Care Quality Commission

Nottingham University Hospitals NHS Trust

Queen's Medical Centre

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

Overall rating for this hospital	**Good**
Urgent and emergency services	Good
Medical care	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

Overall, Queens Medical Centre was rated as good with some elements of outstanding. End of Life services however, required improvement.

Our key findings were as follows:

- There was good incident reporting culture in the trust and staff, systems were in place to report incidents and largely there was effective learning from incidents. The exception to this was a backlog of radiology and maternity incidents where a lack of timely review may affect the ability to quickly implement any learning.
- Staff mostly followed infection prevention and control policies and cleaned their hands between patients. There was mostly suitable hand cleansing facilities in place apart from one area where staff had to leave the toilet to wash their hands. Equipment was cleaned following use and was labelled appropriately.
- Cleaning services were contracted out to a private provider. There had been problems with cleanliness prior to and following our inspection which were identified through the trusts own audits and those carried out by the Trust Development Authority. These were been monitored and action was being taken to improve. Progress was been closely monitored by the executive team. During our inspection, we generally found the hospitals to appear visibly clean.
- Actual and planned staffing levels were clearly displayed across the trust and generally we found then actual levels were in accordance with the planned.
- Although agency staff were used, overall the trust used slightly less bank and agency staff than the national average. There was an induction process for agency staff to make sure they were familiar with their working environment.
- For end of life services we found that there was strong leadership for specialist palliative care services but this was not extended to end of life care provided on other wards.

We saw several areas of outstanding practice including:

Urgent and emergency care services

- In January 2015 the NHS invited individual organisations and partnerships to apply to become 'vanguard' sites for the new care models programme. Vanguards are where groups of providers come together to change the way they

work together to provide more joined up care for patients. Nottingham University Hospitals along with partners in the South Nottinghamshire health community were awarded vanguard status for urgent and emergency care. This has allowed the trust to trial new approaches to improve the coordination of services, and reduce the pressure on A&E departments.

- Working with four local clinical commissioning groups, GPs, and out of hours GP services, the trust reduced unnecessary hospital admissions from 28% to 5% following the launch of the Nottingham Care Navigator programme. This programme offered an alternative to urgent hospital admission, where possible, providing direct access to advice and support from the right clinical service first time via an online health navigation tool.
- During 2014 the trust piloted having GPs at the front door of A&E on two separate peak activity weekends. As a result, patients seen by a GP spent 50 minutes less in the department. There was also a reduction in patients needing to be seen by the minor illness and injury teams. The findings showed 54% of patients were redirected away from A&E to more appropriate services, with the majority being directly discharged home.
- The trust was delivering an Injury Minimisation Programme for Schools (IMPS) in partnership with schools and a public health organisation. The programme was designed with the aim of educating children aged 10 and 11 to recognise potentially dangerous situations and prevent injuries. Small groups of children from Nottingham city schools attended the children's emergency department each morning to learn first aid and resuscitation skills, helping them to respond effectively to accidents and take safe risks. More than 2,300 children received health education through this programme each year

Medical care (including older people's care)

- An occupational therapist on ward F20 had undertaken a six month pilot project called 'Playlist for life'. The project involved asking patients about songs that were personal to them that they would like to listen to. Where patients were unable to list songs that were personal to them, their family or carers were encouraged to create a playlist on the patients behalf. The playlists were then created using hand held devices and provided to patients free of charge. Evaluation of the project was underway.
- With the support of nursing staff, a consultant on ward F20 had started an ice cream project in order to support patients who were nutritionally at risk. Patients who were nutritionally at risk had an ice cream sign placed on the board above their bed, this prompted staff to ensure these patients were supported to eat ice cream. The project had come to an end and the consultant was working on applying for more funding to continue the ice cream project.
- Patients wore a coloured wrist band to highlight the oxygen rate they were prescribed. This ensured staff could easily identify the patient's required rate to ensure they were receiving safe care.

