Nottingham University Hospitals NHS Trust

Quality Report

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

Ratings

Overall rating for this trust	Good
Are services at this trust safe?	Requires improvement
Are services at this trust effective?	Good
Are services at this trust caring?	Good
Are services at this trust responsive?	Good
Are services at this trust well-led?	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

Nottingham University Hospitals NHS Trust is the fourth largest acute trust in England and provides services to more than 2.5 million residents of Nottingham and its surrounding communities. It also provides specialist services to between three and four million people from neighbouring counties. The trust is based in the heart of Nottingham on three separate sites around the city: Queen's Medical Centre, Nottingham City Hospital and Ropewalk House. Queen's Medical Centre is the emergency care site, where the emergency department, major trauma centre and the Nottingham Children's Hospital are located.

Nottingham University Hospitals NHS Trust is registered to provide the following Regulated Activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.
- Assessment or medical treatment for persons detained under the Mental Health Act 1983

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

Overall, this trust was rated as "Good." We made judgements about 16 services across the trust as well as making judgements about the five key questions that we ask. We rated the key questions "are services safe as requires improvement. We rated the key questions, "are services effective, caring and responsive" as good and we rated the key question "are services well led as outstanding.

Our key findings were as follows:

Cleanliness and inspection control

- Staff mostly followed infection prevention and control policies and cleansed their hands between patients.
- Equipment was cleaned following use and was labelled appropriately.
- In most areas clinical waste was suitably managed however at the City Hospital we found that clinical waste areas were not secure.
- Cleaning services were contracted out to a private provider. There had been problems with cleanliness prior to and following our inspection which were identified through the trusts own audits and those carried out by the Trust Development Authority. These were been monitored and action was being taken to improve. Progress was been closely monitored by the executive team. During our inspection, we generally found the hospitals to appear visibly clean.

Staffing levels

- Like many trust in England, there were shortages in some areas for doctors, nurses and allied health professionals. Some areas had higher vacancy levels than others. Generally we found that vacancies were managed well. There was a clear escalation process in place which staff knew how to use.
- The trust were in the process of rolling out an innovative new electronic staffing level monitoring tool. This enabled real time information to be available regarding the staffing levels and the wards that required more resource.
- There were different approaches to managing any shortfalls, such as the use of bank and agency staff, flexible working patterns and reviewing skill mix to create new roles to meet patient's needs.
- Actual and planned staffing levels were clearly displayed across the trust and generally we found then actual levels were in accordance with the planned.

Summary of findings

- Although agency staff were used, overall the trust used slightly less bank and agency staff than the national average. There was an induction process for agency staff to make sure they were familiar with their working environment.
- Recognised staffing assessment tools were used to assess the required numbers and skill mix of staff.
- There were some concerns expressed by staff in the children's service that the assessment there was not robust. We did not observe any negative impact of the staffing levels within the service, but they did not meet suggested levels issued by the Royal College of Nursing. However, these levels are not mandatory but can be used as a guide.

Mortality Rates

- Patient outcomes were monitored across the trust. The Quality and Audit Committee reviewed patient outcome data and this was then reported to the trust board. Each directorate also reviewed their speciality specific outcome data. Many of the patient outcome metrics were in line with or were better than the England average. Where they were worse, improvements had been identified and action plans were in progress.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The trust wide Standardised Hospital Mortality Index (SHMI) was 103.01between August 2014 and July 2015. This meant the SHMI score was higher than expected for the trust.

We saw several areas of outstanding practice including:

- The Department for Research and Education in Emergency Medicine, Acute medicine and major trauma (DREEAM) provided all training for the emergency department. There was a focus on an inter-professional approach to education ensuring all staff groups learnt with, from and about each other. Clinical educators included a consultant, teaching fellows, an emergency nurse practitioner, an advanced nurse practitioner and nurses from nursing bands two to eight. All staff worked clinical shifts in the emergency department. Staff were passionate about learning and without exception they told us education in the emergency department was excellent.
- Trained volunteer simulated patients took part in clinical training. These 'patients' were able to give feedback to staff about how it felt to be their patient. Their feedback included views values and behaviours so staff could develop their approach to patients as well as their clinical skills.
- The initial assessment unit (IAU) in the adult emergency department. There was an initial assessment unit (IAU) operating in the adult emergency department 24 hours a day, seven days a week. All patients arriving by ambulance, except those going straight to the resuscitation area were seen in the IAU. All patients arriving independently and assessed as having a major injury or illness were also sent to the IAU by streaming nurses. Nurse led investigations took place immediately and an advanced nurse practitioner (ANP) or middle grade doctor was available in the area between 10am and 2am to support decisions. The introduction of the IAU had improved initial assessment times for patients. Data provided by the trust showed initial time to assessment was consistently better than the 15 minutes standard from January 2015.It also meant that once patients saw a doctor all the necessary information was available to make a diagnosis and treatment plan.
- The role of trauma case manager. This senior nurse would attend the emergency department and act as scribe for the call. They would introduce themselves to the family and patient on arrival at hospital and would remain their main point of contact for the duration of the patient's stay there. When a patient was discharged the case manager gave them a business card with their contact number so if they had any concerns they could telephone for advice.
- The Injury Minimisation Programme for schools in the children's emergency department. The trust was delivering an Injury Minimisation Programme for

Summary of findings

Schools (IMPS) in partnership with schools and a public health organisation. The programme was designed with the aim of educating children aged 10 and 11 to recognise potentially dangerous situations and prevent injuries. Small groups of children from Nottingham city schools attended the children's emergency department each morning to learn first aid and resuscitation skills, helping them to respond effectively to accidents and take safe risks. More than 2,300 children received health education through this programme each year.

- The ethos of education within the emergency department.
- Trials of GP led front door. During 2014 the trust piloted having GPs at the front door of A&E on two separate peak activity weekends. As a result, patients seen by a GP spent 50 minutes less in the department. There was also a reduction in patients needing to be seen by the minor illness and injury teams. The findings showed 54% of patients were redirected away from A&E to more appropriate services with the majority being directly discharged home.
- Newly qualified or appointed nursing staff wore orange lanyards so they were easily recognised by other staff who could offer them extra support in the emergency department.
- An occupational therapist on ward F20 had undertaken a six month pilot project called 'Playlist for life'. The project involved asking patients about songs that were personal to them and they would like to listen to. Where patients were unable to list songs that were personal to them, their family or carers were encouraged to create a playlist on the patients behalf. The playlists were then created on MP3 players and provided to patients free of charge. An observation tool was created to monitor patient's mood, engagement, responses and communication pre, during and post listening to their playlists. Twelve patients took part in the pilot and the results were then analysed and found to be overwhelmingly positive. At the time of our inspection a meeting was taking place to discuss how the experience could be continued throughout the ward.
- With the support of nursing staff, a consultant on ward F20 had started an ice cream project in order to support patients who were nutritionally at risk. A business case was submitted and supported by the League of Friends for funding to buy a freezer and a supply of high quality, high calorie ice cream. Patients who were nutritionally at risk had an ice cream sign placed on the board above their bed and this prompted staff to ensure these patients were supported to eat ice cream. The project had come to an end and the consultant was working on applying for more funding to continue the ice cream project.
- Patients wore a coloured wrist band to highlight the oxygen rate they were receiving. This ensured staff could easily identify the patient's required rate and ensure they were receiving safe care.
- On ward B47 we saw there was an activities board which detailed activities available for patients each day of the week. We observed activities taking place which were led by a physiotherapist and a health care assistant. We saw patients enjoying diversional therapy in the ward's day room. There was music playing and they were reminiscing about the seaside. They talked about holidays and swimming in the sea and we heard them singing seaside songs. We also saw patients having a tea party, drinking tea from china cups. There were tissues on the table if patients got upset whilst reminiscing. A Pets as Therapy (PaT) dog visited the patients on this ward. We saw that patients enjoyed this and were smiling as the visit took place. We saw these activities had a positive effect on patient's well-being.
- At the Breast Institute, patient escorts met and greeted patients and showed them through the building to the right place. They showed patients where the changing rooms and lockers were, would fetch what they needed and tried to put them at their ease. The Breast Institute also had 'Caring around the Clock '- a nurse visited the patient hourly to communicate between them and the surgery.
- Admissions managers in cardiac services offered emotional support to patients. They dealt with planned and emergency patients. The manager contacted the planned surgery patients promptly and informed that about what to expect, and dealt with any anxieties. For emergency patients, the

Summary of findings

admissions manager took all the details and arranged the admission with the appropriate consultant, streamlining the process and resulting in prompt service. Feedback on the ward's wall showed that patients appreciated this approach.

