Nottingham University Hospital NHS Trust

Nottingham City Hospital

Quality Report

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

Ratings

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Overall summary

Nottingham City Hospital is an acute hospital managed by Nottingham University Hospitals NHS Trust. The 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. There are 1,690 beds across the trust, and it has a budget of £824 million. Nottingham City Hospital is a specialist and planned care site where the cancer cente, heart centre and stroke services are based. The trust employs more than 14,000 people. Of the population of Nottingham, 34.6% belong to non-white minority groups; of this people from the Asian Pakistani groups constitute the largest ethnic group with 5.5%.

We chose to inspect the acute services at Nottingham City Hospital as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. When we announced our inspection, we described the trust as a high risk provider. By the time we undertook the inspection, our risk methodology had revised that assessment to a medium risk provider. Nottingham City Hospital has been inspected four times since it was registered in October 2010. Three inspections took place in 2012, and they found that the hospital was meeting the standards set out in legislation.

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

In general, we found that Nottingham City Hospital provided safe care. Most areas had good processes in place to recognise, investigate and learn from patient safety incidents. The hospital also responded well to the needs of its patients. Patients reported that there were good interpreting services. Written information was available in other languages on request.

The hospital calculated nursing staffing levels using a recognised dependency tool. Although staff were very busy, we found the staffing levels were in accordance with the levels defined by the dependency tool in use.

We found some examples of good leadership in the hospital, and most staff felt very well supported by their managers. Many said that they had excellent training and development opportunities. Doctors who were in training also felt well supported and said that the consultants provided effective supervision.

The vast majority of people spoke positively about their care, and we saw some good examples of staff delivering compassionate care to patients. Nevertheless, some people highlighted areas where they felt the hospital needed to improve.

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Services were safe in the hospital because there were systems for identifying, investigating and learning from patient safety incidents and there was an emphasis in the trust on reducing harm to patients. We found nurse staffing levels were calculated using a recognised dependency tool which we considered to be good practice.

Are services effective?

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

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

Are services caring?

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

Are services responsive to people's needs?

In general, Nottingham City Hospital responded to people's needs. We found the trust actively sought the views of patients and their families. We found that there was good access to interpreting services and all information leaflets could be requested in other languages.

Summary of findings

There were initiatives in place for the trust to work with the local community such as a partnership with a local school for young adults with learning disabilities and supporting the Princes Trust to offer work experience. The new kitchen at the City Hospital had entered into a partnership with the local authority to provide the city's meals at home service.

Are services well-led?

The hospital was well-led. There were clear organisational, governance and risk management structures in place.

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

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

Summary of findings

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

Medical care (including older people's care)

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

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

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

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

There was an effective hospital at night team in place at the hospital. This team triaged referrals using the early warning score and the situation, background, assessment and recommendation tool to provide clinical advice. Doctors and nurses expressed satisfaction with the system.

Summary of findings

Surgery

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

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

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

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

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

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

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

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

Summary of findings

Intensive/critical care

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

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

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

Maternity and family planning

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

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

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

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

In the maternity service we found procedures and practice for infection prevention and control were not always effective. We found specimens were not being stored in accordance with the trusts own policy.

Summary of findings

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

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

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

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

End of life care

We found some good examples of practice in end of life care at the hospital. There were dedicated end of life inpatient wards/units at Nottingham City hospital which we found safe, effective, responsive, caring and well-led. The trust action plan for palliative care services indicated that the speciality had the highest levels of patient satisfaction in the patient experience surveys. When we looked at the complaints data collected by the trust over the past year, it confirmed that there were very few complaints about oncology services and wards, which also indicated patients were generally happy with the service.

We looked at Do Not Attempt Cardio-pulmonary Resuscitation (DNACPRs) orders on all of the wards we inspected. In all cases, staff had completed these in line with guidance published by the General Medical Council (GMC). The trust had systems in place to audit all DNACPR forms. The resuscitation team

undertook this audit and any issues of concern were fed back to the relevant consultant in writing. The consultant was invited to reflect on the DNACPR form they had completed and review the order to make sure it met the standards expected.

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

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

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

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

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

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

Outpatients

We received mixed feedback about the care patients received in outpatients.

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

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

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

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

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

Patients and staff consistently told us that the delays in transport were a significant issue on patient satisfaction and service efficiency. Staff also raised concerns and did not think the patient transport service was satisfactory. They told us this affected the running of the clinics, as patients arrived late and missed appointments. Our evidence demonstrated that the patient transport

systems were not always providing an effective service and this had a potential knock on effect on the effectiveness of outpatient services. All patient transport issues were escalated to the commissioners at regular contract meetings. The commissioners were aware of these difficulties.

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

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

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

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

Summary of findings

What people who use the trust's services say

Nottingham University Hospitals NHS Trust scored 80 out of 100 in the October inpatient Friends and Family Test, which was above the national average.

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

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

Areas for improvement

Action the trust MUST take to improve

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

Action the trust COULD take to improve

- Review the process for the recording of controlled drugs in the maternity and gynaecology departments so records are accurately maintained.
- Ensure all areas of the trust are free from dust and hand gel is always available in all dispensers.
- Ensure people are given information about how long they will have to wait for outpatient appointments.
- Review the availability of information so that it is accessible for people who find it difficult to access.

Good practice

- The effective care being provided by the Critical Care Unit. Outcomes for patients were better than the national average, with the mortality rate for the department being significantly better than the national average.
- The commitment of staff to providing the best possible care. Staff spoke with passion about their work and felt proud of the trust and what they did. They understood the hospitals values.
- The medical staffing levels within the trust and the support given to doctors in training by senior medical staff.
- The quality of the senior leadership was good, particularly that shown by the executive directors.
- The care and range of services offered at Hayward House.
- The bereavement care that was offered in the trust by the multi-faith centre and the compassion shown by the mortuary staff towards relatives and friends of deceased patients.

Nottingham City Hospital

Detailed findings

Services we looked at:
Medical care (including older people's care); Surgery; Intensive/critical care; Maternity and family planning; End of life care; Outpatients

Our inspection team

Our inspection team was led by:

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

Team Leader: Carolyn Jenkinson, Care Quality Commission.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)

Detailed findings

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

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

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

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

Are services safe?