Surgical services

- Theatre staff had successfully standardised practices and processes at QMC and Nottingham City Hospital to ensure safe ways of working and reduce cultural differences. The theatres safety improvement programme implemented a variety of safety projects. It ensured that all theatre staff were trained on team etiquette. This emphasised safety, mutual respect, effective communication, accountability and situational awareness. As a result, theatres ran more safely and efficiently.
- There was a 'Dragons Den' project where staff could present their ideas for service improvements. Theatre staff had been successful in presenting their ideas for improvements in equipment used in vascular surgery at QMC.
- The theatre PPI group had been shortlisted for a Nursing Times Award for Enhancing Patient Dignity and were due to present their work in September 2015.
- The theatre PPI group were working on a DVD to show to patients before their operation. The DVD will show patients what to expect when coming to theatres to help reduce fear and anxiety.

Critical care services

Summary of findings

- Innovative approaches were used to gather feedback from people who used the service through inviting patients and carers to opening of a new bed area and getting their views regarding patient privacy.
- The 'just do it' project to avoid cancelled elective surgery due to lack of critical care beds has been successful. This is also an example of several departments working together to solve a problem.

Maternity and gynaecology services

- A member of staff designed a maternity app specifically for the women at NUH called the 'Pocket Midwife'. The free 'app' had information about each stage of pregnancy, including leaflets and information. The service could add news flash information to the app for women to see, for example flu vaccinations alerts. Maternity leaflets and trust guidelines were easily accessed via a guideline app.
- Maternity services identified successful processes within the hospital and engaged with the staff who were involved. For example the 'breaking the cycle team' had been successful in reducing emergency waiting times. This team were invited to work with maternity services to improve the efficiency of the discharge process.

Outpatients and diagnostic imaging

- In recognition of the challenge to outpatient services, in July2014 the trust came together with five other NHS trusts from across the country to share good practice and highlight themes for development. This was reported in the Health Services Journal.

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

Importantly, the trust must:

- The trust must take action to ensure that nursing staff working in the eye casualty receive training in the recognition and treatment of sick children.
- In surgical services the trust should take action to ensure that the principles of the Mental Capacity Act 2005 are correctly and consistently applied in assessing the capacity of patients to make specific decisions
- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- The trust must ensure midwives have appropriate training to provide safe care for high dependency women in an appropriate environment.
- The trust must ensure midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic.
- The trust must be consistent in the documentation of checking of emergency equipment and ensure that the resuscitation trolleys, neonatal transport systems and resuscitation equipment are checked, properly maintained and fit for purpose in all clinical areas.
- The trust must take action to ensure Do Not Attempt Cardio-Respiratory Resuscitation decisions are documented legibly and fully in accordance with the trust's policy and the legal framework of the Mental Capacity Act 2005.

In addition the trust should:

- The trust should consider holding major incident exercises in the emergency department and ensure that staff in all specialities are familiar with emergency planning and major incident procedures
- The trust should consider improving the availability of patient information leaflets, including those in other languages and accessible formats.
- The trust should consider the appropriateness of the environment and facilities in the eye casualty waiting area for children and young people.
- The trust should consider nurse staffing levels and skill mix in the eye casualty department.

Summary of findings

- The trust should consider availability of consultants to ensure direct admission and transferred major trauma patients are seen by a consultant within five minutes of arrival at the major trauma centre.
- Providers should ensure staff follow policies and procedures to ensure medicines are administered appropriately to make sure people are safe.
- The trust should consider measures to increase the number of nurses receiving appraisals in the emergency departments.
- The trust should consider the availability of hospital play specialists in the children's emergency department.
- The trust should ensure oxygen is prescribed in line with the trust's policy for patients who require it.
- The trust should ensure consistency in the completion of patient's nutritional screening and the completion of nutrition and fluid charts on ward B49.
- The trust should ensure all staff are aware of their responsibilities in relation to infection, prevention and control.
- The trust should consider placing hand washing facilities inside staff toilets to reduce the risk of the spread of infection.
- The trust should ensure patients on all of the health care of older people (HCOP) wards have equal access to meaningful activities.
- The trust should ensure pre-printed care plans are consistently personalised to each individual's needs.
- The trust should ensure care plans reflect how staff should support patients who present with complex and challenging behaviour.
- Ensure that ward temperatures are regulated and that a system is in place to date check equipment in a timely manner
- Put patients at their ease before they go into theatre by providing a suitable waiting area with privacy
- Continue to make efforts to help patients sleep by mitigating noise levels on wards at night.
- The trust should consider using the emergency planning boards on all wards to ensure important information is easily available for staff.
- The trust should consider improving the experience of patients at mealtimes by serving each course separately.
- The trust should consider extending the availability of the Learning Disability Liaison team to include weekends.
- The trust should work towards there being at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- A lack of specialist radiology cover out of hours meant that babies had to be transferred to another hospital to receive this service. The trust should consider how the service can be improved to ensure radiology care could be delivered on site.
- The trust should ensure that staff in the maternity service have received up to date training for the safe operation of equipment.
- The trust should ensure that staffing within the neonatal unit follows the British Association of Perinatal Medicine standards