- Staff offered acupuncture to patients to relieve post-operative nausea and vomiting. This was based on research studies that showed acupuncture to be at least as good as anti-sickness medication.
- Theatre staff initiated the 'Think Drink' project in response to feedback from patients who felt dehydrated whilst waiting for their operation. The project resulted in new guidance for staff to identify which patients could have a drink up to two hours before their operation.
- Theatre staff had successfully standardised practices and processes at QMC and Nottingham City Hospital to ensure safe ways of working and reduce cultural differences. The theatres safety improvement programme implemented a variety of safety projects. It ensured that all theatre staff were trained on team etiquette. This emphasised safety, mutual respect, effective communication, accountability and situational awareness. As a result, theatres ran more safely and efficiently.
- The creation of the Safer Surgery Group had led to improved reporting of incidents, a more open culture, increased productivity and a reduction in serious incidents. There was an effective network of theatre patient safety leads and champions. The theatre patient safety leads had presented their work at an international conference in 2015.
- Adult Critical Care demonstrated outstanding knowledge of safeguarding and MCA and were able to explain its purpose and application in the critical care setting.
- The use of an innovative new pregnancy phone application (pocket midwife) assisted in the information given to women. The phone 'app' consisted of general pregnancy information that was useful to all prospective parents and their families. It also contained information specific to the trust, such the trust's own maternity leaflets and useful contact telephone numbers.
- The shared governance council was very active in maternity services. Staff of all grades volunteered for a term and promoted their ideas to gain funding. For example, staff on the ward carried out an audit of time it took to keep refilling water jugs. Staff presented the audit to the executive team and were granted funding for a self-service water coolant. Staff were extremely proud of this project.
- There were excellent personal and professional development opportunities for staff, and many departments were active in research.
- The use of technology across the trust was outstanding. There was a strong vision for ICT services with excellent clinical engagement.

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

Importantly, the trust must:

- 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.
- In surgical services the trust should take action to ensure that the principles of the Mental Capacity Act 2005 are correctly and consistently applied in assessing the capacity of patients to make specific decisions
- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- The trust must ensure midwives have appropriate training to provide safe care for high dependency women in an appropriate environment.
- The trust must ensure midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic.
- The trust must 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.

Summary of findings

- The trust must take action to ensure Do Not Attempt Cardio-Respiratory Resuscitation decisions are documented legibly and fully in accordance with the trust's policy and the legal framework of the Mental Capacity Act 2005.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Nottingham University Hospitals NHS Trust

Nottingham University Hospitals NHS Trust is the fourth largest acute trust in England and provides services to more than 2.5 million residents of Nottingham and its surrounding communities. It also provides specialist services to between three and four million people from neighbouring counties. The trust is based in the heart of Nottingham on three separate sites around the city: Queen's Medical Centre, Nottingham City Hospital and Ropewalk House. Queen's Medical Centre is the emergency care site, where the emergency department, major trauma centre and the Nottingham Children's Hospital are located.

The trust provides services to more than 2.5 million residents of Nottingham and its surrounding communities. It also provides specialist services to between three and four million people from neighbouring counties. 28% of the population are aged 18 to 29 and full-time university students comprise about one in eight of the population. Also 35% of the population are from ethnic minority groups.

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

The health of people in Nottingham is generally worse than the England average. Deprivation is higher than average and about 33.7% (18,600) children live in poverty. Life expectancy for both men and women is lower than the England average (approx. 8 years). 21.7% of adults are classified as obese. The rate of alcohol related harm hospital, rate of self-harm hospital stays, the rate of smoking related deaths, estimated levels of adult smoking and rates of sexually transmitted infections and TB are all worse than average.

Nottingham University Hospitals NHS Trust were inspected as one of 18 CQC new wave pilot inspections in November 2013, the trust was not rated at this inspection. The purpose of this comprehensive inspection was to award a rating to the trust for the services it provided. We carried out an announced inspection of the three hospital locations between 15 and 18 September 2015. Unannounced visits were carried out on 28 September to medical wards, children's wards and the maternity department, we did not carry out an unannounced inspection to Ropewalk House.

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Head of Hospital Inspection, CQC

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

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

How we carried out this inspection

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

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

Summary of findings

• Is it well led?

Before our inspection, we reviewed a wide range of information about Nottingham University Hospitals and asked other organisations to share the information they held. We sought the views of the clinical

commissioning group (CCG), NHS England, the Trust Development Agency, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch team.

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

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

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

What people who use the trust's services say

Data from the friends and family test (Dec 2013 – Nov 2014) showed over 96% of patients would recommend the trust to their friends and family. The results for September 2015 showed that overall, 96% of patients would recommend the trust. The results for the Emergency Department show 93% would recommend the service to their friends and family. In the maternity service, 99% would recommend the antenatal care, 100% would recommend the care they received during the birth, 93% would recommend the post-natal care and 98% the postnatal community based service.

The 2014 adult inpatient survey looked at the experiences of over 59,000 people who were admitted to NHS hospitals in 2014. Between September 2014 and January 2015, a questionnaire was sent to 850 recent inpatients at each trust. Responses were received from 373 patients. The results showed the trust performed in the bottom 20% s for one question, but in the top 20% of trusts for three questions. For the remaining 30 questions analysed, the trust performed at a similar level to other trusts.

Facts and data about this trust

The Nottingham University Hospitals provided integrated services to a population of 2.5 million patients. In total the trust had 1,996 beds: 1,793 general and acute; 134 maternity; and 69 adult critical care beds across two sites. Ropewalk House provided outpatient services only.

