relatives regarding DNACPR decisions were not always documented in patients' medical record.
- Mental Capacity Act assessments were not always completed for relevant patients when making DNACPR decisions.
- Care plans, although personalised and improved since last inspection, did not always document conversations about patient's mental health needs, spiritual and pastoral needs.
- There was a lack of audit processes to monitor the effectiveness of end of life care.
- The service did not monitor or audit if end of life care patients died in their preferred place of death (PPD).
- The trust was not providing a HPCT seven days a week. However, this would commence in April 2019.
- The service did not record palliative or end of life care patients as delayed transfers of care

## Is the service safe?

**Good**   

Our rating of safe stayed the same. We rated it as good because:

# End of life care

- Comfort observations were conducted every two hours and were based on tools that were specific for end of life care. These included pain control, nutrition and hydration, skin checks, agitation, oral care and anticipatory medicines.
- Staff used a suite of risk assessments to identify patient's specific needs and health risks whilst in hospital
- Staff had access to an on-call palliative care consultant on a face to face basis during the day and could receive 24-hour telephone advice from the on-call consultant and staff Hayward House based at the City campus during the out of hours period, including weekends.
- Staff who worked on the mental health elderly care wards required support to manage challenging behaviour and had daily access to a mental health nurse and fast access to the mental health crisis team.
- There were dedicated end of life care champions on every ward who provided specialist support on a day to day basis at ward level.

However:

- Care plans, although personalised and improved since last inspection, did not always document conversations about patient's mental health needs, spiritual and pastoral needs.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Do Not Attempt Cardio Respiratory Resuscitation (DNACPR) forms were not always documented fully.
- Mental capacity Act assessments were not always completed for relevant patients when making DNACPR decisions.
- There was a lack of audit processes to monitor the effectiveness of end of life care.
- The service did not monitor or audit if end of life care patients died in their preferred place of death (PPD).
- The trust was not providing a HPCT seven days a week. However, this would commence in April 2019.
- The service did not record palliative or end of life care patients as delayed transfers of care

However:

- The trust had implemented the SWAN initiative in order to improve care for patients at the end of life and to raise awareness of the importance of providing more effective and personalised care for patients at the end of their life and their relatives.
- The trust used a baseline assessment tool for care of dying adults in the last days of life. This was aligned to NICE clinical guideline (NG31) Evidence provided by the trust showed that they were meeting 97% of the recommended guidelines.
- The trust participated in benchmarking activities such as Essence of Care benchmarking and provided action plans which had been discussed in meetings.
- An individualised last days of life care plan documentation bundle had been implemented across the trust. This was based on the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying People. The documentation bundle included a medical documentation record, nursing care plans and a medicines administration card that was specific to end of life care.

# End of life care

- The Trust had implemented an electronic system (EPaCCS) whereby EOLC patients were identified to the palliative care team on admission, and made the fast-track discharge process more streamlined.
- They completed the National Care of the Dying (NACEL) audit which is due to be published in May 2019.

## Is the service caring?

Good ● → ←

Our rating of caring stayed the same. We rated it as good because:

- The Trust had implemented the SWAN initiative to improve end of life care for patients.
- The trust had a comprehensive chaplaincy service, team and facilities for most faiths, and the chaplaincy team were extremely motivated to provide exceptional support for all. They told us they always went that extra mile to help people who were dying and grieving relatives as well as supporting staff.
- The chaplaincy team could facilitate weddings with a community registrar very quickly if required.
- The mortuary staff had devised a priority system which identified the viewing state of a deceased person. This identified viewings where additional support may be required for relatives and situations where viewing may be postponed briefly to allow for relatives to receive counselling about how their loved one might look.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The trust had recognised the need to increase access to the hospital palliative care team to seven days a week and had recruited 3 WTE band seven nurses to the team. This was due to commence on 1 April 2019.
- The trust had responded to feedback from relatives and were in the process of securing free parking for the family and relatives of dying patients.
- Relatives were provided with a comfort box which contained toiletries and other essentials when staying overnight with their loved one.
- Normal visiting times were waived for relatives of patients who were at their end of life.
- Free parking was available for bereaved relatives to use when visiting the bereavement service.
- A SWAN unit was being created in the emergency department for relatives to sit with their loved one immediately after death.
- The chaplaincy advised nursing staff about different religious beliefs and practices that might impact on care, and were in the process of re-writing guidance for staff about different faiths and religions. They also worked with local faith leaders to ensure deceased patients were cared for following their cultural and religious requirements.
- Patients were referred to the specialist palliative care Team (HPCT) electronically by staff on the wards and would usually review patients within 24- 48 hours. Urgent reviews of patients were responded to on the same day.