Summary of findings

- The trust should ensure that an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.
- The trust should ensure that they have written formal arrangements in place with the children and adolescent mental health team so that the needs of children and young people with mental health problems are met.
- The trust should ensure all midwifery guidelines are available for staff to use when providing care.
- The trust should work towards capturing the users' comments on the partners in maternity committee.
- The trust should review the home from home values of the midwife led unit.
- The trust should ensure medical staffing ratios in midwifery meet national recommendations.
- The trust should review the elective caesarean section pathway to improve the experience for women and families.
- The trust should consider formulating an overall strategy for end of life care across the trust which is disseminated to all staff across all divisions.
- The trust should consider increasing the number of consultants providing end of life care to reflect the recommendations of the National Council of Palliative Care.
- The trust should consider increasing the hours of the specialist palliative nursing team to ensure patients who require it can receive a face-to-face consultation seven days a week as per NICE (National Institute for Health and Care Excellence) Quality Standard number 10 published in 2011 for end of life care for adults.
- The trust should consider ensuring end of life 'champions' are allocated protected time to disseminate matters relating to good practice end-of life care to other staff in their team.
- The trust should consider updating the end of life care bundle to ensure a patient's preference for involvement of the pastoral care team is recorded.
- The trust should provide a structured programme of end of life care training for all staff to ensure patients receive appropriate care at the end of their life.
- The trust should ensure effective monitoring of 'fast-track' discharges and compliance with patients' wishes regarding preferred place of care and preferred place of death. Good practice in these areas should be shared across the trust and appropriate action taken to address any issues.
- The trust should consider ensuring up to date information reflecting good practice at end of life is readily available in each area and staff are aware of its location.
- The trust should ensure all staff have access to on-going training for end of life care to ensure staff understand their roles in delivering quality care.
- The trust should ensure regular auditing of 'fast-track' discharging and patients preferred place of death is undertaken to identify any concerns and put actions in place to address the issues
- Ensure that all reports of radiation incidents are investigated in a timely manner, and ensure recommendations are put in place in a reasonable timescale.
- Ensure all staff are able to attend annual fire safety training.
- Ensure that small portable sanitising hand gel dispensers are safe to use in outpatient departments.
- Ensure that the risks of lone working are reviewed and managed in all relevant outpatient and diagnostic departments.

Summary of findings

- The trust should ensure the system for maintaining and testing clinical equipment is timely, effective and consistent to ensure it is safe to use.
- Extend outpatient and diagnostic imaging services beyond working hours, Monday to Friday.
- Improve the outpatient appointment booking procedures to reduce the rate of cancelled appointments.
- Improve the visual environment in the eye centre.
- Provide varied seating in outpatient waiting areas to meet different people's requirements.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	Overall, we rated the Urgent and emergency services at Queen's Medical Centre as good with the leadership of the service rated as outstanding. Reliable systems and processes were in place to promote safe care. Emergency preparedness plans were available. Patients received care and treatment based on best available, national evidence based standards and guidelines. Effective and consistent levels of care were available 24 hours a day, seven days a week. Patients and relatives were all positive about the care they had received. Staff offered care that was kind, respectful, and considerate. They responded to patients' anxiety or distress with compassion and offered emotional support. Patients' access to timely care and treatment had significantly improved. Services were planned, organised and delivered to meet people's needs. Leadership and management was focussed on the delivery of high-quality, person centred care. There were high numbers of nurse vacancies in the adult emergency department, and insufficient numbers of nurse practitioners in the eye casualty. These nurse practitioners had not received training in the recognition and treatment of the sick child. Staff were proud of working at Nottingham University Hospitals and spoke highly of the team culture. There was a proactive approach to seeking out and embedding more sustainable models of care.
Medical care	Good 	Overall we rated medical services (including older people's care), as good. Patients were protected from avoidable harm and staff were encouraged to report incidents and monitor risks. Staff understood their responsibilities to raise concerns, to report and record safety incidents and near misses, and there was appropriate investigation of incidents.