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

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

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

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? Overall we rated safety at the trust to require improvement. For specific information please refer to the reports for Queens Medical Centre, Nottingham City Hospital and Ropewalk House. We made 16 separate judgements about the safety in the organisation. Six services were judged as requiring improvement for safety, nine services were judged as being good for safety. • Staff were aware of their responsibilities under the new Duty of Candour regulations. • Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children. • Throughout the trust there was a very good reporting culture. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. However we also found that • There were backlogs in investigating some radiology and maternity incidents with some being open since 2014. • Nursing vacancies were managed differently across the trust with some concerns in the children's and young people's service. **Duty of Candour** • The Duty of Candour regulation came into force in November 2014. It intends to ensure providers are open and transparent with patients and sets out specific requirements that providers must follow when things go wrong with care and treatment. These include informing people about the incident, providing reasonable support, providing truthful information and an apology. • The policy and procedures available to staff included a 'Degree of Harm' Descriptor guidance. This ensured staff would report incidents consistently in accordance with the serious incident procedure. • There was a trust approved 'Being Open (Duty of Candour) Policy dated March 2015.	**Requires improvement** 

- Clinical staff were aware of their responsibilities under the duty of candour requirements. All of the executive directors, the Chief Executive and the Chairman were able to describe the duty of candour and had a detailed understanding of the regulation.
- We reviewed a number of complaint investigations and serious incident root cause analysis investigations and we saw examples of how the trust had complied with the duty of candour regulation.
- There was a strong patient safety culture in the trust and during our interviews and staff focus groups, staff would often comment that it was important to them to be open and transparent with patients if things did go wrong.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children.
- We reviewed incident records and saw that staff had reported safeguarding concerns for a range of concerns. Staff we spoke with told us of situations where concerns had been escalated, this include the Patient Advice and Liaison Services (PALS) team who identified concerns after a complaint was brought to their attention.
- The trust had safeguarding leads for adults and children and staff knew where to contact them for guidance and advice. The safeguarding leads took a role in training staff and reported good working relationships with ward based staff. In addition there were ward based safeguarding champions who could provide support and advice to their colleagues. The medical director was the executive level lead for safeguarding.
- There were two nursing staff employed to support patients who experienced domestic abuse. These provided support and guidance for staff. This domestic abuse nurses also worked with community groups such as Women's Aid and reported good relationships with community services.
- The trust had provided all staff with information relating to safeguarding adults. The information could be kept in their ID badges and was therefore readily available to them. It explained the types of abuse that could occur and contact numbers for key personnel in the trust to seek advice if needed both in and out of normal working hours.
- The head of children's safeguarding received peer supervision from peers at another trust.
- The trust had a safeguarding Children and Young People committee which was chaired by the executive lead for safeguarding. The minutes of these meetings show that there

was good oversight of safeguarding within the trust with actions being monitored on a monthly basis. An annual report was produced and we saw evidence of the last report being presented to the trust board.
- The adult safeguarding committee met bi-monthly. An annual safeguarding report was produced, this set out the trust position and plan going forward to demonstrate how safeguarding responsibilities would be met.
- The trust had considered the recommendations from the Lampard report into the lessons learnt from the Saville investigation. They had an action plan in place which was monitored by the board's Quality Assurance Committee.
- The trust recruitment process included all the required checks such as identify, references and Disclosure and Barring Service checks (DBS) before anyone started employment.
- In 2014, the Care Quality Commission carried out a review of health services for children looked after and safeguarding. The report was generally positive for the trust. The recommendations from the review were being actioned and performance was being monitored by the safeguarding committee.

Incidents

- Throughout the trust there was a very good reporting culture. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. The trust was in the top 25% of trusts in England for reporting incidents.
- Lessons were learned from incidents and we saw many examples of this in practice.
- Staff knew about recent incidents that occurred and learning from incident investigations was used to change practices and prevent reoccurrence.
- There were backlogs in investigating some radiology and maternity incidents with some being open since 2014. These backlogs were known to the trust and were on the relevant risk registers. Numbers of open incidents had reduced however, further work was required to ensure learning from incidents was identified quickly. Actions plans had been put in place to address the shortfalls within maternity incidents.
- The trust had done some work on human factors and staff had attended training. Human Factors encompass all those things that can influence people and their behaviour. There was a recognition in the trust of the importance of considering human factors when looking at risk management and preventing incidents from occurring.

Summary of findings

Staffing

- Like many trust in England, there were shortages in some areas for doctors, nurses and allied health professionals. Some areas had higher vacancy levels than others. Generally we found that vacancies were managed well. There was a clear escalation process in place which staff knew how to use.
- There were different approaches to managing any shortfalls, such as the use of bank and agency staff, flexible working patterns and reviewing skill mix to create new roles to meet patient's needs.
- Actual and planned staffing levels were clearly displayed across the trust and generally we found then actual levels were in accordance with the planned.
- Although agency staff were used, overall the trust used slightly less bank and agency staff than the national average. There was an induction process for agency staff to make sure they were familiar with their working environment.
- Recognised staffing assessment tools were used to assess the required numbers and skill mix of staff.
- There were some concerns expressed by staff in the children's service that the assessment there was not robust. We did not observe any negative impact of the staffing levels within the service, but they did not meet suggested levels issued by the Royal College of Nursing. However, these levels are not mandatory but can be used as a guide.

Are services at this trust effective?

Good

Overall we rated effectiveness at the trust to be Good

For specific information please refer to the reports for Queens Medical Centre, Nottingham City Hospital and Ropewalk House.

We made 16 separate judgements about the level of effectiveness in the organisation. Thirteen out of sixteen of the services were judged to be Good. End of life services at Queen's Medical Cntre as rated as requiring improvement. Outpatient and diagnostic services are not rated for effectiveness.

- Care and treatment was provided in line with local policies which took into account national guidelines.
- The trust board were sighted on the outcome of national audits and actions taken as a result of them.
- The trust had taken appropriate action to investigate why Standardised Hospital Mortality rates were outside of national expectations.
- The trust had a policy in respect of assessing patient's mental capacity.

Summary of findings

However we also found that:

The completion of DNACPR forms was inconsistent. The trust were aware of this but had failed to implement any actions as a result of their own audit.

Evidence based care and treatment

- Care and treatment were provided in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines. A clinical effectiveness committee reviewed all new and updated NICE guidance.
- There were specific pathways and protocols for a range of conditions.
- The trust had an electronic application ("app") that staff used to access clinical guidelines on their hand held device. Records showed this app was very well used by staff.

Patient outcomes

- Patient outcomes were monitored across the trust. The Quality Assurance Committee reviewed patient outcome data and this was then reported to the trust board. Each directorate also reviewed their speciality specific outcome data. Many of the patient outcome metrics were in line with or were better than the England average, for example, the major trauma centre for the East Midlands was amongst the top 5% of the highest performing in England. Where they were worse, improvements had been identified and action plans were in progress.
- The Summary Hospital-level Mortality Indicator (SHMI) is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The trust wide Standardised Hospital Mortality Index (SHMI) was 103 between August 2014 and July 2015. This meant the SHMI score was higher than expected for the trust.
- The CQC intelligent monitoring of the trust indicated an elevated risk for the composite of hospital standardised mortality ratio (HSMR) indicator and composite indicator in

hospital mortality and genito-urinary conditions. The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect.

- The trust had been active in investigating why the mortality rates were higher than expected for the trust. During the summer of 2015 they commissioned an external review of the trusts mortality. The report was presented to the trust in July 2015 and highlighted the root cause to be the incorrect coding of mortality. Action was in place to address the areas of improvement recommended in the report. The trust board were fully sighted on this review and its outcome.
- The Standardised Relative Risk (SRR) of re-admission for elective admissions at trust level was 128, above the benchmark value of 100. It was worse than the benchmark for emergency admissions standing at 109. For respiratory medicine the relative risk of re-admission was 132 and clinical oncology at 140.
- Between December 2014 and February 2015, non-elective emergency readmission rates were mostly in line with the national benchmark range of 100, with the exception of diabetic medicine which was slightly above national rate at 118. For the same timeframe, elective emergency admission rates were significantly higher than the national benchmark range of 100. Gastroenterology was the highest with a rate of 199.
- The endoscopy department at Nottingham City Hospital was awarded Joint Advisory Group (JAG) accreditation and had been re certified in January 2015. However, the endoscopy unit at the Queen's Medical Centre was not JAG accredited. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards. Action to address the areas needing improvement was underway.
- Medical physics were International Standardization Organisation (ISO) accredited with the last visit in spring 2015. Medical physics were actively engaged with the radiology department plans to receive Imaging Services Accreditation Scheme (ISAS) accreditation. ISAS accreditation is a patient-focussed assessment and accreditation is designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff working in safe environments.