Summary of findings

Services were generally safe. There was evidence that staff learnt from patient safety incidents. Arrangements to minimise risks to patients were in place, including measures to prevent falls, pressure ulcers and venous thromboembolism.

Our findings

Patient safety

Services were safe in the hospital. Patients told us they felt safe and the majority of comments we received were positive.

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

Managing capacity

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

Medicines management

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

Whistleblowing

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

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

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

Staffing levels

We looked at whether the hospital had safe staffing levels. Many patients commented that staff, particularly nurses, were very busy. We observed this on the wards we visited. It was particularly evident on the older people's wards or other areas of the hospital where patients were elderly and frail. The trust calculated nursing staffing levels using a recognised dependency tool which we considered to be good practice. It demonstrated openness and transparency by publicising the daily staffing levels on the wards. We did not find evidence to suggest that staff were not meeting patients' needs. However, we did observe that staff were very busy. They told us they could request additional staff if the dependency of their patients had increased. However, we were very aware that the trust faced significant difficulties recruiting new staff due to a shortage of registered nurses in the area. This was a problem affecting other hospitals in the East Midlands. Both the student nurses and Allied Health Professionals who were in training all told us that they wanted to work at the trust when they qualified. We also saw the trust had just undertaken a nursing recruitment drive in Portugal to find resources for the additional beds that had been opened to assist with winter pressures.

Are services safe?

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

Reducing harm

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

Infection prevention and control

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

We saw good hand washing techniques in the operating theatres.

Safeguarding vulnerable adults

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

The trust had analysed the reasons why some areas had achieved lower benchmarking scores, and it had discovered that scores were related to whether staff attended relevant training. The trust had set out actions to address this. The use of benchmarking provided the trust with an overview of their employees' understanding of safeguarding and their roles and responsibilities in protecting vulnerable patients.

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

Are services effective?

(for example, treatment is effective)

Summary of findings

The services provided at Nottingham City Hospital were generally effective and were focused on the needs of patients. Outcomes for patients were mostly as expected, but in some cases they were better than expected. This meant that patients got either the same standard of treatment or better treatment at the hospital when compared with other hospitals in England.

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

Our findings

Intelligent monitoring data

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

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

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

Hospital at Night team

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

Medical equipment

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

Policies and guidelines

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

Mandatory training and induction

The trust had identified that not all staff had received mandatory training. This was because it had changed the way mandatory training was organised, but the new system for booking onto the training was not working. As a result of

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

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

Allied health professionals and pharmacists told us they thought their access to training and development was excellent.

Are services caring?

Summary of findings

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

Our findings

What people told us

The vast majority of patients we talked to in the hospital told us that staff were caring and that they treated patients with dignity and respect. However, many patients or relatives commented on how busy the staff were. We observed many examples of compassionate care during our inspection. We saw good interactions between staff and patients on most of the wards we visited. Staff were offering patients who were receiving end of life care a very good standard of care. A relative of a patient who had died at the hospital told us, "The staff are so caring and compassionate. [The patient] was here for three years of his life. If we paid for it we couldn't have got better care."

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

We also received information from members of the public via our website. Again, feedback was mixed, but comments were generally positive. Where we did receive concerns, they generally related to staff not being able to meet patient's needs, particularly patients who were elderly and or frail.

Data from our intelligent monitoring system reinforced our findings. Patients using NHS services were asked whether they would recommend a hospital to their friends and family if they required similar care or treatment. Nottingham University Hospitals NHS trust performance was above the national average.

Staff attitude

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

Trust-wide initiatives

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

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

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

Our findings

Patient feedback

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

Visitors to clinical areas were able to see displays of information, including information about complaints and comments from the previous months and how the trust had taken patients' views into account when improving a service.

Interpreting services

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

Discharges and access to treatment

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

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

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

Care of patients who have dementia

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

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

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

Choice

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

Pain management

We talked to patients about how well they felt their pain was managed. One patient told us they had been moved from a general ward to an oncology ward to control their symptoms. They said, "I was not given adequate pain relief, but I had a contrasting experience when I moved here: they

Are services responsive to people's needs?

(for example, to feedback?)

are very responsive to me. If I am in pain in the night they get the doctor to reassess me quickly." Another patient told us the staff were responsive if they complained of any pain. The patient said, "I have pain relief. The staff say I can have it every hour if I want but I prefer not to do this." Another patient told us they had "no pain, it is very well controlled".

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

Are services well-led?

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

Summary of findings

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

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

Our findings

Governance and leadership

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

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

Recruitment and retention of staff

Student nurses and doctors said that they wanted to work for the trust after they had qualified, but demand for nurses was exceeding supply. The trust had just undertaken a recruitment drive in Portugal and had offered posts to nurses to help with staffing the extra winter pressures beds.

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

Staff feedback

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

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

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

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

We received information from staff either before or during our inspection. Some staff felt there were instances when they were not listened to. The vast majority of staff told us that they did feel listened to and that they could effect change. Nevertheless, it is important for all staff to feel they have the chance to he heard. We saw that the trust had a raising concerns policy in place and that all staff had access to a 24-hour telephone counselling service.

Are services well-led?

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

Complaints

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

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

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

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

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

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

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

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

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

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The acute medical services at City Hospital are provided on several wards in several departments within the hospital. In 2012/13 the Acute Medicine Directorate provided care and treatment to 106,295 patients and employed over 1,200 whole time equivalent staff. During out visit we spoke with patients, visitors and staff and used information from comment cards. We attended a number of focus groups and we observed care being delivered on the wards.

Summary of findings

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

The hospital offered a stroke service which was based on evidence-based guidelines. This meant patients had the best chance of a good outcome following a stroke.

We found that, generally, the wards/departments were well-led.

Medical care (including older people's care)

Are medical care services safe?

Managing risk

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

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

On two wards we saw documentation used for the prevention of pressure ulcers. The documentation was called the 'Sskinn Bundle' (surface, skin assessment, keep moving, incontinence, nutrition). The documentation had high, medium or low risk categories. Medium risk patients should have daily risk assessments. In the care plans we looked at we saw evidence that they had been carried out. In the trust's Nursing and Midwifery Annual Report 2012/13 the trust said that Sskinn bundles were used across the trust. However, the bundles were not evident on all the wards. The trust aimed to reduce all avoidable pressure ulcers. Although it had not achieved this, its performance was consistently improving and the numbers of pressure ulcers had significantly reduced.