# End of life care

- The trust engaged with their clinical commissioning group (CCG) for NHS Continuing Health Care funding to enable some patients to be discharged home using a Fast Track Pathway. This enabled staff and a discharge coordinator to expedite care provision in the setting of the patient's choice so they could be discharged as quickly as possible with all appropriate care in place.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- There had been a number of improvements since our last inspection. For example, the trust now had a lead end of life care (EOLC) nurse and consultant, who worked within the hospital palliative care team (HPCT). A network of EOLC champions that were ward and division based across the trust, had raised the profile of end of life care and assisted in local education and are supported by the team.
- Since our last inspection in 2016 The trust had implemented the SWAN model of care across the organisation in November 2017, enabling staff to prioritise the patients and families' priorities and recognise the future bereavement of the families going forward, thereby providing person centred care.
- In May 2018, the Trusts end of life care lead nurse was Nottingham nurse & midwifery nurse of the year in the NHS 70th Anniversary category. The trust participated in the NHSI improvement programme having implemented the use of EPaCCS within the specialist palliative care service.
- There was an End of Life Care Strategy in place for the period 2017 to 2019, which was separate from the overall trust's strategy and vision. The vision and strategy was developed through engagement with the end of life care steering group and the end of life care champions.
- The Trust had implemented an end of life care Champions initiative whereby at least two champions were available on each ward or service to provide direction, guidance and advice to staff on a day to day basis.
- There were governance arrangements specific to end of life care that were embedded within the Trust's overarching governance framework.
- The trust promoted the culture that care of the dying was everyone's responsibility.
- There was good team working between the specialist palliative care team, the mortuary team, the bereavement service and the chaplaincy service.
- There was an end of life care dashboard which was reviewed within quarterly reports.
- There was an end of life care steering group which reported into the clinical effectiveness committee and the quality assurance committee.
- There was a corporate risk register where risks relating specifically to end of life care were flagged. We saw end of life care risks were identified and actions were documented to mitigate the risk by the palliative care team.
- 

However:

- There was a lack of a robust audit programme. The trust did not routinely monitor patients preferred place of care for example.
- There was a lack of oversight in relation to DNACPR form completion and work was required to improve this.

# End of life care

## Outstanding practice

We found one area of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found six areas for improvement. See areas for improvement section above.

# Nottingham City Hospital

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## Key facts and figures

Nottingham University Hospitals NHS Trust (NUH) was established in 2006 following the merger of Nottingham City Hospital and Queen's Medical Centre. NUH 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 surrounding counties. NUH have a budget of just under £1 billion

Nottingham City Hospital is the trust's planned care site, where the cancer centre, heart centre and stroke services are based.

## Summary of services at Nottingham City Hospital

**Good**   

Our rating of services stayed the same. We rated it them as good because:

- Staff understood how to protect patients from abuse and the services worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The service mostly had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment, however actual staffing levels did not always meet planned levels.
- The services provided care and treatment based on national guidance and monitored patient outcome to monitor for the effectiveness.
- Staff worked together as a team to benefit patients.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff involved patients and those close to them in decisions about their care and treatment.
- The trust planned and provided services in a way that met the needs of local people.
- The services took account of patients' individual needs.

# Summary of findings

- Managers at all levels in the core services had the right skills and abilities to run a service providing high-quality sustainable care.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

# Medical care (including older people's care)

Good   

## Key facts and figures

Medical services provided at Nottingham City Hospital include gastroenterology, respiratory, stroke, diabetes, cardiology, clinical oncology, nephrology, infectious diseases, renal medicine and urology. Medical care services comprised of 22 wards at the City Hospital

The trust had 105,278 medical admissions from July 2017 to June 2018, a 36% increase from July 2016 to June 2017 admissions. Emergency admissions accounted for 48,247 (45.8%), 2,347 (2.2%) were elective, and the remaining 54,684 (51.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine: 25,719
- Clinical oncology: 20,680
- Gastroenterology: 14,108

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During our inspection:

- We visited the Dialysis Unit, Endoscopy Unit, Fraser ward, Hyper Acute Stroke Unit, Berman One ward, Southwell ward, Morton ward, Lister One ward, Patience One ward, Fleming ward and the Cardiac Short Stay unit.
- We spoke with 24 members of staff including nursing care assistants, associate nurses, registered nurses, senior managers, doctors, dieticians, pharmacists and senior managers
- We also spoke with eight patients and four relatives.
- We observed care and treatment, inspected ward and department areas and reviewed a variety of documents and patient records.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Patients were protected from avoidable harm and abuse.
- Patients had good outcomes because they received effective care and treatment that met their needs.
- Patients were supported, treated with dignity and respect, and were involved as partners in their care.
- Patients' needs were met through the way services were organised and delivered.
- The leadership, governance and culture promoted the delivery of high quality person centred care.

However:

- Patients medicines were not always stored in a locked cupboard.
- Potassium infusions were not stored separately from other infusions.
- Some drug fridges had two thermometers and staff were not clear what the purpose of the second thermometer was.