Summary of findings

There was a good culture around reducing the risk of falls for patients who were identified as being at high risk. There was good engagement with the falls team and continual assessments were completed to identify any changes to the risk of these patients.
Staff mostly demonstrated a good understanding of infection prevention and control. However, we saw isolated incidents where staff did not adhere to the appropriate procedures.
Staffing levels were set to meet patients' needs and shortfalls had been filled by agency nurses and staff from other wards. However, there were high numbers of nurse vacancies across all of the medical wards.
Risks to patients were assessed, monitored, and managed appropriately, including patients with signs of deteriorating health. Where patients conditions deteriorated, concerns were appropriately escalated to the responsible clinician.
We saw numerous examples of staff responding to patients with kindness and compassion. We saw isolated incidents where staff did not use person-centred or appropriate language when referring to patients.
Patients, and those important to them, were positive about their experience of care and the kindness that staff showed towards them.
Systems were in place to receive, review, and learn from complaints and compliments. Staff listened to patients and took action to improve the quality of care.
The leadership, management, and governance of acute medical services formed a good basis for the delivery of the services it provided. Annual plans were in place for each of the specialities within the directorate of acute medicine; and quality, performance, and risks were understood. There were effective governance frameworks in place to support the delivery of the division's plan.

Surgery

Good

Overall we rated surgical services as good, with outstanding leadership.
Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. Lessons were learnt from incidents and shared widely to support improvement in all areas.

Summary of findings

Systems, processes and practices in place to keep patients safe were mostly reliable. The exception to this was the system for ensuring equipment was maintained in line with manufacturers and other guidance. Many items of equipment on the wards had not been checked or tested for over a year.
Staffing levels were generally maintained as planned. There was safe and effective management of infection control measures, medicines and patient records.
Risks to patients were assessed, monitored, and managed appropriately. This included patients with signs of deteriorating health.
Care and treatment achieved good outcomes for patients, were evidence based and in line with local and national guidance. Outcomes for patients were generally in line with or better than national averages.
Patients' pain relief, and their nutritional and hydration needs were generally well managed.
Consent to care and treatment was not always in line with legislation and guidance.
Surgery services were planned and delivered to meet the needs of local people and those from further afield requiring specialist services.
Multidisciplinary team working was well established and effective in ensuring patients' needs were met.
Staff treated patients with compassion, kindness, dignity and respect. Most patients we spoke with or had feedback from were positive about the care they had received.
The leadership, management and governance of surgery services assured the delivery of high quality, person-centred care. Service strategies and objectives were supporting by stretching, but achievable action plans. Quality, performance and risk management was in line with best practice and effectively promoted continuous improvement.
Staff were proud of working for the trust and felt valued and respected. They actively sought patient feedback and worked collaboratively to provide new solutions for patients.

Critical care **Good**

Overall, we found the adult critical care service at QMC to be good.

Summary of findings

Patients and visitors consistently expressed satisfaction with the care and treatment they received, stating that staff went out of their way to support them during a difficult time.
There was a genuinely open and honest culture in which incidents and concerns were shared across the service, and changes were implemented to improve patient safety. National, trust, and local audit data was used to support service improvements and developments.
Training and support for staff development was established, however we did have concerns that there was limited access to the post registration critical care module for registered nurses.
Care was patient centred and focussed on continual assessment, including an outstanding approach to safeguarding and the application of Deprivation of Liberty when required.
There was a collective enthusiasm across all staff groups with a clear knowledge of the vision, values and strategic goals for adult critical care.
The service had a comprehensive annual plan with clear actions, measurable outcomes, named responsibility and targets.
There was a systematic approach to working across the trust to improve care and outcomes for patients and provide best value for money.
Staff worked very well together across hospital sites and across departments. There was a collective enthusiasm across all staff groups and a clear knowledge of the vision, values and strategic goals for critical care. Staff told us they were proud to work in the department.
Governance processes were established across adult critical care with active involvement from all staff groups. Staff unanimously spoke highly of the local leadership and said they felt supported and able to raise concerns or challenge decisions about patient care.
There was a positive culture of innovation and service development which was not only shared within the critical care and across the trust but also extended to other trusts through training within the departments clinical simulation centre.
Information in the form of data analysis and audit was used to proactively drive service improvement.