Multidisciplinary working

- We found there was effective multi-disciplinary working across the trust. Staff worked well together to provide coordinated care to patients. There was evidence of close working with other organisations such as social services and the commissioners of care.
- One of the trusts objectives was to develop new integrated models of care in partnership with other organisations and there were a number of projects underway to deliver on this.
- Staff across the trust reported excellent multi-disciplinary working.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- The trust had an up-to-date Mental Capacity Act 2005 (MCA) policy which included the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to make advance decisions and statements to plan ahead in case they are unable to make important decisions in the future. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not restrict their freedom inappropriately.
- There were processes in place to apply for authorisation if a patient needed to be deprived of their liberty. With the exception of surgical services, most of the staff we spoke with understood this process.
- We found a mixed picture regarding the completion of do not attempt cardiopulmonary resuscitation (DNACPR). The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. Many forms were completed well, but some were lacking some of the required information. The forms were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and absence of a senior clinician's signature supporting the DNACPR decision.
- A trust wide audit of 121 DNACPR'S was completed between January and March 2015 to assess if the DNACPR process was fully documented. The data showed 73% of forms had a

documented summary of communication with the patient and 88% of relatives or friends had been involved in the DNACPR decision. There were no recommendations or actions from the findings stated in the report.

Are services at this trust caring?

Good

Overall we rated caring at the trust to be good.

For specific information please refer to the reports for Queens Medical Centre, Nottingham City Hospital and Ropewalk House. We made 16 separate judgements about the level of caring in the organisation. One service, critical care at the City Hospital was regarding as providing outstanding care with the remaining services being judged as good.

- Staff provided care with kindness and respect.
- We saw some good interactions with patients but we did see some isolated occurrences when there were missed opportunities to engage with patients.
- The trust performed about the same as the average in the national in patient survey.

Compassionate care

- As part of our inspection, we observed care on wards and observed staff interacting with patients and relatives. In order to gain an understanding of people's experiences of care, we talked to patients and their relatives.
- On the whole, patients and relatives told us they were happy with the care they received and thought the staff were caring towards them. Generally we saw that staff engaged and interacted with patients and relatives in a kind, respectful and caring manner. Our inspectors saw many examples of extremely kind and compassionate care being delivered. However, there were some isolated examples where staff did not use opportunities to engage with patients.
- We noted that when we spoke to staff in interviews and in focus groups, being able to provide excellent care to their patients was really important to them.

Understanding and involvement of patients and those close to them

- The 2014 National Inpatient Survey asked patients about their overall experience of inpatient care. Out of the 12 survey questions, the trust was performing 'about the same' as other trusts in all areas
- In the Cancer Patient Experience Survey, the trust was within the top 20% for one question, in the middle band for 32 out of

the 34 questions asked and in the worst 20% for one question. The question where the trust performed in the top 20% related to hospital staff providing information on support groups. The worst performing question for the trust relating to receiving enough care from health or social services.

Emotional support

- Patients and their relatives and friends received emotional support during their stay in hospital. The hospital chaplaincy service and bereavement service provided support for patients and relatives.
- In the 2014 National Inpatient Survey the trust scored about the same as others for patients receiving enough emotional support from hospital staff.

Are services at this trust responsive?

Good

Overall we rated the responsiveness at the trust to be good.

For specific information please refer to the reports for Queens Medical Centre, Nottingham City Hospital and Ropewalk House. We made 16 separate judgements about the level of responsiveness in the organisation. All services were rated as good apart the responsiveness of outpatient and diagnostic services at Queen's Medical Centre and Nottingham City Hospital.

- The trust monitored capacity and put systems in place to ensure responsiveness whilst protecting patients from avoidable harm.
- The trust was responsive to the needs of older people through the opening of additional capacity.
- Information was available to patients with specific needs and support available from specialist nurses in many areas.
- Patient living with dementia experienced a good service that met their needs.
- The trust assessed capacity three times a day and was below the national average in most areas.
- Evidence showed that the trust learnt from the complaints it received.

Service planning and delivery to meet the needs of local people

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

Summary of findings

- The trust had expanded Healthcare of Older People (HCOP) beds to meet the needs of local people. These were spread over nine wards. Ward B47 provided specialist mental health care to patients with complex needs due to dementia and delirium.
- The trust had an Acute Medicine Receiving Unit (AMRU) for the assessment of adult patients who required medical admission or ambulatory emergency care. Patients were referred to AMRU via their GP. The unit provided a dedicated ambulatory care area and aimed to discharge patients within 12 hours. Patients requiring further care were assessed to ensure they were sign posted to the right clinical environment first time.
- The surgical triage unit (STU) was set up in January 2015 to assess patients with acute general surgical problems. Patients came into the STU from the emergency department or directly from home after seeing their GP. Protocols were in place with the East Midlands Ambulance Service to bring some patients directly to STU, bypassing the emergency department. Children were not seen in the STU; though young people aged 16 to 18 were given the choice of being seen in the STU or the children's ward.
- Ultrasound scans were available in the STU Monday to Friday. This cut down waiting time for scans and meant patients did not have to go elsewhere in the hospital.
- City Hospital was developing surgery facilities that were more appropriate for future needs. It built a new theatre block for orthopaedic and other planned operations with self-contained admission and recovery facilities. These were designed around patient's needs. The service consulted its patients who made suggestions about décor, and the chair of the patient partnership group advised on the design. Patients had separate cubicles and their own armchair and television set. The service staggered admission times to minimise waiting times in this new facility – 6:45 am, 10:00 am and 12:00 noon. There was a drinks station in the communal waiting area where friends and family could also wait. The admissions area was flexible, attractive and could be adapted to mostly male or female patients and offer privacy.
- Within the maternity service, The Sanctuary was described by as a more home-from-home environment; however, we observed it to be clinical and medicalised. Some attempts had been made to make the areas more homely with soft lighting and bean bags. We saw equipment in the Sanctuary rooms that would be used for high-risk women such as fetal monitoring equipment, neonatal resuscitation equipment and instruments to assist an instrumental birth. The presence of medical equipment was not following the values of midwife led care.

The distinction between the high and low risk areas appeared blurred. During our visit the senior team acknowledged our concerns about the values of the MLU and agreed that they had not got the model of home from home for a MLU implemented. They had discussed options and decided to arrange a working group to change the practises to meet the standards of low risk, home from home care.

Meeting people's individual needs

- Pictorial menu cards were available for people who had difficulty reading or understanding a menu.
- The majority of leaflets and information available was in English; however we were told that leaflets could be made available in other languages if required.
- Staff told us they could access interpreters or they used a telephone translation service to communicate with patients where English was not their first language. An in-house Polish translation service was available and an audit of this service was conducted in March 2015.The results were positive with the majority of patients reporting that the service met their needs and they would recommend the service to others. Some staff spoke other languages and were able to translate. Patients who required a British Sign Language interpreter were required to let staff at the trust know. Staff knew they could access this service but told us they had never needed to.
- There was a trust wide learning disability team, this included three learning disability nurses. This team had grown over the past few years in response to increased demand. A business case was also being put forward to expand the team further.
- The role of the learning disability nurses included training staff, strategic, and support and liaison.
- The learning disability nurses accepted referrals from anyone in the trust. In the past year they received in excess of 800 referrals.
- Where patients had accessed the learning disability nurses previously there was an alert system in place to tell the team that a patient had accessed the hospital services.