# Medical care (including older people's care)

- Mental Capacity assessments were not always reviewed as required.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- There was an openness and transparency about safety, staff understood their responsibilities and knew how to raise concerns and report incidents.
- Staff had received up to date training on all safety systems including safeguarding vulnerable adults and children.
- There were enough staff on duty to care and treat patients safely. Staffing levels were monitored and reviewed regularly. Systems were in place to manage staff shortages. Staff handovers were well planned with adequate overlap of time to ensure all patient information was safely conveyed. There had been improvements in staffing since our last inspection despite planned staffing levels not always meeting actual staffing, we did not find any evidence of impact on patient care.
- There had been improvements in infection control practices and equipment maintenance since our last inspection.
- There were good patient risk assessments in place and completed by staff, this included the escalation of patients who displayed signs and symptoms of deteriorating health.

However:

- As identified at our last inspection we found large yellow clinical waste bins in public areas unlocked.
- Patients medicines were not always stored in a locked cupboard.
- Some drug fridges had two thermometers and staff were not clear what the purpose of the second thermometer was.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Peoples care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation.
- People had comprehensive assessments of their needs including mental health and wellbeing, staff had regard to the Mental Health Act Code of Practice.
- There was participation in relevant local and national audits including benchmarking, peer review and accreditation. Information about effectiveness was shared internally and externally and was used to improve patient care treatment and outcomes.
- Staff were competent to carry out their roles effectively and were supported through meaningful and timely supervision.
- Care was well coordinated between staff, teams, and other services involved in patient care, when patients were transferred to other services their individual needs, circumstances and ongoing care was taken account of.

# Medical care (including older people's care)

- Consent to care and treatment was obtained in line with legislation and guidance, patients were supported to make decisions and where appropriate their mental capacity assessed.

However:

- Locum medical staff were not invited to training sessions.
- Mental Capacity assessments were not always reviewed as required.
- We were unsure whether all staff had attended training in the Mental Health Act, the trust did not supply compliance figures for this training.
- There were no clear systems for flagging vulnerable patients or those living with a disability or sensory loss.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

- Patients were treated with dignity, respect and kindness, feedback from patient was positive about the way they were treated.
- Patients and their carers received adequate information to be partners in decisions about their care, they were communicated with in a way they understood and worked together with staff to plan care and treatment.
- Patients privacy and confidentiality was respected always and staff responded compassionately when patients needed help and support.
- Staff supported patients and those close to them to cope emotionally.

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- Services were planned and delivered in a way that met the needs of the local population.
- The needs of different people were considered when planning and delivering services. Reasonable adjustments were made to remove barriers for people who found it hard to access services.
- Access to care took account of people's needs including those with urgent needs.
- Appointment systems were easy to use, waiting times, delays and cancellations were managed appropriately.
- It was easy for patients to complain and they were treated compassionately when they did so. Complaints were treated seriously and improvements were made to quality of care because of complaints.

However:

- There were no clear systems for flagging vulnerable patients or those living with a disability or sensory loss, whilst this might have been identified on admission on the IT system, staff did not know how to access this.

# Medical care (including older people's care)

## Is the service well-led?

Good ● → ←

Our rating of well-led stayed the same. We rated it as good because:

- There was a clear statement of vision, understood by staff and driven by quality and safety which was translated into a credible strategy and well-defined objectives which were regularly reviewed. Strategic objectives were supported by quantifiable and measurable outcomes.
- There were effective governance structures in place that reported effectively to the board and other relevant meetings below board level.
- Information used in reporting, performance management and delivering quality of care was valid, reliable timely and relevant and included patients experience.
- Effective and comprehensive processes were in place to identify, understand, monitor and address current and future risks.
- Leaders were visible, staff told us that leaders were supportive and approachable. Leaders had the expertise and knowledge to prioritise safe, high quality, compassionate care and promote equality and diversity.
- There was a culture of openness and honesty, staff told us they could speak freely about any concerns.
- Information and analysis was key to the development of services, the collection and information and its scrutiny ensured the impact on quality and financial sustainability was monitored effectively.
- There was a strong focus on continuous learning and improvement.

However:

- The working environment for staff in the David Evans Building was not conducive to their health and wellbeing.

## Areas for improvement

We found 10 areas for improvement in this service. See areas for improvement section above.

# Maternity

**Requires improvement** ●

## Key facts and figures

The trust's maternity service sits within the division of family health and provides a range of services from pregnancy, birth and post-natal care and is based across two campuses and Nottinghamshire community.

The trust provides inpatient antenatal, intrapartum and postnatal beds on Nottingham University Hospital (NUH) City campus and Queen's Medical Centre (QMC) campus for both high and low risk women. Both labour suites have alongside them midwifery led units and the trust provides a homebirth service.

From April 2017 to March 2018 there were 8,885 deliveries at the trust

The trust has maternity services across two sites therefore there will be some similarities within the two reports.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During this inspection we:

- Spoke with 43 staff members; including service leads, matrons, midwives, medical staff, maternity care support workers, housekeeping and administrative staff.
- Spoke with seven women and three partners who were using the service.
- Examined 17 pieces of equipment.
- Reviewed 10 medical records.
- Reviewed nine prescription charts.

## Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated safe and well-led as requires improvement and effective, caring and responsive as good. We rated it as requires improvement overall because:

- The service had enough midwifery staff with the right qualifications, skills, training and experience, however, low staffing levels were affecting staff morale and reducing their ability to complete tasks such as cleaning and mandatory training.
- The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.
- The service had suitable premises and equipment, however some clinical areas were not appropriate for the activity. Women were not always assessed in the most appropriate place and their ongoing treatment was sometimes delayed due to workload. Checking of emergency equipment was inconsistent.
- The service did not always follow best practice when prescribing, giving, recording and storing medicines, however women received the right medication at the right dose at the right time.
- Staff did not always recognise, report and grade incidents appropriately, however managers shared lessons learned with the whole team and the wider service.

# Maternity

- Although women could access the service when they needed it, sometimes women had to wait for long periods to be seen in outpatient areas.
- Although the trust had made improvements to the leadership and governance structures, the changes had not yet been fully embedded and there was still a lack of oversight and assurance in some areas.
- There was not a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Managers had not effectively engaged with all junior staff, who did not fully understand the new structure, however we saw managers were trying to implement change.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Managers monitored the effectiveness of some care and treatment provided and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.
- The service took mostly account of women's individual needs.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from women, and key groups representing the local community. The trust engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively

## Is the service safe?

**Requires improvement** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated safe as requires improvement because:

- The service had enough midwifery staff with the right qualifications, skills, training and experience, however, low staffing levels were affecting staff morale and reducing their ability to complete tasks such as cleaning and mandatory training.
- The service did not always control infection risk well. Staff kept themselves clean but did not always keep equipment and the premises clean.
- The service had suitable premises and equipment, however some clinical areas were not appropriate for the activity. Women were not always assessed in the most appropriate place and their ongoing treatment was sometimes delayed due to workload. Checking of emergency equipment was inconsistent.
- The service did not always follow best practice when prescribing, giving, recording and storing medicines, however women received the right medication at the right dose at the right time.
- Staff did not always recognise, report and grade incidents appropriately, however managers shared lessons learned with the whole team and the wider service.

However:

# Maternity

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of women's assessments, care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

## Is the service effective?

**Good** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated effective as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave women enough food and drink to meet their needs and improve their health. and monitored women regularly to see if they were in pain. They gave additional pain relief to ease pain.
- Managers monitored the effectiveness of some care and treatment provided and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff worked together as a team to benefit women. Doctors, midwives and other healthcare professionals supported each other to provide good care.

However:

- Whilst managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service, the service did not always make sure staff were competent for their roles.

## Is the service caring?

**Good** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.
- Staff provided emotional support to women to minimise their distress.
- Staff involved women and those close to them in decisions about their care and treatment.

# Maternity

## Is the service responsive?

**Good** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated responsive as good because:

- The trust planned and provided services in a way that met the needs of local people.
- The service took mostly account of women's individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results.

However

- Although women could access the service when they needed it, sometimes women had to wait for long periods to be seen in outpatient areas.

## Is the service well-led?

**Requires improvement** ●

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings.

We rated well-led as requires improvement because:

- Although the trust had made improvements to the leadership and governance structures, the changes had not yet been fully embedded and there was still a lack of oversight and assurance in some areas.
- There was not a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Managers had not effectively engaged with all junior staff, who did not fully understand the new structure, however we saw managers were trying to implement change.
- The approach to continually improving the quality of its services and safeguard high standards of care was not fully robust, however we saw plans in place to make improvements.
- Some staff told us they did not always feel supported and valued by the senior leadership team.

However:

- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from women, and key groups representing the local community. The trust engaged well with women, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

# Maternity

## Areas for improvement

We found nine areas for improvement. See areas of improvement section above.



# Neonatal services

Good   

## Key facts and figures

Family Health 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 East Midlands Neonatal Operational Delivery Network (EMNODN) who require specialist care. The NUH neonatal service is the lead centre for the EMNODN and serves a population of 23,000 births per year.

The Neonatal Units provide complex, highly specialist levels of care for the smallest and most vulnerable babies. The neonatal unit at Nottingham City Hospital comprises neonatal intensive care, high dependency care and special baby care for newborn babies from 23 weeks old. At the time of our inspection the City site had 6 intensive care cots, 6 high dependency cots and 10 special care cots.

From June 2017 to July 2018 admissions to the unit totalled 145 babies.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

During this inspection we:

- Spoke with 38 staff members; including service leads, matrons, midwives, medical staff, neonatal care support workers, housekeeping and administrative staff.
- Spoke with eight parents and three relatives who were using the service.
- Examined 26 pieces of equipment.
- Reviewed 22 medical and nursing records.
- Reviewed nine prescription charts.