Summary of findings

Maternity and gynaecology

Good

Overall, we rated maternity and gynaecology services as good.
There were recently developed local and divisional risk and governance arrangements, staff felt the service had a profile on the trust board agenda.
There were processes in place to share lessons learnt from incidents and investigations.
There was a multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women. All staff told us that that working relationships between the professional groups was excellent.
Women using the women's health services received care based on up to date guidelines and national guidance. The guideline for admission of a woman to the midwifery led care unit had been removed from the intranet to be reviewed and ratified by governance staff, leaving staff to admit women to the midwife led unit without a criteria.
The departments were found to be caring and compassionate. Women, families, and visitors were treated with respect and their wishes considered.
Support was given to women in their chosen method of feeding their babies.
Services responded well to the needs of the individual, and women were given a choice of where to birth. New methods of sharing information had been introduced with the use of the new maternity phone application.
Maternity care was offered between the two hospital sites, and women's care was occasionally diverted due to staff and bed shortages.
Leadership and culture in the hospital encouraged openness and transparency. Staff all felt very supported and enjoyed their work at the hospital.
Staff worked hard to provide new and innovative projects to improve the service for women.
The midwife led care centre did not fully embrace the 'home from home' values of midwife
Staff had not always documented that essential lifesaving equipment had been checked. Midwives were delivering post-operative care without the required formal training and competency assessments.

Summary of findings

Services for children and young people

Good

Overall, the children's and young people's service was rated as good.

We found services for children, young people and their families were effective, caring, responsive and well led. However, improvements were needed for the service to be safe.

Although, staffing shortfalls had been recognised some staff felt this had impacted negatively on staff morale, although the staff survey results for children's services were largely positive. Additional monies were identified for the recruitment of trained nursing staff within the children's and neonatal service. The 2015 workforce review document identified 25 vacancies in children's services, and 28 vacancies in the neonatal service. The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels.

Shortfalls in trained nurse provision on the neonatal unit and within children's services were managed through escalation pathways. The family health directorate recognised that staffing did not meet Royal College of Nursing (2013) and British Association of Perinatal Medicine Guidelines (2011) and had identified this on the trust risk register.

There was generally good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS). However, the admission of children who experienced mental health problems had increased and we were told their needs were not always met. This meant that children were cared for in an environment, which did not meet all of their needs.

Risks to patients were assessed but we did not see that all risks had been addressed. Ligature risks remained in place, despite ligature audits, which had been completed within the clinical areas we visited. Actions remained to remove these risks to reduce the risk to children and young people with mental health needs who may be at risk of self-harm.

Summary of findings

There were difficulties when discharging children to tier four mental health beds which had delayed children's and young people's discharges. Tier four beds are specialist mental health beds.
Monitoring records of resuscitation equipment and neonatal transport systems showed that monitoring of this equipment had not taken place daily.
Whilst the trust identified they did not have one nurse per shift with either the 'Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training', there was a plan where the trust were aiming for one nurse per ward (resuscitation link nurse). A training schedule was in place to monitor and plan the delivery of training. However, we were aware that the children's service were supported by children's critical care and retrieval services which meant that these staff may be available to support emergency resuscitation situations throughout the children's service.
The children's service had no planned out of hours radiology support and a full review of the paediatric forensic examinations service and environment was required. Both had been recognised as a risk by the trust.
Staff were caring, compassionate and respectful. Staff were positive about working in the service and there was a culture of flexibility and commitment. The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. Governance processes, clinical risks monitored, and feedback from staff, parents and children and young people had resulted in changes to aspects within the service.

End of life care — **Requires improvement**

Overall, we judged that end of life care for patients required improvement.
The National Council for Palliative Care recommends one whole time equivalent consultant for every 250 beds; the trust did not meet this. End of Life services protected patients from avoidable harm, and staff were able to raise concerns and report incidents although learning from them was not always shared.