Dementia

- The trust had a dementia strategy for 2013 – 16. This set out the trust strategy to caring with patients living with dementia in relationship to the national dementia strategy. The strategy update dated July 2015 recorded the progress being made against individual assessment and care plans, training, dementia friendly environments, active research, and involving and supporting the carers of people living with dementia.

Summary of findings

- The trust offered dementia care to a wide range of staff including the contracted portering and domestic staff, chaplains and volunteers. It was reported that uptake from these groups of staff was good.
- Training for clinical staff in dementia care was included in the induction programmes for nursing, midwifery, and medical staff.
- On wards we saw that 'About Me' booklets were in place. These were completed by relatives and friends of patients who were living with dementia. This gave staff an overview of the person's life, what was important to them and their likes and dislikes. There was however no specific care plans or pathways in place for patients with a dementia.
- An innovative programme had been piloted for patients living with dementia call 'Playlist for Life', this used MP3 players to compile playlists of patients favourite music. An observation tool was created to monitor patient's mood, engagement, responses and communication before, during and after listening to their playlists. Twelve patients took part in the pilot and the results were then analysed and found to be overwhelmingly positive
- The trust used an electronic system to capture information for all patients who were over the age of 75 years and were admitted as an emergency. This enabled them to screen these patients for dementia as required by NHS England.
- The FAIR (Find, assess, investigate and refer) dementia CQUIN screening was in place with a trust target of 90% for finding and screening emergency patients over the age of 75. The dementia strategy update in July 2015 reported progress being made with a monthly average of between 85- 88%.
- Each ward had a staff member who was a 'dementia champion', these were staff who could advise and support other staff in caring for patients living with dementia. Dementia champions did not have protected learning time but they did receive updates on new policies which they then cascaded to other staff.
- A Dementia Committee met every two months where recent innovations and research findings were discussed.
- One ward at Queen's Medical Centre B47 was a dedicated to providing care to patients living with dementia. There were three mental health nurses employed on this ward and there were activities offered to patients as interactive and diversional therapy. This ward also had a higher staff to patient ratio to meets the needs of patients living with dementia.

- The trust undertook a 'carers of patients with dementia' survey and results were collated on a monthly basis. Between April 2015 and August 2015, 13 carers took part in the survey. At the time of our inspection the outcomes of the survey were not yet available.

Access and flow

- The trust had a patient flow and bed escalation policy. Site matrons and bed managers met three times each day. These meetings looked at how to safely and quickly manage the flow of patients through the hospital. Staff matched up patients waiting for beds on the wards with the beds available and made suitable arrangements for patients waiting to go home.
- The average length of stay trust wide was similar to the England average. However, the Queen's Medical Centre had a longer length of stay for Some elective services such as neurology.
- Bed occupancy levels throughout the trust were generally below the national average, although in the health care of older people wards the level was averaging 95%. It is generally accepted that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Bed capacity plans were presented to the trust board and detailed the actions the trust had taken to deal with bed capacity issues. There were plans for further action to lower the risk of future bed capacity issues.
- On ward B3, the short stay acute medical admissions unit, consultants provided a GP referral triage service from Monday to Friday between the hours of 9am to 5pm. This enabled consultants to provide advice to GPs and determine whether the patient's condition required admission to hospital, or whether they could be managed at home, therefore avoiding an unnecessary hospital admission.
- The wards had discharge coordinators who had responsibility for patient flow and discharges in their ward areas.
- There were difficulties accessing specialist children's and adolescent mental health (CAMHS) specialist beds. This caused some delays in transferring children and people to the specialist services. This was a standing agenda item at the Safeguarding Children & Young People Committee. The CAMHS service was provided by another trust and work was ongoing to resolve the bed shortage.
- The Department of Health target for emergency departments is to admit, transfer or discharge 95% of patients within four hours of arrival at A&E. Between April and July 2015 the emergency department consistently performed below the

standard and below the England average. However from June to July 2015 the department met the four hour standard at 96.5%. We asked senior managers how this had been achieved and they told us about an emergency pathway taskforce set up to look at the four hour standard as a trust wide target. We looked at the minutes of the meetings of this group. These showed how the trust had focused on the 'front door' of A&E, discharge processes and transfers within the hospital. This had led to improvement in the flow of patients and timely access to emergency care.

Learning from complaints and concerns

- Good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of patient care. In 2013, the Patients Association published good practice standards for complaints handling, and all NHS organisations are expected to meet them. They provide guidance on how to investigate and respond to a complaint as well as how to manage complaints as an organisation. In 2014 the Parliamentary and Health Service Ombudsman, the Local Government Ombudsman and Healthwatch England published a comprehensive guide to what good outcomes for patients look like if complaints are handled well.
- The complaints handling team had a director of complaints, three complaints manager and three complaint officers. Each of the complaints managers was allocated to specific directorates to enable good working relationships to develop. The responsibility for complaints investigations lay with clinical divisional leads usually matrons however a pilot was underway to allocate investigations to medical staff.
- The trust had suitable arrangements for handling complaints. Staff were aware of how to handle concerns and complaints, comment cards were available for patients and their representatives to complete although we found in some areas these were not readily available. There was cohesive management of the trust's complaints service and the Patient Advice and Liaison Services (PALS).
- The management of complaints, concerns, comments and compliments policy was reviewed and agreed on 26 March 2015. The policy was clear in describing the roles and remit of staff at each level of organisation.
- There were individual pathways in place for each directorate that described how learning from complaints would be shared. This included examples of learning and changes that had taken place.

Summary of findings

- Patients or their representatives could raise concerns and complaints directly with the complaints team or through PALS. The complaints team had a clear triage system in place to determine the severity of complaints should be dealt with. The PALS did not have a triage system so staff used their own judgement to determine if complaints required escalation to the complaints team. The lack of clear triage pathways could lead to an inconsistent approach to complaints handling.
- There was a PALS office at Queen's Medical Centre that the public could access, a visiting service provided on request to the City Hospital and Ropewalk House.
- At the initial stage of receipt of the complaint patients or their representatives were asked about what outcome they would like to see. Initial contact was by telephone but letters were sent if the telephone contact was not successful.
- The 2014/5 Annual Complaint, Concern, Comment and Compliment (4Cs) report showed all complaints were acknowledged within three days.
- Between July 2014 – June 2015 there were 645 complaints received. Some complaints were reopened after complainants received their response, this accounted for 10% of the complaints.

There was a decrease of 7% in the number of complaints received between the period 2012/13 and 2014/15. Of the 645 complaints 407 were closed complaints, the complaints was upheld in 100 instances (25%). Apologies were readily given where complaints were upheld.

- Complaints were reviewed at all levels of the trust. A complaints report was submitted to the board each month. The Chief Nurse reviewed all complaints responses and the Chair reviewed a sample of complaints each month before they sent out. The response letters were signed by the investigating lead officer and a covering letter from the chief executive was included. The trust board also heard patient stories.
- In July 2014, the Patients Association developed a partnership with the NHS Benchmarking Network to manage and facilitate benchmarking of complaints management in NHS trusts, Nottingham University Hospitals participated in this. In the Complaints Survey for the period April 2015 – June 2015. The trust generally performed similarly to other trust but better that other trust for the use of PALS and initial response times. The trust performed worse than other trusts regarding how quickly the complaint was dealt with.