## Summary of this service

Our rating of this service stayed the same. We rated it as good because:

- Babies received high quality care from dedicated and caring staff who had received appropriate training and education to enable them to provide safe care and treatment. The service had nursing staff with additional training in a variety of quality roles such as research, tissue viability, feeding, infection prevention and control and safeguarding.
- The NICU 2017/18 annual infection control report stated the Nottingham service were one of the units completing 100% data input of blood cultures in the data system for 2017 allowing them to be part of the NNAP report. Data demonstrated that for units delivering >500 central line days in infants <32w the service were ranked 3rd best overall in terms of infections per 1000 central line days. The rate of 5.6/1000 line days was below the UK average of 8.2. The unit was well maintained and decorated with appropriate equipment and facilities to care for patients and provide a caring, supportive environment for parents and families.
- Staff completed and updated risk assessments for each baby. They kept clear records and asked for support when necessary. Senior staff had identified a risk of pressure damage to babies' nasal septum so had introduced a new style of ventilator cap. Staff were being trained in the use of the new cap during our inspection to reduce the risk of pressure ulceration.

# Neonatal services

- Specialist staff supported mothers to improve breast feeding rates. There were facilities to help mothers express and store breast milk.
- Feedback from parents and families was without exception positive about the care their babies had received. We saw many examples of the care and support offered to parents and siblings. The bereavement team offered comprehensive, caring support to bereaved families including siblings.
- The service used technology to support mothers who could not visit the unit and minimise mother and baby separation.
- Staff we spoke with were proud to work for the service. There was a positive open culture in which staff felt able to ask for help and report concerns. Staff were encouraged to develop themselves and services for patients and families.

## Is the service safe?

Good  

Our rating of safe improved. We rated it as good because:

- The service had increased staff numbers with the right qualifications, skills, training and experience to keep babies safe from avoidable harm. The service had a clear three-year plan that was progressing and had resulted in significant improvements.
- The service now mostly met the British Association of Perinatal Medicine standards for optimal staffing in neonatal intensive care units. The service was continuing to recruit and train staff to ensure over establishment. This would ensure staffing numbers remained adequate for the cross-site cover of the unit.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well. There was secure access through the reception area, which was light, bright and welcoming.
- Staff assessed the risks for each patient using a neonatal early warning score. They kept clear records, asked for support when necessary and understood the process to escalate concerns when a patient became unwell. Staff attended annual simulation training to ensure they understood their role if a medical emergency occurred.
- The service ensured that the nurse acting as room coordinator for each shift was 'qualified in speciality'.
- The service had enough medical staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment. The service had consultant cover on the unit 24-hours a day and had trained Advanced Neonatal Nurse Practitioners who worked as part of the team.
- The unit had consultant neonatologist cover 24-hours a day, seven days a week from on an onsite consultant and additional on-call consultant.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff.
- The service followed best practice when prescribing, giving, recording and storing medicines. This ensured that patients received the right medication at the right dose at the right time.

# Neonatal services

- The service managed patient safety incidents well.
- Managers investigated incidents and shared lessons learned with the whole team and wider service. When things went wrong staff apologised and gave patients honest information and suitable support.
- The service used safety monitoring results well. Staff collected safety information and shared it with staff, parents and visitors. Safety performance information on hospital acquired infections and pressure wounds was displayed at the entrance to the unit.

However:

- Ventilation within the unit did not meet minimum standards and could increase the risk of cross-infection. This was mitigated where possible and the trust had ongoing process in place to support improvements.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance through local audits. The service was working towards Unicef Baby Friendly Initiative accreditation.
- Staff used special feeding and hydration techniques when necessary. A specialist feeding team supported mums to breast feed their babies and there were suitable facilities for breast feeding, expressing and milk storage within the unit.
- Staff assessed and monitored patients regularly to see if they were in pain using a specialised neonatal pain assessment tool. They gave additional pain relief to ease pain and monitored this through analgesia audits.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared their results in national audits with those of other services and had action plans to address underperformance which were reviewed quarterly.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and compliance with appraisal rates for nursing and medical staff was 100%.
- Staff worked together as a team to benefit patients. The daily ward round was attended by medical and nursing staff of different grades. Doctors, nurses and other healthcare professionals supported each other to provide care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff understood how and when to assess whether a patients' parents had the capacity to make decisions about the patients' care. They followed trust policy and procedures when they were concerned a parent could not give consent. We saw that appropriate parental consent was obtained for care.