Staffing levels

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

One patient told us, "If I press my buzzer at night, the staff can take time to answer but it is ok in the daytime." One member of staff told us, "It's the staffing levels that have allowed us to give a good level of care."

Training for staff

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

Hospital at night

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

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

Effective care

Berman 1 ward was the hyper acute stroke unit, which provided care for patients who had had a suspected or confirmed stroke. It admitted patients directly from home and provided 24 hour, seven days a week thrombolysis.

Medical care (including older people's care)

Calls were triaged via phone and patients were admitted directly to the ward. The out of hours thrombolysis service was co-ordinated by the band 6 nurse practitioner, who liaised with the on-call consultant via the telemedicine unit. Patients who were taken directly to the stroke unit avoided any unnecessary delays in treatment. The rehabilitation wards had an effective stroke multidisciplinary team that was patient centred. This meant patients who had suffered a stroke had the best chance of a good outcome.

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

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

Managing deteriorating patients

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

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

Caring for patients with learning disabilities

The learning disability acute liaison team had been set up by the trust in partnership with Nottingham Healthcare to improve healthcare for patients with learning Disabilities and to support staff treating these patients. Within the cardiac treatment centre, the learning disability liaison nurse was present when a patient with learning disabilities came for pre-assessment. An About Me document and a traffic light system were used to let staff know about a patient's needs, so that staff could meet them. The traffic light system placed important information such as a patient's medication or allergies into a red section. An amber section included information about the way the patient liked to be communicated with. A green section was for things that related to making their stay in hospital more comfortable, such as the food they liked. It was a simple guide and an effective way of sharing information about the patient.

Patient records

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

Collaborative, multidisciplinary working

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

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

Monitoring performance

The trust had identified a problem in the system for allocating patients for coronary artery bypass graft (CABG) surgery. The multidisciplinary team (MDT) reviewed patients and allocated them to a pooled list for surgery. If the surgeon who was then assigned the patient was not at the MDT meeting and did not agree the surgery should take place, the surgeon could refuse to operate. There had been no monitoring of this, which meant that the trust was not tracking outcomes for patients. We found that the trust was fully aware of the issue and had taken action to change the

process. The MDT was recording the decision-making process so that the trust could track and monitor decisions. We asked one of our professional medical advisors to review this, as we were aware there was a mortality outlier alert in place for CABG (this means that the incidence of deaths for CABG was higher than expected). On review of the evidence, we were satisfied that the cardiology service recognised the problem and was working effectively towards improvements.

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

Movement of patients to other wards

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

On the respiratory ward, three patients had been moved to another ward which was not under the speciality for their medical condition. The patients were highlighted on a board so that the medical team could see who they needed to review on a different ward. This meant there was a system in place to ensure that patients who were moved onto another ward remained under the care of the appropriate medical team.

Winter planning

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

Care plan audits

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

Care for patients who have suffered a stroke

Stroke services at City Hospital had a therapy treatment room, which was a dedicated room on the ward and contained adjustable height plinths and therapeutic equipment which individuals or groups of patients could use in physiotherapy activities such as balance and gait training.

City Hospital also provided a stroke outreach service to continue patients' care and treatment after discharge. The team consisted of a physiotherapist, occupational therapist, speech and language therapist and therapy support workers. The team worked in partnership with patients who had suffered a stroke and their families or carers.

In addition to this service, there was also a community-based early supported discharge team for stroke patients. This was an example of partnership working between City Hospital and Nottingham Citycare Partnership (a local provider of community NHS services). The team was established to help support and rehabilitate stroke patients after their discharge from hospital. Patients were referred by healthcare professionals on the stroke unit at City Hospital, and the team provided intensive rehabilitation and support for up to seven days a week for a period of four

weeks after discharge from hospital. The team ensured that patients who had been discharged home from hospital were supported and that stroke specialist rehabilitation continued to optimise the patients' independence.

Are medical care services caring?

Patients were well cared for.

Patient feedback

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

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

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

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

Interactions with patients and relatives

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

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

Care planning

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

Are medical care services responsive to people's needs?

(for example, to feedback?)

Ward environment

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

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

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

Responding to patient feedback

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

Medical care (including older people's care)

Mealtimes

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

Care of patients with dementia

We found that some wards used the About Me document. It enabled health and social care professionals to see the patient as an individual and deliver person-centred care that was tailored specifically to the person's needs. It could therefore help to reduce distress for the person with dementia.

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

We saw that a patient with dementia had been referred for cardiac investigations. The consultant and team had ensured that a mental capacity assessment was carried out and written consent obtained before treatment commenced.

Are medical care services well-led?

Visibility of senior management

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

Ward rounds

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

Staff feedback

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

Appraisals

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

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

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The acute surgical service at Nottingham City Hospital provides a range of surgical specialities, including transplant surgery. All planned surgery is carried out on the Nottingham City Hospital campus.

We visited seven wards, operating theatres, three pre-assessment clinics and the Trent cardiac centre. We talked with thirteen patients, three visitors, seven managers and 16 staff. We observed care and treatment, looked at care records and we received information from people who contacted us about their experience. We also reviewed the trust performance data in our intelligent monitoring tool.

Summary of findings

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

Surgery

Are surgery services safe?

Staffing arrangements

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

Cleanliness

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

Risk of harm

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

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

Environment and equipment

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

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

Teamwork

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

Staff in operating theatres told us they were well supported by managers. There was good analysis and learning from incidents. Senior clinical staff from City Hospital met with

counterparts from Queen's Medical Centre to share experience of practice and learn lessons from each other. Displays of information throughout operating theatres reminded staff of any changes in policy and practice.

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

Performance information

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

Are surgery services caring?

What patients told us

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

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

Are surgery services responsive to people's needs?

(for example, to feedback?)

Pre-operative assessment

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

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

Elective orthopaedic surgery

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

outliers'. This means they were cared for on a ward which was a different speciality. One of these patients told us that they were being looked after by their medical team and that their doctors had visited every day.

Are surgery services well-led?