Summary of findings

- In 2014/15 there were 20 referrals to the Parliamentary and Health Service Ombudsman (PHSO) .Currently seven were still being processed and one had been returned to the trust with requested interventions. Six were not upheld, four were fully upheld and one partially upheld. One was withdrawn.
- Our review of complaints showed that most were responded to fully and in a timely manner. Timescales were monitored and we saw responses were chased by email where timescales were not met. There were however, occasional delays in responses being provided where multiple agencies were involved. The average number of day that complaints were open was 90 days. Where there were delays in investigations being completed we saw that most patients or their representatives received letters giving new timescales for resolution, the responsibility for communicating delays lay with the investigation leads.

Are services at this trust well-led?

Outstanding ☆

Overall we rated leadership at the trust to be outstanding.

For specific information please refer to the reports for Queens Medical Centre, Nottingham City Hospital and Ropewalk House. We made 16 separate judgements about the leadership in the organisation. Five core services were rated as having outstanding leadership, nine had good leadership and the leadership in end of life services at Queen's Medical Centre and Nottingham City Hospital required inpprovement.

We found that:

- The trust had a clear governance and risk management structure and accountabilities for assurance were well defined.
- The senior team were well known amongst staff and seen as approachable and good leaders. There was a strongly shared vision which underpinned the day to work of staff.
- Overwhelmingly staff were positive about working at the trust. They talked about being proud of the name of the trust, the facilities they had and about the care they delivered. There was an open door policy and staff reported an open culture at the trust at all levels.
- Staff were empowered to speak out and put forward ideas and initiatives. The Better for You initiative was seen to have improved the quality of care provided to patients.
- The use of IT systems empowered staff to provide positive and high quality care for patients.

However we also noted that:

- The sickness policy was not consistently applied and there were concerns regarding standard template letters being generated.

Disciplinary processes could be protracted causing anxiety and stress for the individual at the centre of these.

Vision and strategy

- There were clear vision and strategies in place. The majority of the staff we spoke with were aware of the trusts vision which was, "Working together to be the best for patients." There were three key areas in the vision; team work, continuous improvement and innovation and proud people in our quest to be the best. In our discussions, interviews and focus groups with staff, there was a clear sense that this vision underpinned their day to day work. However we found that in end of life care this vision was not as well-known as other areas.
- There were four main strategic objectives in place: to enhance patients' experience, develop new integrated models of care in partnership with other organisations, improving efficiency and effectiveness and implementing key service developments.
- There were values and behaviours, these were, "to make sure patients feel cared for, safe and good about the treatment they get."
- The values were used when investigating complaints. Where staff had not acted in a manner which met expectations apologies were extended and suitable action taken to address the deficits displayed by staff.
- Whilst there was a vision and strategy for specialist palliative care services there was not an clear strategy for end of life service provision where patients were not referred for specialist care.

Governance, risk management and quality measurement

- The trust had a clear governance and risk management structure and accountabilities for assurance were well defined. The trust board used various methods to gain ward to board assurance.
- There was a Board Assurance Framework (BAF) in place and we saw evidence of how this was monitored at the trust board. The board reviewed a section of the BAF every month with a full review every six months. If the board were not sufficiently assured by the actions being taken to mitigate risks, they would request further assurance. For example, in 2015, the board

reviewed the progress being made in relation to the areas on the BAF around research and innovation. They were not sufficiently assured so they commissioned an external review. The review identified areas for further improvement.

- A Significant Risk Register was in place which contained nine of the trusts highest risks at the time of the inspection. This risk register was monitored by the trust board. Lower scoring risks were reviewed through the Quality Assurance Committee and the Directorate Governance Forums. However, we found that the trust was unable to disaggregate some of its own data which meant that the board were potentially unaware of individual areas which may not be performing well or were carrying risk.
- We observed a Quality Assurance Committee meeting during our inspection. Overall, we found it to be a well-run committee with good engagement and challenge from the non-executive directors. There was evidence of a thorough review of clinical issues.
- The trust was an early supporter of "Sign up to Safety." This is a national patient safety campaign which aims to make the NHS the safest health care system in the world. There were three areas of focus for the trust, medicines management, failure to rescue and patient engagement. We saw evidence of different initiatives relating to these three areas during our inspection. For example, the trust had carried out improvement work relating to failure to rescue and had improved compliance with the sepsis 6 care bundle.
- Patient safety conversations had been running in the trust for several years, up to two conversations took place every month where an executive and non-executive director and senior manager visited a ward or department to talk to a number of staff about patient safety. The conversations were documented and there was action taken as a result of any issues raised.
- The 15 steps challenge took place twice a year. Every ward and department was visited by a team of four involving patients/ volunteers and executive and clinical staff. The findings from the visits were reported back to the quality assurance committee and directorate governance forums.
- The internal audit team reported good working relationships with the trust. They did not raise any specific concerns about the trust assurance processes.
- Nurses and midwives were involved with Shared Governance. It was an approach that was embedded across the trust and had been in place for some time. Shared governance places power in the hands of frontline nurses and midwives, giving them the chance to influence decision-making as close to patients as

possible. We heard many examples of how shared governance had led to improvements in practice. We noted the it was often lower banded staff who were taking the lead in shared governance. At our nursing and health care support worker focus groups, staff talked about shared governance and how this had empowered front line nursing and midwifery staff to make changes that were important in their clinical areas. There was plans to encourage shared governance amongst the medical staff workforce.

- The trust were open and honest, being confident to celebrate their successes. Whilst acknowledging their challenged areas. The trust were committed at all levels to doing the best for their patients.

Leadership of the trust

- The trust had a very stable and well established executive team. The executives were very visible throughout the trust. They worked with clinical staff so they could get proper insight into the challenges the staff faced. Executive directors were mature leaders and listened carefully to one another and to their staff.
- Staff at all levels spoke extremely highly of the executive leadership in the organisation. Without exception, staff highly regarded the chief executive and made very positive comments about his leadership style. They were proud of the Chief Executive and felt he was in touch with what happened at the front line of services. We were struck by the number of positive comments made from staff at all levels across the organisation. One nurse at a focus group told us “The thing I am most proud about our trust is the chief executive.” Another nurse said, “He (The CEO) will pick up rubbish off the floor and help us if we need him.”
- The chief executive had provided the trust with stability, having been in post for nine years. He was well regarded at both a local and national level and was one of four independent experts appointed by Robert Francis QC in 2012 to help review the final recommendations of his report following the Mid Staffordshire Foundation Trust public inquiry. He was also a member of The Freedom to Speak Up Review team, led by Sir Robert Francis QC, an independent review into creating the open and honest reporting culture in the NHS.
- There had been a fairly recent change in the nursing leadership following the retirement of the previous post holder. The new chief nurse had been in post about six months at the time of

the inspection. Staff knew who she was and commented positively on her visibility. The maternity service were particularly positive that the chief nurse had raised the profile of maternity services in the trust.