## Is the service caring?

Good   

Our rating of caring stayed the same. We rated it as good because:

# Neonatal services

- Staff cared for babies and parents with compassion. Feedback from parents was overwhelmingly positive about the way staff treated babies, parents and those close to them.
- We observed a strong person-centred culture with staff always introducing themselves to parents when they had not met them before and treating patients with dignity and respect.
- Staff provided emotional support to patients and their families to minimise their distress. Specialist bereavement nurses provided ongoing support to families when their baby was dying.
- The service had recently employed a psychologist to support parents and families.
- Bereavement nurses and neonatologists were available to meet with bereaved parents to give the opportunity for them to ask questions about their baby's care and treatment. An independent bereavement service started by a bereaved family was also available onsite offering a quiet comfortable space for parents to go and talk about their loss.
- The service recognised that parents needed access to wider support networks and peer support. There was a social media page for parents which was advertised throughout the unit and weekly parents support groups.
- Staff involved parents and those close to them in decisions about the care and treatment of their baby. Parents were encouraged and supported to care for their baby and care was shared between staff and parents where appropriate.
- The service empowered parents to have a voice and worked with them to develop the skills they needed to be partners in their baby's care. The service allowed open visiting so that parents had the opportunity to care for their baby at all times.

## Is the service responsive?

Good ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- The service planned and provided services in a way that met the needs of local people.
- The service provided both outpatient and inpatient screening for damage to vision in premature babies which meant that premature babies were screened for retina damage and treated immediately.
- The service took account of patients' and parents individual needs. The service provided free of charge facilities for parents to stay on the unit and in the hospital 'Patient Hotel'.
- The service had made innovative use of technology to support mothers who were separated from their babies due to illness or who were still on a maternity unit in a different hospital following delivery. Mothers were given hand held computers with an application that allowed them to see their baby in the unit and talk to their baby and the nurse.
- People could access the service when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.
- The neonatal team worked with maternity teams to reduce admissions to the neonatal unit. This improved flow into the neonatal unit and ensured the service acted to reduce the amount of time baby and mother were separated.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. The service had received no formal complaints in the last six months and staff resolved concerns as they were raised with support from managers.

# Neonatal services

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care. Staff we spoke with told us managers were visible, approachable and supportive.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff spoke positively about the open, 'no blame' culture within the team.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. There were robust governance structures that ensured quality and safety was monitored at service, divisional and managed clinical service level.
- The service created an environment in which excellence in clinical care would flourish and monitored this through comprehensive clinical effectiveness meetings.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risks recorded on the risk register and recognised by leaders aligned with the concerns and worries of staff.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. They had acted to improve data collection and documentation of patient outcomes.
- The service engaged well with parents, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service engaged with past and present families to design facilities for parents and families and worked with local businesses and the community to plan and refurbish facilities.
- The service was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. The neonatal research nurse coordinated research studies in the unit supported by research link nurses.

However:

- The service had a vision for what it wanted to achieve, the plans to move the neonatal and maternity service to one site were in discussion at our previous inspection and had still not come to fruition. A further business case was due to be presented to the trust board during the weeks following our inspection. The vision for the Family Health directorate included all women's and children's services to be located at one site.

## Outstanding practice

We found two areas of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found two areas for improvement. See areas for improvement section above.

# End of life care

Good  

## Key facts and figures

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services.

From July 2017 to June 2018, the trust had 3,530 deaths.

At Nottingham University Hospital City campus, there is a specialist palliative care unit; Hayward House, providing inpatient, outpatient and day therapy services. The hospital palliative care team (HPCT) supported by the palliative care consultants provide a specialist palliative care service across Nottingham University Hospitals (NUH).

NUH has a lead end of life (EOL) nurse & consultant, who work within the HPCT. A network of end of life care champions that are ward and division based across the trust, raise the profile of end of life care and assist in local education and are supported by the team.

The trust report that when someone is recognised as dying, a medical and nursing care plan is used to facilitate care, alongside an end of life care drug card, to ensure anticipatory medications are available. All clinical areas are trained to use the T34 syringe driver.

The SWAN model of care is being used at NUH, raising the profile of end of life care for all staff regardless of role, enabling staff to support patients in achieving what is important to them in their final days and supporting families and significant others into their bereavement. The Swan model of care is process of end of life and bereavement care which is used to support and guide the care of patients and their loved ones at the end of life and after they have died. The aim of the SWAN is to promote, dignity, respect and compassion at the end of life. We saw patient's records where staff were using the SWAN individualised care plans for the dying patient. This gave clear guidance for staff on how to meet the patient's needs in respect of repositioning, food and fluid intake, communication needs and pain relief.

We found the trust's end of life-individualised SWAN care plans were being used consistently throughout the hospital where patients were identified as end of life to ensure they received evidence based end of life care. Staff were also able to tell us about the current NICE guidance relating to end of life care.

Using 'nerve-centre' the trust has a mechanism in place to identify patients who have been identified as end of life and fast track them at NUH. All families are offered the opportunity to give feedback through completion of the Care of the Dying Evaluation Tool (CODE). There is a multi-professional end of life steering group with support from the bereavement, mortuary & chaplaincy teams.

Following a comprehensive inspection in 2016, the trust was required to ensure staffing levels at Hayward House were sufficient to meet the needs of patients

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

We inspected the whole core service for end of life care for adults over 18 years.