Summary of findings

We saw elements of good practice including infection control and prevention. The organisation of some patient records was poor which could lead to a loss of documents and breach of patient confidentiality.
End of life training was not delivered regularly to staff. Patients' needs for pastoral care was not assessed or identified within their care plan.
Patients did not have access to a seven day face-to-face service from specialist staff, and staff were not adhering to the trust's policy for the completion of Do Not Attempt Cardio-Respiratory Resuscitation decisions.
Patients were involved in their care as much as possible and were treated with dignity and respect; although care was not always responsive to patients' specific needs. Audits of patients dying in their preferred place had not taken place. The last audit relating to the length of time patients were waiting for a 'fast track' discharge had been completed in 2013/14. It was therefore not possible to identify and address any current concerns or potential delays.
The trust did not have an overall strategy for end of life care. Although there was one in place for those receiving palliative care, it had not been communicated across the trust. The quality, risks, and performance issues within end of life care were monitored through the clinical effectiveness committee. There was a dedicated executive lead in place for end of life care within the trust, although most staff were unaware of who this was.
Staff on occasions wished they had more staff to deliver good quality care to patients at the end of their lives. Although most wards had a designated end of life 'champion' in place, they did not have protected time to study or teach their ward colleagues about giving good quality end of life care. Where staff had access to a palliative care resource folder these were not always up to date to support staff in the provision of best practice when providing end of life care.

Outpatients and diagnostic imaging

Good

Overall, we judged the outpatients and diagnostic imaging services to be good.
There were reliable processes to protect patients from avoidable harm. Departments were mostly

Summary of findings

clean and hygienic, and risks to patients attending appointments were monitored and well managed. Staffing levels were appropriate to the needs of each outpatient clinic, but there were unfilled vacancies in radiology which had an impact on the service. Patient records were not always well managed; paper files were overdue for collection and secure storage and patient letters were sometimes misfiled.

The care and treatment of patients was delivered in line with current evidence based practice and recognised national guidance. Staff had good opportunities for personal and professional development. There was effective multidisciplinary working in many departments. There were few seven day services. Staff supported patients in a caring, kind and compassionate way. They respected patients privacy and dignity, and made sure that people's individual needs were met.

Services were largely planned to meet people's needs. While the trust was able to provide timely assessments for people with non-urgent conditions, the trust did not meet national standards for urgent referrals. There were higher than average rates of cancelled appointments, both by hospital staff and patients. The hospital had put in place some innovative methods aimed at reducing cancellation and unattended appointments. There were largely effective governance structures, but not all risks were recorded and addressed. There was work in progress to re-design the outpatient pathway and improve the trust-wide outpatient service. Staff were committed to their roles and in most departments there was a positive, supportive working culture. There was good staff and public engagement, and a focus on continued improvement.

Queen's Medical Centre

Detailed findings

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

Detailed findings

Contents

Background to Queen's Medical Centre

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

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

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

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

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

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett, Chair Thames Valley Clinical Senate

Head of Hospital Inspections: Carolyn Jenkinson, Care Quality Commission

Detailed findings

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

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

How we carried out this inspection

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

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

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

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

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

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

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

Facts and data about Queen's Medical Centre

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

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

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

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

The Emergency Department at Nottingham University Hospitals provides consultant-led emergency care and treatment 24 hours a day, seven days a week. There is a separate co-located children's emergency department. Last year 168,219 patients attended the emergency department, of which approximately 25% were children.

From April 2012 Nottingham University Hospitals was accredited as a regional major trauma centre. Patients from across the East Midlands, both adults and children, have 24 hour access to specialist teams for the care and treatment of very serious, multiple injuries. Last year 1490 patients were treated in the major trauma centre, this included 96 children.

An independent Eye Casualty Department treats patients from across the East Midlands with emergency eye problems. Last year the department treated 26,384 patients. Approximately 10% of these patients were children. The department is open from 7am to 10pm seven days a week. Outside of these hours adult patients are directed to the eye ward and children to the paediatric emergency department.

The emergency department and acute medicine team share a 20 bedded short observational stay ward called the Lynn Jarrett Unit. This is where patients can be admitted under an emergency or medical consultant for short term observation.