Surgical services were well-led.

Management arrangements

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

Clinical teams

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

Improving efficiency and safety

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

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

We inspected intensive and critical care services at Nottingham City Hospital. We visited adult intensive care and cardiac intensive care departments. We spoke with seven senior and medical staff and six nursing staff. We asked patients and relatives for their views on care.

Summary of findings

The hospital met all standards. We found that the effective systems of management and clinical improvement we saw at the Queens Medical Centre were in also place or shared at the City Hospital site. There were robust systems of incident analysis and learning to improve care. Staff provided safe and effective care, and we saw that the trust had taken into account patient and relative viewpoints in improving the service.

Intensive/critical care

Are intensive/critical services safe?

Staffing levels

Services were appropriately staffed to ensure safe care for critically ill people. Certain staff had specific responsibilities or interests, such as infection control or end of life care. There was good educational support to promote practice improvement, and arrangements to learn from research and any incidents. The medical cover for the critical care unit was good and there was a consultant in the department sixteen hours a day.

Learning from incidents

Staff and departments were open about discussing and learning from incidents. We found there was a real focus on learning from incidents. There were clear arrangements for recording and reporting untoward incidents. Staff were included in root cause analysis of the reports and took ownership of the process by developing plans to reduce the possibility of recurrence. We saw that departments had changed practice in the management of arterial lines following learning from an incident in another department. Staff appeared to be very engaged in making care as safe as possible.

Facilities

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

Are intensive/critical services effective? (for example, treatment is effective)

Audit data

The trust contributed data to the Intensive Care National Audit and Research Centre (ICNARC) audit, which aims to improve critical care across the UK. The trust's results from this audit were outstanding and revealed that standardised mortality rates were much better than expected. The trust had between 82 and 94 more patients survive than expected. Graphical comparison with other similar critical care units shows good comparative performance. The standardised mortality rate for the critical care units across the trust was 83 for the year June 2011 to July 2012. A score of 100 is average mortality and a score less than 100 is better than average. This meant that the critical care units were providing effective care because more patients were surviving when compared to rates at other hospitals.

Specialist staff

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

Teamwork

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

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

Are intensive/critical services caring?

Patient care

Patients in intensive care departments told us that care was good. We saw that critical care areas were clean and

well organised and that patients looked comfortable. We observed a nurse just quietly sitting holding a patients hand. A relative of a patient who had been in intensive care for many weeks told us, "Nothing is too much trouble for the staff." Another relative told us, "The staff on the Coronary Care Unit were incredible, very professional and hardworking and they genuinely cared about the patients."

Support for patients

We examined patient's records and saw that they carried risk assessments that included dietary needs, pain control, pressure sores and the patient's pre-assessment, if they had had surgery. We saw that critical care staff used a booklet specifically designed to prompt appropriate risk assessment for the type of very ill patients they cared for. This meant that staff assessed patients' needs and managed major risks.

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

(for example, to feedback?)

Patient views

Clinical areas had displays of information that included complaints and comments from the previous month and explanations of how the trust had taken into account patient views when improving the service.

We saw staff had taken into account patients' and relatives' views and changed practice as a result.

We had no concerns that the critical care service at the hospital was not providing responsive care.

Are intensive/critical services well-led?

Clinical leadership

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

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

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

Clinical teams

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

another doctor reviewed their case to check that care was appropriate and identify lessons to be learned. This meant the service used audits and reviews of clinical practice to improve the quality of patient care.

Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The trust had a single maternity service with maternity units located on both hospital campuses. In addition, the trust also provided community midwifery services. The maternity service at City Hospital provided antenatal, intrapartum and postnatal care to patients. It consisted of a labour suite and delivery theatres, a feto-maternal unit and a neonatal unit.

The labour suite consisted of 15 delivery rooms. There were two maternity theatres, and these were located within the labour suite. The service had a dedicated bereavement facility within the labour suite. There was a hotel facility which could be used by patients and relatives. The neonatal unit comprised of 12 cots and provided neonatal intensive care facilities.

More than 5,500 babies are delivered at Nottingham City Hospital per year.

We visited the labour suite, antenatal clinic, antenatal and postnatal wards, the feto-maternal unit, and the neonatal unit. We spoke to six patients and eight relatives in obstetrics, and 21 staff in obstetrics, including student midwives, midwives, matrons, doctors, consultants, senior managers, support staff and domestic cleaning staff. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

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

Staff provided care to patients in line with their needs. There was a multidisciplinary approach to the provision of professional, supportive and sensitive care to patients.

Staff had not always appropriately followed and managed procedures relating to the management of medicines and the prevention and control of infection.

City Hospital maternity service had clear management and governance structures. However, some policies and guidelines were out of date and required review. Some staff told us that they did not always feel that directorate and trust senior management listened to them. Figures for the completion of trust mandatory training were low.

Maternity and family planning

Are maternity and family planning services safe?

Patient safety

Staff were aware of the trust's incident reporting system and used the online system to report incidents. Maternity clinical governance staff told us that nominated individuals reviewed and investigated reported incidents. This meant that staff were confident of the correct procedures to follow when incidents occurred and that they knew how to access the incident report form. We saw an example of a change that the service had made following an investigation into a patient safety incident.

Staffing and skill mix

The maternity service used a dashboard to monitor and review key performance indicators within the service. The dashboard showed that City Hospital had a ratio of midwives to patients of 1:29.5, which was slightly above the standard rate of 1:28. This meant there were slightly fewer midwives to patients than the national standard. The maternity service senior management team confirmed that it had recruited 20 new midwives across both hospitals, and these people were due to commence work soon. This meant that the trust had taken action to address the midwife to patient ratio.

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

We looked at medical cover arrangements for the neonatal Units at both City hospital and QMC. The units were both covered by a separate consultant out of hours, but there were occasions when there was one consultant to cover both units. We spoke with senior staff about this, and they told us that each unit had a ward-based team of doctors that included a senior registrar. On rare occasions, one consultant would indeed cover both units out of hours. If this happened, the registrar could get support from the paediatric consultants based at QMC. Staff were not concerned about the out of hours cover arrangements. We were also reassured that there had never been an incident where safety had been compromised.