During our inspection:

# End of life care

- We visited the Hayward house, Harvey two ward, the specialist receiving unit, Patience one and Patience two ward, Southwell ward the critical care unit (CCU) the mortuary viewing area, the bereavement office and the chaplaincy service.
- We spoke with nine patients and eight relatives.
- We spoke with 22 members of staff including clinical nurse specialists, hospital porters, ward managers, nurses, the hospital palliative care team (HPCT) healthcare assistants, volunteers, doctors and leads of service.
- We looked at 19 sets of medical and nursing records and reviewed 22 not for resuscitation in the event of cardiac or respiratory arrest orders.

## Summary of this service

Our rating of this service improved. We rated it as good because:

- Staff had a good understanding of how to protect patients from abuse and could describe what safeguarding was and the process to refer alerts.
- Staff were aware of the trusts whistleblowing procedures and what action to take if they had concerns.
- There were comprehensive risk assessments completed in the medical and nursing notes. These were commenced on admission and there was evidence that risk assessments continued throughout the patients stay in hospital.
- We saw good examples of good multi-disciplinary working and involvement of other agencies and support services.
- All patients and their relatives we spoke with, told us they were fully included in discussions around their plan of care.
- The chaplaincy service had a key performance indicator of for referral to treatment times for emergency and urgent calls. Data showed that from January 2018 to October 2018, the chaplaincy service had achieved 98% against the trust target of 95%.
- There were systems in place to ensure that staff affected by the experience of caring for patient at end of life were supported. For example, staff had access to counselling, and alternative therapies through a self-referral system.
- Staffing ratios at Hayward house had improved since our last inspection and were now meeting the needs of the patients
- The Trust had implemented the SWAN model of care across the organisation in November 2017, enabling staff to prioritise the patients and families' priorities and recognise the future bereavement of the families going forward, thereby providing person centred care

However:

- There were no audits to identify the ratio of cancer to no-cancer patients treated by the service
- The CQC had previously identified that the service did not monitor if end of life patients died in their preferred place of death. This was still not being undertaken
- The trust did not separately monitor delayed transfers of care for end of life care patients.
- The CQC had previously identified that the service did not provide a seven day a week service from the hospital palliative care team. This was still not being undertaken
- There were significant difficulties with the removal of the deceased patients from Hayward House



# End of life care

## Is the service safe?

**Good** ● ↑

Our rating of safe improved. We rated it as good

- Since our last inspection in 2016, patients were now protected from avoidable harm because staffing levels at Hayward House matched the levels required to meet patients' needs
- There were comprehensive risk assessments completed and evidence that risk assessments continued throughout the patients stay in hospital.
- Staff demonstrated good practice with regards to hand hygiene and infection control.
- Staff understood their roles and responsibilities regarding safeguarding vulnerable adults and children. Nursing staff had received appropriate levels of safeguarding training and could tell us about examples of where they had identified and raised concerns.
- There was sufficient equipment available to meet the needs of people receiving end of life care on all the wards we visited.
- Medical and nursing notes for patients who were receiving end of life care were accurate, complete, legible and up to date.

## Is the service effective?

**Requires improvement** ● → ←

Our rating of effective stayed the same. We rated it as requires improvement because:

- There was a lack of audit processes to monitor the effectiveness of end of life care.
- The service did not monitor or audit if end of life care patients died in their preferred place of death (PPD).
- The trust was not providing a HPCT seven days a week. However, this would commence in April 2019.
- The service did not record palliative or end of life care patients as delayed transfers of care

However:

- We saw good examples of multi-disciplinary working and involvement of other agencies and support services.
- There were end of life care champions on every ward including the critical care unit. They were actively supporting the role out of education and training of staff around end of life care.
- The chaplaincy service had a key performance indicator of for referral to treatment times for emergency and urgent calls. Data showed that from January 2018 to October 2018, the chaplaincy service had achieved 98% against the trust target of 95%.
- We looked at 22 Do not resuscitate orders (DNACPR) across the trust. All the 22 DNACPR orders all (100%) were completed accurately.



# End of life care

## Is the service caring?

**Outstanding**  

Our rating of caring improved. We rated it as outstanding because:

- Without exception, staff throughout the hospital and at Hayward House were dedicated to ensuring all end of life and palliative care patients were treated with dignity, both before and after death. Staff ensured they found out about patient wishes and respected these always. For example, Hayward House had a viewing room known as the Swan Suite which had been newly refurbished in white and lilac. It was used to provide families of patients who had died with a quiet area where they were able to say good bye. As this was a cooled area, this allowed loved ones to spend an extended amount of time with the patient
- Staff had gone the extra mile to try and ensure patients received exemplary care included accompanying a patient to a gay pride event as they had never been able to attend one previously as well as arranging for patients to have visits from their pets or animals which they had always wanted to see (including a miniature pony).
- Special holidays such as Easter and Christmas were always an opportunity to provide an individualised experience for patients. Staff had recently provided a Christmas experience for a patient who was within their last days of life.
- Staff gave an example where a patient was transferred to them from intensive care unit (ICU) to Hayward House following a short illness whilst still ventilated. Whilst they were still ventilated, an ICU nurse accompanied them to ensure they were appropriately cared for until the point when the treatment was withdrawn.
- At Hayward House, they had a 'All you need is love a coffee morning by the sea' in June which included pony rides, (two ponies were brought to the site). Entertainment included Pets as therapy (Pat dogs), cakes and various other stalls. We saw that a booklet of the event was held at Hayward house for everyone to see