During our inspection we spoke with 63 patients, 29 relatives or carers, 60 staff members, nine non-trust staff, for example, ambulance crews, police officers, and three volunteers. We looked at 38 records of care and treatment. As part of our inspection we used the Short Observational Framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us

Urgent and emergency services

Summary of findings

Overall urgent and emergency services at Queen's Medical Centre were rated as good.

Reliable systems and processes were in place to promote safe care. Emergency preparedness plans were available. However, there were high numbers of nurse vacancies in the adult emergency department and insufficient numbers of nurse practitioners in the eye casualty. These nurse practitioners had not received training in the recognition and treatment of the sick child.

Patients received care and treatment based on best available, national, evidence based standards and guidelines. Effective and consistent levels of care were available 24 hours a day, seven days a week. Patients and relatives were all positive about the care they had received. Staff offered care that was kind, respectful, and considerate. They responded to patients anxiety or distress with compassion and offered emotional support.

Patients access to timely care and treatment was improving. Services were planned, organised and delivered to meet people's needs. Leadership and management was focussed on the delivery of high-quality, person centred care.

Staff were proud of working at Nottingham University Hospitals and spoke highly of the team culture. There was a proactive approach to seeking out and embedding more sustainable models of care.

Are urgent and emergency services safe?

Good

Overall we judged the safety of emergency and urgent care services as good.

The emergency department protected people from abuse and avoidable harm. Lessons were learnt and improvements made when things went wrong. Openness and transparency about safety was encouraged. There were reliable systems and processes to promote safe care, including approaches to infection prevention and control, and the safe management of medicines. Hand washing and cleaning in the department was instinctive and seen as the responsibility of all staff.

Staff recognised and responded promptly to any deterioration in a patient's health and they worked with others to prevent and respond appropriately to any signs or allegations of abuse. Staffing levels were set to meet patients' needs. However, there were high numbers of nurse vacancies in the adult emergency department and insufficient numbers of nurse practitioners in the eye casualty. These nurse practitioners had not received training in the recognition and treatment of the sick child. Effective emergency preparedness plans were in place.

Incidents

- No serious incidents had been reported by the department in 2014/15. Two higher level incidents (which is how the trust referred to serious incidents) were reported between April and September 2015. One related to the Lyn Jarrett Unit (LJU) and one to the adult emergency department. Both incidents had been investigated and learning had been shared.
- Staff were aware of the trust's electronic incident reporting procedure and how to use it.
- Staff at all levels received feedback from incidents via the roll call (handover) presentation. This feedback was recorded in the minutes of clinical governance meetings.
- Following a serious incident on the LJU staff had implemented a system for ensuring patients at risk of

falling were always monitored. Information provided by the trust showed this had resulted in a reduced number of falls. Where falls had happened there was no harm, or low levels of harm to patients.

- Following a patient fall on the major trauma unit, the team had completed an investigation and made appropriate changes to reduce future risk.
- Mortality and morbidity meetings were used in emergency departments to review deaths and learn from them. As the East Midlands regional trauma centre, the major trauma unit held and recorded separate mortality and morbidity meetings monthly. Minutes of these meetings recorded learning and actions. These meetings were attended by staff from all hospital departments involved in the major trauma pathway. External partners, such as the ambulance service and air ambulance staff also attended.
- The emergency department held monthly mortality and morbidity meetings. We saw evidence that learning from these meetings was shared with staff.
- Most staff were aware of the duty of candour regulation. This regulation requires providers to be open and transparent with people about the care they receive in particular circumstances where things go wrong. Information about this regulation was displayed in the room used for roll call as a reminder to staff, and also in the staff room.

Cleanliness, infection control and hygiene

- The emergency departments were visibly clean. Staff were aware of, and practised current infection prevention control guidelines. Adequate hand washing facilities and alcohol gel were available and staff were observed washing their hands appropriately. They followed 'bare below the elbow' guidance and used personal protective equipment such as gloves and aprons to prevent the spread of infection. We saw that hand washing was instinctive for staff and cleaning took place continually by all staff, not just housekeepers.
- Clinical and domestic waste was separated and disposed of correctly.
- The emergency department had a decontamination room which we saw being used appropriately and cleaned according to procedure during our inspection.
- Although curtains in the department were not disposable, there was a regular cleaning and replacement schedule. Soiled curtains were removed and replaced immediately.
- The LJU had recorded actions planned and taken to improve hand hygiene as a result of a five moments of hand hygiene audit. Unannounced dashboard audits by matrons from another area of the hospital had resulted in compliance with infection control improving from 66% to 98%.
- The adult emergency department also audited hand hygiene and results for August 2015 showed 86% compliance for nurses, 77% for support staff and 73% for doctors.