Infection prevention and control

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

We checked procedures for the safe storage and disposal of specimens and waste materials. Tubs in the labour suite dirty utility room, which were used to collect waste material, had not been labelled appropriately or collected in a timely manner. We also found that specimens had not been collected in a timely manner from the labour suite, and staff told us that the pod collection system for specimens was not working. We checked a fridge on a corridor in the labour suite which contained blood specimens and two cord specimens. One of the cord specimens was stored in a single plastic bag, which was not in line with trust policy. Neither of the cord specimens had been appropriately labelled, and staff on the labour suite had not ensured specimens were collected on a regular basis. This meant that staff had not followed appropriate procedures for managing the risk of infection.

We discussed the specimens with managers during our inspection, and they took action to ensure the blood and cord specimens were collected without further delay.

Medicines management

Staff in the City Hospital neonatal unit wore tabards during medication rounds to ensure that staff who were administering medicines were not distracted or disturbed from their work. Staff told us that the service had introduced the tabards to address issues resulting from patient safety incidents. This meant staff were able to concentrate on the safe administration of medicines. It also demonstrated that the trust made changes to practice as a result of learning from incidents.

We looked at the management of medicines, including the procedures for storing, recording and administering controlled drugs to patients on the labour suite and Bonnington Ward, which provided mixed antenatal and postnatal care. Every delivery room in the labour suite had a lockable storage facility for medicines. We checked one delivery room and found that ampoules of medicines had been left on top of the storage facility and were not locked

away. We discussed this with staff, and they were aware of issues related to medicines storage. They told us that they were regularly reminded to store medicines appropriately in the lockable facilities.

In the labour suite and Bonnington Ward, we found that staff had not appropriately recorded information relating to medicines management. We checked the controlled drugs books. Controlled drugs are a group of medicines that have the potential to be abused. For this reason, the handling of these drugs is subject to certain controls set out in law. We saw that staff had not always accurately recorded information on the administration of controlled drugs to individual patients.

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

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

Are maternity and family planning services effective?
(for example, treatment is effective)

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

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

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

Equipment and resources
Staff had access to required equipment, including single-use items of stock. We found that stock items and equipment were stored in an organised manner and were available to staff when needed. We also checked the emergency equipment trolleys in the labour suite and found they were well stocked. We saw evidence that these trolleys were checked regularly. This meant staff had access to emergency equipment which was routinely checked and maintained.

Are maternity and family planning services caring?

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

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

Maternity and family planning

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

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

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

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

Maternity Survey

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

Are maternity and family planning services responsive to people's needs? (for example, to feedback?)

Responding to patients' and relatives' needs

We spoke with one patient, from outside the trust's local area who was receiving care in the hospital. They told us that the service had provided excellent care and had been very responsive to their needs.

Another patient told us that patients could not refer themselves to City Hospital, and this had caused them some inconvenience and anxiety. Staff told us that patients were always asked which trust site they would like to attend, and staff made every effort to respect patients' wishes. Staff told us they could not always guarantee a patient's first choice of hospital. However, staff communicated regularly with patients to keep them updated about their hospital admission.

One person told us that they had not been able to stay on the same ward as a family member who was being treated at the hospital. They said that they had been offered alternative accommodation in the hospital hotel, and this had met their requirements.

We looked at three care plans and found that staff had assessed patients' individual needs and had documented information relevant to their care.

Multidisciplinary team working

We found that the multidisciplinary approach to care provision in City Hospital maternity service worked very well. The working relationship between consultants and midwifery staff was responsive to the needs of patients. This meant the service and its staff had worked together to deliver appropriate care.

Bereavement facilities

The labour suite had a delivery room dedicated to supporting bereaved patients and their relatives. There were facilities and arrangements in place for staff to support recently bereaved patients and their families. These included memory boxes. The labour suite had a quiet room, which patients and relatives were able to use to discuss concerns with staff. The trust employed bereavement nurses and a specialist bereavement midwife who could refer parents whose babies had died for counselling services. This meant that the labour suite at City Hospital had effective systems and practices in place to help support bereaved patients and their relatives.

Are maternity and family planning services well-led?

Leadership and governance

The maternity service at City Hospital worked alongside QMC's maternity service to provide obstetrics and gynaecology care across the trust. Key roles within the maternity service (for example matrons and midwifery clinical educators) worked across both City Hospital and QMC campuses. Staff told us that senior managers (including ward and directorate managers) were accessible and visible to staff at City Hospital.

Maternity and family planning

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

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

Staff support and involvement

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

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

Cross-site working

Staff described the current working practices for maternity staff working across both the Queen's Medical Centre (QMC) and City Hospital campuses. They said that midwives worked across both sites at a management level if the need to do so was identified. For example, a team of midwifery clinical educators provided learning and feedback from incidents to multidisciplinary teams at 'skills drills' sessions for both sites. This meant maternity staff at QMC and City Hospital benefitted from a standardised approach to operational practice, procedure, learning and development.

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

We noted that the maternity notes within the City Hospital campus did not follow the same structure as those at QMC. This meant that although the trust's maternity service was delivered from both sites, note-keeping, records and care plans were not always standardised.

Training, learning and development

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

End of life care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The trust's oncology department is based at City Hospital campus and serves a resident population of 1.1 million. The department currently sees around 4,000 new patients every year. It provides a comprehensive range of chemotherapy and radiotherapy treatments as well as an acute oncology service.

Acute oncology services are provided 24 hours a day, and a consultant and specialist registrar are available and on call to see patients urgently. Between the hours of 8am and 5pm Monday to Friday, there is an acute oncology team of specialist nurses who provide emergency triage and assessment of acutely ill patients.

Twenty beds are provided for patients who need palliative inpatient, outpatient or day care services. These services are provided at Hayward House on the City Hospital campus. The day care and outpatient services are elective and, although most of the inpatient admissions are planned, some of the admissions are emergency admissions. Admissions are accepted 24 hours a day. A hospital palliative care team works across Queens Medical Centre and City Hospital and provides a specialist palliative care service to all the wards across the trust Monday to Friday between the hours of 8am and 5pm.

Outpatient services for oncology are provided within a specialist oncology outpatient department, which has a total of 7 clinic suites across the trust. Outreach oncology outpatient and chemotherapy treatment is also undertaken at Sherwood Forest Hospitals. Annually, outpatient clinics see approximately 4,000 new patients and have 22,000 patients attending for follow-up appointments or treatment.