- Many nurses that we spoke with were positive about the chief nurses presence because she wore a more traditional nurse's uniform and was very visible and worked with staff. Staff felt this had raised the profile of the profession within the trust. The chief nurse was aware of this and planned to introduce a new hospital badge for the nursing staff. Traditionally, nurses were awarded a badge to wear on their uniform when they qualified. There was a real sense that the brand of nursing was being promoted in the trust and this was promoting many nurses to feel proud of their profession, their uniform and what it stood for.
- The medical director was well established and provided strong leadership within the medical workforce. There were no concerns about medical leadership at executive level raised during the inspection. Services were cohesive.
- The trust chair had been in post for two years and prior to this had been a non-executive director of the trust for seven years. The chair had a clear understanding of the risks and opportunities' for the trust. She was very visible and known to staff. The chair was well respected within the health and social care community and was very clear about the direction the trust needed to take for the benefit of the trust as well as the local population.
- The non-executive directors had different backgrounds and there had been conscious decisions made to appoint people with certain areas of expertise. There was a good balance of those with clinical and non-clinical backgrounds. One of the non-executive directors took a lead role for quality and safety, however, all of the non-executives were equally responsible for quality and safety and it was an integral part of the work of the trust board.
- The trust structure was one of clinical directorates with triumvirate leadership. The clinical director had the overall accountability within the division, but there was nursing and managerial leadership as well. There was a review of the structure at the time of the inspection and the number of clinical divisions was to decrease from nine divisions to five.
- Leadership within divisions was good and our inspection found evidence of outstanding leadership within the emergency

department, critical care and surgery. The trust had traditionally invested in leadership development for its staff and there were various leadership programmes in place for clinical and medical staff groups.

Culture within the trust

- Staff side representatives reported an open culture at the trust with open door polices at all levels of the organisation. The philosophy of the trust was said to be consistent and we were told there a willingness to try to get things right.
- Overwhelmingly staff were positive about working at the trust. They talked about being proud of the name of the trust, the facilities they had and about the care they delivered. There was no doubt that staff found their roles increasingly challenging and worked really hard to deliver the best care they could, but they remained positive that the leaders in the trust did the best for them.
- There were many opportunities for staff to have a voice within the trust. Staff were empowered to speak out and to offer ideas and solutions to problems. Many of the initiatives to promote improvement were being led by the lower banded staff within the organisation. The long standing improvement programme, "Better for You," had provided many opportunities for staff to make changes to their work to benefit patients. The trust had been committed to this programme for the long term and staff saw this as part of their day to day work.
- We saw some excellent examples of how staff worked together in the best interests of patients, crossing over traditional barriers and hierarchy's.
- There was an open culture regarding reporting and learning from incidents. This was reinforced by the staff survey results for 2014 where one of the top five scoring questions related to staff feeling the incident reporting process was fair and effective.

Fit and Proper Persons

- The fit and persons requirement (FPPR) for directors was introduced in November 2014. It is a new regulation that intends to make sure senior directors are of good character and have the right qualifications and experience.
- The trust had appropriate systems and processes in place to ensure that all new and existing directors were and continued to be fit and proper persons. These had been approved by the trust board.
- The executive directors were able to demonstrate an understanding of the regulation.

- We looked at a selection of five executive directors' personnel files. Evidence of checks were available and we found they all contained a signed self-declaration form.

Staff and public engagement

- The staff engagement score from the 2014 NHS staff survey was 3.83 which put the trust in the top 20% of trusts for staff engagement.
- Generally staff told us they liked working for the trust and were proud of it. During out focus groups and interviews many staff told us they felt listened too and part of the trust. They particularly valued the chief executive and held him in the highest esteem.
- The non-executives and executive directors told us they believed it was important to look after and value staff.
- The trust ran a health and wellbeing programme, offering health checks, stress management, mindfulness courses and a physiotherapy service. There were onsite fitness classes and on site gyms at the two main sites. The trust had also run a number of staff challenges; the Big Bike challenge, NUH Walk Off and a Pedometer challenge. There was also a bicycle service and repair project where staff could get their bicycles repaired while they were at work.
- There were annual staff awards and the trust had worked with the local media for a nurse of the year award, with the nurses photograph being displayed on one of the cities trams.
- The overall staff sickness rate for 2014/15 was 3.3% which was better than the national average of 4.7%. The trust has reported below the national average sickness absence rates for the last four consecutive years.
- We spoke with four staff side representatives, they told us there was positive, and regular engagement with good relationships with the trust board. There was 'open door' access reported with the human resources department and industrial relations were reported to be good.
- There was currently restructuring proposals underway for administrative and clerical staff. This was causing some anxiety for staff regarding their job security.
- There was excellent support provided to staff who were sick. This included access to physiotherapy, and a staff counselling service (which was also extended to family members of staff).
- Some concerns were raised by staff side representatives regarding the application of the staff sickness policy as they considered this did not take into account where staff had long

term conditions or had planned elective care. Where staff sickness absence triggered a series of standard letters were generally issued regardless of the staff members circumstances. The staff side representatives and human resources manager told us that there could be consideration given to these but that it was down to individual managers to direct the sickness processes. It was acknowledged that inconsistencies could occur depending on the skill and confidence of managers.

- Staff side representatives told us that where disciplinary procedures were commenced that investigations could sometimes be long causing anxiety and pressure on staff. Data obtained by the trust included start dates for disciplinary procedures but end dates were not completed, so we were not able to assess the trust performance on timely disciplinary investigations.
- There was a 'Speak up' group for staff to share concerns but this was reported to be poorly attended.
- The trust was performing as expected in 11 of the 12 Survey areas of the General Medical Council National Training Scheme and performing worse than expected in relation to induction.
- Of the 29 indicators within the NHS Staff Survey, the trust had 2 negative findings, seven findings that were within expectations and 20 findings that were in the top 20% of all trusts. The top five scoring areas related to career development, job relevant training, appraisal, fairness and effectiveness of the incident reporting process.
- During 2014 the trust carried out a large public engagement programme to help them develop their vision. This was known as "Events in Tents." They received 5000 comments from patients and the public which contributed to the development of the vision for the trust.
- The trust were active in promoting prevention of accidents and recent campaigns had been run by the safeguarding leads to raise the profile of the accidental ingestion and risk of burns to children.

Innovation, improvement and sustainability

- The trust had a well-established programme of transformation called "Better for You." This was a programme introduced over six years ago as a continuous improvement programme using change methodology to support improvement. It involved people who the change would affect the most. Better for You was embedded across the whole organisation and there were numerous examples of change as a result that had involved all different areas/teams such as medical secretaries, receptionists

and nursing staff. It was impressive to see a change programme that had become embedded. As a member of staff said, “Better for you wasn’t another five minute wonder, it carried on and its part of the trust now.”

- The trust had a strong information communications technology (ICT) department which was working hard to provide solutions to benefit staff and patients alike. There was a clear vision for ICT services which took the trust through to 2020. We saw some impressive use of technology which was making a real difference to the way care was being delivered across the trust. There was clinical engagement with the ICT projects, with nursing staff seconded to work with the ICT teams. This meant, services were developed that were meaningful and practical for front line staff. During our focus groups with staff at all levels, they told us how proactive and forward thinking the trust was in the use of technology to help them do their jobs more efficiently.
- The trust used an electronic patient observation system, but rather than have a number of hand held devices which stayed on the wards, they had provided all clinical staff with their own hand held device. Staff brought this to work with them to use for the electronic patient observations. There were benefits for staff and the trust alike with this approach. It meant staff took responsibility for keeping their own device in good working order and ready for use and it also allowed staff to receive their work emails and read them at a time and place convenient for them. Staff told us they felt more in touch with the trust because they could take their device home.
- There were plans in place to expand the use of the handheld electronic patient monitoring system. For example, pilots were ongoing to use Electronic nursing assessment.
- The devices were also used to record staffing levels and there was a pilot underway which was in the process of being rolled out across the trust to use the devices to record staffing levels and flag areas where there were concerns. It meant managers were able to see real time information about the status of all the wards.
- The trust worked in partnership with the University of Nottingham and operated two National Institutes for Health Research Biomedical Research Units for hearing and digestive diseases.