## Is the service responsive?

**Good**   

Our rating of responsive stayed the same. We rated it as good because:

- Free car parking space were allocated to bereaved families who were due to meet with bereavement services. These were called SWAN spaces. Information about car parking services was available in the end of life resource box located in each ward area.
- Hayward House and the day unit had recently decorated the large garden for Remembrance Day. There were a number of patients for which Remembrance was an important time of the year the garden decoration had thereby enabled them to have a participation in a Remembrance service.
- Hayward had access to an 'alcohol trolley' which patients were welcome to whilst admitted. Staff were aware many patients had their traditions and routines which included an alcoholic beverage and did not want to restrict them from this whilst admitted. The trolley was locked away whilst not in use, and staff would adapt their practices if they had patients admitted on the ward with illnesses related to alcoholism
- During our inspection we saw that all the wards we visited had a SWAN resource box. The SWAN sign was used when someone was dying or had died. As part of the SWAN model of care, the offer of handprints, hair locks, jewellery pouches, memory boxes, literature specific for supporting children, canvas property bags, tissue donation information were in the resource boxes.

# End of life care

- There was a relative's hotel in the grounds of the hospital, where relatives and loved ones could stay while the patient was in hospital.
- Interpreters were available when required for patients whose first language was not English.

However:

- Mortuary porters who told us the internal ambulance was regularly not working and that it was due to be replaced. The porters also said that accessing Hayward House to remove the deceased could at times be very difficult, because there were several cars parked near the entrance, and that Hayward House was situated at the bottom of a hill. This meant the porters had to often reverse the internal ambulance as there was no room to turn the vehicle round and to then remove the deceased in the full sight of visitors, patients and staff
- Due to the unreliability of the internal ambulance, staff had accessed an external provider who were able to transfer patients from Hayward House to the hospital mortuary. Within the last 12 months, staff told us more than £14,000 had been spent acquiring the service of the external provider to come to the hospital to transfer patients to the mortuary.
- We requested from the trust their policy on how long it should take to remove the deceased to the mortuary. The policy stated this should be done within 2 hours. This meant the trust were not adhering to their own policy.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- There had been a number of improvements since our last inspection. For example, the trust now had a lead end of life care nurse and consultant, who worked within the hospital palliative care team (HPCT). A network of end of life care champions that were ward and division based across the trust, had raised the profile of end of life care and assisted in local education and are supported by the team.
- Since our last inspection in 2016 The trust had implemented the SWAN model of care across the organisation in November 2017, enabling staff to prioritise the patients and families' priorities and recognise the future bereavement of the families going forward, thereby providing person centred care.
- In May 2018, the Trust's end of life care lead nurse was named Nottingham nurse & midwifery nurse of the year in the NHS 70th Anniversary category. The trust had been part of the NHSI improvement programme having implemented the use of EPaCCS within the specialist palliative care service.
- Staff reported an open and transparent culture within the trust. They reported good engagement at ward level and felt they could raise concerns and these would be acted on.
- There was an End of Life Care Strategy in place for the period 2017 to 2019, which was separate from the overall trust's strategy and vision. The vision and strategy was developed through engagement with the end of life care steering group and the end of life care champions.
- There were governance arrangements specific to end of life care that were embedded within the Trust's overarching governance framework.
- The trust promoted the culture that care of the dying was everyone's responsibility.
- There was good team working between the specialist palliative care team, the mortuary team, the bereavement service and the chaplaincy service.

# End of life care

- There was an end of life care dashboard which was reviewed within quarterly reports.
- There was an end of life care steering group which reported into the clinical effectiveness committee and the quality assurance committee.
- There was a corporate risk register where risks relating specifically to end of life care were flagged. We saw end of life care risks were identified and actions were documented to mitigate the risk by the palliative care team

However:

- There was a lack of a robust audit programme. The trust did not routinely monitor patients preferred place of care for example.

## Outstanding practice

We found one area of outstanding practice. See outstanding practice section above.

## Areas for improvement

We found four areas for improvement. See areas for improvement section above.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

# Our inspection team

The inspection was led by Simon Brown, Inspection Manager. Carolyn Jenkinson supported the inspection of well led for the trust overall. An executive reviewer supported our inspection of well-led for the trust overall.

The team included 23 [further] CQC inspectors, two pharmacist specialist inspectors, two bank inspectors, four assistant inspectors and 25 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.