There are three wards at City Hospital that specialise in providing oncology services. One of these has a unit for teenagers and young people who need oncology services.

Hayward House provides a 20-bedded inpatient ward. We inspected all of these wards. We also inspected a number of end of life support services, including the multi-faith centre, chaplaincy service, the bereavement centre, the mortuary and chapels of rest.

We spoke with nine patients, four relatives, one volunteer and 23 staff, including nurses, doctors, consultants, senior managers, a physiotherapist, a person providing complementary therapy, faith leaders, mortuary staff, a specialist palliative care nurse, a member of staff from the Hayward House day unit and other support staff.

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

End of life care

Summary of findings

Overall, patients received safe end of life care, and patients and relatives we spoke with reported very high levels of satisfaction. We found some examples of exceptionally good compassionate care.

Staffing levels were higher on the oncology and palliative care wards to give patients the care and support they needed when they were at the end of their life. Patients commented to us about the level of staffing and how this meant staff were very responsive to their needs.

Steps were taken to ensure patients' symptoms were stabilised as quickly as possible to enable patients to be discharged quickly if they wanted to die at home. Staff were committed to ensuring patients' wishes about their place of death were met.

A range of complimentary therapies were being provided, which were highly valued by patients and their relatives.

There were robust audits taking place with clear feedback to governance leads indicating what improvements needed to be made.

Are end of life care services safe?

Pressure ulcers

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

Safeguarding

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

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

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

End of life care

Do not attempt Cardio-Pulmonary Resuscitation orders

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

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

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

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

Protecting against infection

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

The risk register for end of life care services actively considered the risks of patients with compromised immune systems coming into contact with infections. It highlighted steps which must be taken to protect patients against such risks.

All of the wards we inspected were very clean, fresh and tidy. Alcohol hand gel was available in several places on the wards we inspected, and we saw that all staff used this regularly and washed their hands regularly. There were ample hand washing facilities available on each ward, and liquid soap and hand towel dispensers we checked were adequately stocked.

One patient told us, "The ward is very clean and tidy. It always is, and the staff always wash their hands before they offer me assistance."

Staffing levels and supporting workers

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

The senior nurses on all of the wards we inspected had a considered approach towards increasing staffing levels to meet particular needs, for example distress and agitation or panic. Most of the wards said they were more likely to use bank staff for healthcare assistant roles rather than nursing roles, as they felt it important to have continuity of care for patients and clear accountability and clinical responsibility. This meant that patients were cared for by staff who they were familiar with.

Two ward managers said they would only use bank staff for 'special' one-to-one observations so the staff member only had to read and understand the care needs, wishes and treatment of one person. They felt this made it more likely that staff would provide good quality care to patients. Some wards told us they asked for the same member of bank staff to ensure continuity. This demonstrated how committed ward managers were to ensuring the provision of safe and positive care and treatment for patients at the end of their life.

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

End of life care

This showed there were staff available to offer support and reassurance to patients nearing the end of their life and that the care they offered was centred on the patient rather than being task focussed.

Safety and suitability of equipment

We checked the resuscitation equipment on all of the wards we inspected and found it was clean. We also found that single-use items were sealed, in date and that emergency equipment had been serviced. This meant the equipment was safe for use in an emergency.

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

Are end of life care services effective?
(for example, treatment is effective)

Mortality rates

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

28-day readmission and rapid discharge

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

The trust had a lower length of stay than the national average for oncology patients, but its figures were broadly similar to those of other local trusts. This may be because the trust had a lower bed to population ratio than the national average for palliative care (having 20 beds as opposed to 32), or it may be because it worked more effectively with community-based services to effect an earlier discharge in order to meet patients' end of life wishes.

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

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

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

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

End of life care

Staff satisfaction and commitment

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

Implementing national guidelines

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

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

Two patients we spoke with on the palliative care unit told us how staff had controlled their symptoms effectively since their arrival. One patient told us, "I was so breathless when I came in, I couldn't breathe but I am calm now and off oxygen." Another told us, "I have no pain now. My breathlessness is much better. I panic and that does not help, but the staff are supporting me." We were assured that patients were monitored to ensure effective symptom control when they were nearing the end of their life.

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

Nutrition and hydration

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

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

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

Staff handovers

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

When we asked staff about the patients we were speaking with, they showed an in-depth understanding not only of their diagnosis and current physical and emotional needs but also of their family situation, their preferred place to

end their life and their current understanding of their prognosis. This indicated that care planning, staff handovers and staff relationships with patients were very effective.

A physiotherapist on the palliative care unit who told us that they received a verbal handover from the ward about patients and their need for assessment every day. They told us that there was an embedded multidisciplinary approach towards planning care and treatment at the unit to get patients ready to be discharged back home if this was their wish.

Spiritual support

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

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

Complementary therapies

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

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

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

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

Are end of life care services caring?

Patient satisfaction and complaints

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

Patients' and relative's views

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

One patient told us the staff at the unit had helped them break bad news to their children, and they had been very grateful to have the support. The patient said the staff had shown care and compassion for them and had been supportive throughout without being intrusive. The patient felt the staff were very intuitive and understood what patients needed. They told us, "I honestly do not know what I would have done without the care, compassion and support I have received." Staff on the palliative care unit told us that they signposted and referred children who were bereaved to a specialist counselling service. They also had books available for children of different age groups to help them understand and come to terms with their loss.

All of the staff we spoke with demonstrated a real commitment to enabling patients at the very end of their life in hospital to die in a calm environment and in a private

and dignified manner. Staff told us that side wards were allocated to patients who were at the end of their life wherever possible, to allow them and their relatives privacy.

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

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

Support services at the end of life

City Hospital had a bereavement centre on site, which was located near to the chapel of rest and the mortuary. We spoke with two staff from the service.

The bereavement staff told us they worked with families when patients had died. They said they would also refer people to the chaplain or to CRUSE (a bereavement counselling service) if needed.