Overview of ratings

Our ratings for Queen's Medical Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	☆ Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	Good	☆ Outstanding	Good
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Our ratings for Ropewalk House

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Overview of ratings

Our ratings for Nottingham City Hospital

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

Our ratings for Nottingham University Hospitals NHS Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

Urgent and emergency care services

- In January 2015 the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme. Vanguards are where groups of providers come together to change the way they work together to provide more joined up care for patients. Nottingham University Hospitals along with partners in the South Nottinghamshire health community were awarded vanguard status for urgent and emergency care. This has allowed the trust to trial new approaches to improve the coordination of services, and reduce the pressure on A&E departments.
- Working with four local clinical commissioning groups, GPs, and out of hours GP services, the trust reduced unnecessary hospital admissions from 28% to 5% following the launch of the Nottingham Care Navigator programme. This programme offered an alternative to urgent hospital admission, where possible, providing direct access to advice and support from the right clinical service first time via an online health navigation tool.
- During 2014 the trust piloted having GPs at the front door of A&E on two separate peak activity weekends. As a result, patients seen by a GP spent 50 minutes less in the department. There was also a reduction in patients needing to be seen by the minor illness and injury teams. The findings showed 54% of patients were redirected away from A&E to more appropriate services, with the majority being directly discharged home.
- The trust was delivering an Injury Minimisation Programme for Schools (IMPS) in partnership with schools and a public health organisation. The programme was designed with the aim of educating children aged 10 and 11 to recognise potentially dangerous situations and prevent injuries. Small groups of children from Nottingham city schools attended the children's emergency department each morning to learn first aid and resuscitation skills, helping them to respond effectively to accidents and take safe risks. More than 2,300 children received health education through this programme each year

Medical care (including older people's care)

- An occupational therapist on ward F20 had undertaken a six month pilot project called 'Playlist for life'. The project involved asking patients about songs that were personal to them that they would like to listen to. Where patients were unable to list songs that were personal to them, their family or carers were encouraged to create a playlist on the patients behalf. The playlists were then created using hand held devices and provided to patients free of charge. Evaluation of the project was underway.
- With the support of nursing staff, a consultant on ward F20 had started an ice cream project in order to support patients who were nutritionally at risk. Patients who were nutritionally at risk had an ice cream sign placed on the board above their bed, this prompted staff to ensure these patients were supported to eat ice cream. The project had come to an end and the consultant was working on applying for more funding to continue the ice cream project.
- Patients wore a coloured wrist band to highlight the oxygen rate they were prescribed. This ensured staff could easily identify the patient's required rate to ensure they were receiving safe care
- Patients receiving oxygen through a nasal cannula were at risk of developing pressure ulcers where plastic tubing went over the tops of their ears. Sponge covers were placed over the tubing to prevent this from happening. (A nasal cannula is a lightweight tube which splits into two prongs placed in the nostrils and from which a mixture of air and oxygen flows).

Surgery

- Theatres benchmarked activities against their own standards and compared their practices with external organisations. For example, they had compared some of their processes with neighbouring hospitals and as a result asked a trained band six nurse to do a specific eye procedure instead of a consultant.
- Theatre staff had successfully standardised practices and processes at QMC and Nottingham City Hospital to ensure safe ways of working and reduce cultural

Outstanding practice and areas for improvement

differences. The theatres safety improvement programme implemented a variety of safety projects. It ensured that all theatre staff were trained on team etiquette. This emphasised safety, mutual respect, effective communication, accountability and situational awareness. As a result, theatres ran more safely and efficiently.

- There was a 'Dragons Den' project where staff could present their ideas for service improvements. Theatre staff had been successful in presenting their ideas for improvements in equipment used in vascular surgery at QMC.
- The theatre PPI group had been shortlisted for a Nursing Times Award for Enhancing Patient Dignity and were due to present their work in September 2015.
- The theatre PPI group were working on a DVD to show to patients before their operation. The DVD will show patients what to expect when coming to theatres to help reduce fear and anxiety.

Critical Care

- A critical care consultant at the trust was developing a tool to support the complex decision making process for critically ill patients. The tool was based on an ethical and balanced approach to selecting a suitable treatment plan for patients and act as a base for further clinical decisions. The tool would then be used as a tracking system so that clinicians understood previous treatment choices and clinical outcomes. This was supported by colleagues and was considered to be an innovative development in tracking the decision making process in treating critical care patients.
- The use of the trust's simulation centre had helped staff in developing advanced communication skills.
- Innovative approaches were used to gather feedback from people who used the service. One example was that patients and carers were invited to the opening of a new bed area to get their views on patient privacy.
- The 'just do it' project to avoid cancelled elective surgery due to lack of critical care beds has been successful. This is also an example of several departments working together to solve a problem.
- In recognition of the challenge to outpatient services, in July2014 the trust came together with five other NHS trusts from across the country to share good practice and highlight themes for development. This was reported in the Health Services Journal.

Areas for improvement

Action the trust MUST take to improve

- 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.
- In surgical services the trust should take action to ensure that the principles of the Mental Capacity Act 2005 are correctly and consistently applied in assessing the capacity of patients to make specific decisions
- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- Ensure that at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- The trust must ensure midwives have appropriate training to provide safe care for high dependency women in an appropriate environment.
- The trust must ensure midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic.
- The trust must 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.

Outstanding practice and areas for improvement

- The trust must take action to ensure Do Not Attempt Cardio-Respiratory Resuscitation decisions are documented legibly and fully in accordance with the trust's policy and the legal framework of the Mental Capacity Act 2005.
- Ensure that trained nurse presence on the neonatal unit meets the 'British Association of Perinatal Medicine Guidelines (2011).'(BAPM).
- Ensure that there is sufficient neonatal consultant cover during the out of hour's period so that both hospital sites can access their own individual on call consultant. This is in line with the BAPM standards (3rd edition – section 5.1.4).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities. They should be supported to obtain further qualifications and provide evidence, where required, to the appropriate regulator to show that they meet the professional standards needed to continue to practise. How the regulation was not being met: Regulation 18(2)(a) The trust must take action to ensure that nursing staff working in the eye casualty receive training in the recognition and treatment of sick children. The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units. The trust must ensure midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic. The trust must ensure midwives have appropriate training to provide safe care for high dependency women in an appropriate environment.

This section is primarily information for the provider

Requirement notices

In the maternity service, the consultant cover did not meet national guidance. There were 68 hours per week of dedicated consultant cover for the labour suite. For the number of babies born in the maternity service each year there should be 168 hours per week of consultant cover.

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Care and treatment of service users must only be provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the Mental Capacity Act 2005.How the regulation was not being met: Regulation 11(1)(3) HSCA (RA) Regulations Staff in surgical services did not always understand or correctly apply the principles of the Mental Capacity Act 2005 (MCA).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users by ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

Regulation 12 (2)(e)

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The care and treatment of service users must - a Be appropriate b Meet their needs, and c Reflect their preferences. By enabling and supporting relevant persons to understand the care or treatment choices available to the service user and to discuss, with a competent health care professional or other competent person, the balance of risks and benefits involved in any particular course of treatment How the regulation was not being met: Regulation 9 (2)(c) The provider did not have robust audit systems in place to ensure 'Do Not Attempt Cardio-Respiratory Resuscitation' decisions were always documented legibly and fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005. The trust was not meeting the national cancer waiting time standard of seeing at least 93% of patients urgently referred by their GP with a suspicion of cancer within two weeks of referral.

This section is primarily information for the provider

Requirement notices

The trust was not meeting the national standard of starting to treat patients who are urgently referred by their GP with a suspicion of cancer who are subsequently diagnosed with cancer within 62 days.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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