Staff told us there were specialist bereavement nursing staff who focused on providing support to children and young people who were either nearing the end of their lives or who had lost their parent. Staff on the palliative care ward told us they would assist families or take the lead in breaking bad news to children in a compassionate manner. Staff told us that there were age appropriate information packs, books and memory boxes available for children who had been bereaved. Children could fill memory boxes with items such as handprints, locks of hair, key rings or candles as well as personal items selected by children themselves. The staff would also refer children or adults who were struggling with their loss to counselling services.

Staff on the palliative care ward told us that there was structured bereavement support after a patient died. The patient's relative was sent a letter inviting them to get in touch. The unit had a room for reflection which contained a prayer tree, a remembrance book and memory candles. The nursing staff told us there was an annual remembrance service which families were welcome to attend and relatives' meetings were held at the unit four times a year to offer on-going support. This was an area of outstanding and compassionate practice.

All of the patients we spoke with told us their families had received good support from the staff at the hospital.

Arrangements following a patient's death

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

These wishes were recorded to avoid anything being missed.

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

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

(for example, to feedback?)

The speed of response for symptom control

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

Where patients needed to be admitted to specialist oncology or palliative care beds for symptom control, staff arranged this with minimal delays. The trust gave us information from a data sample of 100 patients at the end

of their life between February 2012 and May 2012. It showed that patients waited an average of 1.5 days for a palliative bed if they were a trust in patient on a general ward and an average of 2.7 days if they were admitted from the community. This indicated the service responded quickly when patients were in crisis or when they were inappropriately placed and needed specialised support.

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

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

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

Rapid discharge

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

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

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

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

Responsiveness to the needs of patients

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

We spoke with two patients who had been admitted to general wards before being transferred to specialist oncology wards. One of the patients told us, "It [the general ward] felt crowded, like a battle-zone. It was too busy and noisy, especially at night. I was not given adequate pain relief. I have had a very contrasting experience here [on the oncology ward]. The care is very good, staff have time and they are responsive to my needs for example if I am in pain at night."

The other patient had received good care, but their symptoms were not controlled or managed until they were admitted to the palliative care unit. The patient told us, "I made the decision not to have any further treatment, and then panicked about what that meant. The staff have been so kind and reassuring."

We spoke with the relative of a patient who was rapidly relapsing. We saw staff were trying to identify the reasons for the rapid deterioration, and the patient's relative told us the staff team were working hard to try and identify the right place for the patient to end their life. The patient had a clear wish to end their life at the hospital, and the team was trying to facilitate this.

We saw that all of the wards had made real attempts to provide furniture for day spaces that was comfortable and homely. They attempted to provide a pleasant environment for patients and their relatives as patients approached the end of their life.

End of life care

Planning for the needs of the local population

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

Spiritual support

The National Bereavement Survey 2011 indicated that patients did not feel they received the spiritual support they needed in the last two days of their life. We saw the trust had taken robust action to address this, and staff we spoke with at City Hospital told us about the availability of spiritual support for people and the end of their life.

The chaplain and Catholic sister told us they were available across the City Hospital site 24 hours a day and that they also operated an on-call service. They told us they had well established links with maternity services, Linden Lodge and Hayward House but that they had good relationships with all wards.

The staff in these services provided support for a very wide range of patients, from children to older people, and they also provided support for staff who were in need of spiritual guidance. The staff working in the service were kind, calm, dedicated and compassionate. There was an A–Z folder about the chaplaincy service and about all faiths, and this had been provided to all wards.

Responsiveness to concerns and complaints

We saw suggestions and comment boxes for patients and visitors on the wards and in the complementary therapy suite at Hayward House. We also saw 'You said, we did' boards on the wards. These were boards which hospital staff used to indicate what feedback patients had given about the ward and what the department had done to address the issues of concern.

One ward we inspected had received patient feedback about the noise from doors at night, and the ward manager was looking at how this could be addressed.

A patient we spoke with was next to a radiator, and they told us the heat made it difficult for them to breathe, although they said they did not want to complain. With their permission we raised this with the ward manager, who asked the other patients if anyone would prefer being nearer to the heater. The patients were moved before we left. We checked that this was better with the patients, and they were very happy with the response.

None of the patients we spoke with raised any concerns about the end of life service. One patient told us, "If I had a concern I would raise it. I am certain that it would be dealt with."

Are end of life care services well-led?

Are wards well-led?

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

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

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

Clinical governance

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

There were trust-wide and speciality-specific risk registers which identified areas of high, medium and low risk to

patients and staff. The trust had used data from national patient safety alerts to identify risks, as falls and pressure ulcers featured on the end of life risk register. We saw evidence that actions the trust had taken had been understood and embedded in practice on most of the wards we inspected. This had had a positive impact on patient safety.

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

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

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

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

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

Outpatients

Information about the service

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

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

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

Summary of findings

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

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

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

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

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

Although we identified some very well managed clinics, we were concerned that no one person at the trust had overall responsibility for assessing and monitoring the

quality and consistency of the service across the trust. This resulted in a lack of shared learning and consistency across clinics and across the trust. This needed to be addressed.

Are outpatients services safe?

Preventing falls

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

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

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

A manager in one clinic told us that they sometimes received inadequate information about patients' past medical history from their GP, and this could make it challenging to assess the risks to patients. They said the staff tried to be vigilant. There was a constant staff presence in communal waiting areas in this clinic to alert nurses if people were unwell or had fallen. Other clinics were limited by their environment, and this meant that not all communal waiting areas could be easily observed. These factors made it harder to reduce the risks of patients falling.

Protecting against infection

CQC's 2011 Outpatient Survey indicated that patients found the outpatients department clean but did not feel the patient toilets were maintained to the same standards of cleanliness. The clinics we inspected were clean and tidy overall, but the standard of cleaning in the disabled toilets in the general outpatients department was not adequate. There was a layer of dust on a shelf, indicating it had not been dusted properly for some time. This demonstrated there might be an ongoing issue in this area.

Outpatients

The outpatient risk register identified that patients with compromised immune systems (such as clinical haematology patients) were at risk of harm from hospital acquired infections. The trust had indicated the steps it had taken to address this. The areas used for the outpatient clinic at Hayward House were clean and fresh throughout.

There were handwashing facilities in all clinic treatment and consultation rooms we inspected. The liquid soap, paper towels and alcohol gel dispensers were adequately stocked in all of the areas we checked. We saw the staff making use of these to try and prevent the spread of hospital acquired infections.

One patient commented to us, "The clinic is clean and tidy." Another told us, "The doctors and nurses wash their hands before they examine you and afterwards too. I am very happy with the standards of cleanliness."

Safeguarding

When we analysed data on reported outpatient incidents for May 2013 to October 2013 we identified several incidents which had been correctly identified as safeguarding issues. We saw that staff had taken action to report these to either children's or adult's safeguarding teams for them to investigate. This demonstrated that staff working in the clinics had a clear understanding of safeguarding and how to respond to any concerns about the safety of a child or adult.Patients told us they felt safe with the staff at the clinic. One patient told us, "I feel very safe with the staff, I trust them. If I was concerned I would report my concerns, but I'm not."

Staffing levels and supporting workers

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

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

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

Safety and suitability of equipment

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

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

Outpatient Survey 2011

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

Patient and relative feedback

We received mixed feedback from patients about different clinics and parts of the trust's services. Feedback was, without exception, highly positive for the care and treatment patients experienced at the women's centre, breast clinic, Dundee House, Hayward House and the urology centre.

The vast majority of patients we spoke with were very satisfied with the service they had received from the outpatient clinic they had attended. Comments included "I attended this clinic for my diagnosis and treatment. The risks of the surgery were really clearly explained and I could ask any questions. The follow up I have received has been excellent. My treatment has worked", "The care and treatment I have received has been excellent throughout my journey" and "All treatment was explained clearly and talking throughout the procedure helped greatly".

Outpatients

Some patients had not had as positive an experience. One patient said they had not been given an explanation of their condition in a way they understood. "On the first appointment I had 'abnormal cells', on the second 'cancer cells'."

When we interviewed senior managers about the outpatient services, they could identify pockets of excellent practice and name clinics which were not performing as well. In spite of this knowledge, there was no one in the trust taking overall responsibility for ensuring clinics were providing effective treatment across the trust. This meant positive practice in excellent clinics was not shared and replicated in clinics which were not performing as well to ensure a consistently good quality service across the trust.

Consent to treatment

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

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

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

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

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

Multidisciplinary team working

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

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

Are outpatients services caring?

Outpatient Survey 2011

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

The trust performed less well when it came to treating patients with dignity. Many patients reported that doctors or nurses spoke in front of them as if they were not there, and they said that they were not always afforded privacy when discussing their condition or treatment. One patient said, "The stroke consultant did not speak directly to patients, and the staff did not understand my diabetes." However, during our inspection all of the patients we spoke

with who needed to be examined told us that this was conducted in private. One patient commented, "I was examined in private, and I felt really comfortable throughout."

Patient and relative feedback

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

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

- "A caring and professional service, thank you."
- "I was made to feel comfortable and relaxed from the minute I arrived. Thanks to all."
- "Thank you for being so kind and helpful."
- We saw that the consultant and nursing staff on this unit were approachable, welcoming, compassionate and helpful.

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

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

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

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

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

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

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

Patient Cancer Survey 2013

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

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

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

Outpatients

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

Appointment times and delays

The trust performed well in the 2011 Outpatient Survey in terms of how quickly it offered patients an appointment, its choice of appointment times and how it explained to patients what would happen at their appointment. The trust results were tending towards worse than expected in respect of patients being informed of delays and how long they would have to wait to be seen in the outpatient department.

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

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

We analysed the number and type of formal complaints received about outpatient services at City Hospital. There were five for spinal outpatient department, three for the women's centre and one for urology. However, none of the patients we spoke with in these clinics raised any concerns about delays.

Concerns about the transport service

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

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

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

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

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

Patient comments and incidents

The staff at the women's centre told us they had introduced a system to ensure the results of patients' diagnostic tests were always communicated to them and to ensure results

were not missed. This system was developed following an incident when a patient was not informed of the results of diagnostic tests and showed a willingness of staff at the clinic to learn from untoward events.

We saw 'You said, we did' boards in many of the clinics we inspected. These were boards which hospital staff used to display information about feedback patients had given about the clinic and what the department had done to address the issues of concern.

The spinal outpatient clinic staff informed us they had changed their outpatient clinic time from morning to afternoon to avoid patients missing their appointment due to transport delays.

A number of outpatient clinics had run 'ad hoc' evening or weekend clinics to help them meet their targets but also to provide appointments at times patients who work could manage. This showed that the outpatient clinics were responsive to the needs of patients and to their feedback. However, senior managers told us clinics were sometimes set up at short notice, making it difficult for patients to attend. Consequently, we were informed this led to high rates of patients who did not attend their appointment. This meant the ad hoc clinics did not always represent good value for money.

Patients who miss appointments

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

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

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

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

Are outpatients services well-led?

Accuracy and availability of records

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

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

Organisational and service delivery risk

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

Local leadership of clinics

Many patients praised individual outpatient clinics as being well organised and well-led. In particular, patients commented made positive comments about the urology,

breast and women's clinics. Patient comments included "This is a well organised and run clinic" and "The staff are extremely quick and efficient at getting you in for your appointment on time."

Management and clinical leadership

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

Good practice and areas for improvement

Areas of good practice

- The effective care being provided by the Critical Care Unit. Outcomes for patients were better than the national average, with the mortality rate for the department being significantly better than the national average.
- The commitment of staff to providing the best possible care. Staff spoke with passion about their work and felt proud of the trust and what they did. They understood the hospitals values.
- The medical staffing levels within the trust and the support given to doctors in training by senior medical staff.
- The quality of the senior leadership was good, particularly that shown by the executive directors.
- The care and range of services offered at Hayward House.
- The bereavement care that was offered in the trust by the multi-faith centre and the compassion shown by the mortuary staff towards relatives and friends of deceased patients.

Areas in need of improvement

Action the hospital MUST take to improve

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

Action the hospital COULD take to improve

- Review the process for the recording of controlled drugs in the maternity and gynaecology departments so records are accurately maintained.
- Ensure all areas of the trust are free from dust and hand gel is always available in all dispensers.
- Ensure people are given information about how long they will have to wait for outpatient appointments.
- Review the availability of information so that it is accessible for people who find it difficult to access.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

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