Environment and equipment

- There were adequate supplies of available, accessible, and suitable equipment; including resuscitation equipment. There was a schedule for regular checks for equipment which had been followed in all areas we inspected. However, some checks of emergency resuscitation equipment in the majors area of the adult emergency department had been missed when we made our unannounced inspection.
- There was a safe and effective system in place for the repair and maintenance of equipment.
- All necessary environmental safety issues had been assessed and mitigated following a health and safety check of the adult emergency department, children's emergency department and LJU in July 2015. For example; curtain rails in all areas were collapsible, and all ligature points had been removed.
- Although there were toys and books provided in the front row area there was no separate waiting area for children in eye casualty. The staff were aware of this and the waiting area was in view of the nurses stations. The Royal College of Paediatric and Child Health recommend departments should have separate children's waiting and treatment areas or a reasonable compromise. During our inspection there were children waiting on seats next to an adult with challenging behaviours. There were also patients with eye injuries which may have been distressing for children to see. Plug sockets were located above the skirting boards at child level.

- Two dedicated, appropriately equipped interview rooms were available in the emergency department for patients with mental health conditions.

Medicines

- Medicines including controlled drugs were stored, managed, administered, and recorded safely and appropriately. All areas we visited used an electronic storage system for medication which was activated by staff finger prints.
- Qualified nurses in the Initial Assessment Unit (IAU) were working under a patient group direction (PGD) for the prescription and administration of simple pain relief. Patient group directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines, such as painkillers, to a predefined group of patients without them having to see a doctor.
- On LJU patients' own medications were stored in a locked cabinet in a slot relating to the bed they occupied.
- Agency staff were provided with a temporary access code for the medication storage system.

Records

- Staff accessed patient records electronically. Computers not in use were locked for confidentiality.
- We looked at 38 records of patient care and found that they were all completed according to the requirements of the trust's policy. Appropriate risk assessments had been completed, for example, in relation to the risk of falls. Regular observations and early warning scores were completed as required.

Safeguarding

- Policies and procedures were available to staff and they knew how to raise concerns regarding adults and children.
- Safeguarding children training at level three had been completed by 95% of staff in the emergency department and by all staff in the eye casualty.
- Staff were aware of the trust's specialist domestic abuse nurses and how to make referrals.
- Staff in the adult department shared information about children at risk who were not patients but part of a family unit where an adult at risk had attended the department.
- A liaison health visitor attended the children's emergency department each morning to review concerns and referrals. They were also available to attend urgently if staff had concerns about a child.

Mandatory training

- Mandatory training for emergency department staff was delivered by the department for research and education in emergency medicine, acute medicine and major trauma (DREEAM)three mandatory training days were delivered each year and mandatory updates were scheduled over a three year cycle. Completion rates fornursing and permanent medical staff were 92% against a target of 90% at the time of our inspection. Nursing staff told us, "Training here is really good".
- All nursing staff in the eye casualty unit had completed paediatric intermediate life support training (PILS), as they treated children.
- Mandatory training completion rates for the major trauma ward were 100%.
- A regional major trauma unit must have advanced trauma nursing course (ATNC) trained nurses on duty 24 hours a day, seven days a week. All emergency department nurses at band six or seven had received ATNC training and one of these was on duty at all times. All trauma case managers on the major trauma ward had completed ATNC.

Assessing and responding to patient risk

- Staff in the department used a recognised early warning score to identify when a patient's condition was serious or deteriorating. For children, the department used a paediatric early warning score. Staff responded promptly to the deteriorating condition of a patient during our inspection.
- Between January 2014 and January 2015 the time to initial assessment of patients was worse than the England average at between 15 and 20 minutes against

a target of 15 minutes. However, from January 2015 to August 2015 data provided by the trust showed all adult patients had been initially assessed in under the 15 minute target.

- For the same period time to treatment was usually within the standard of 60 minutes but occasionally slightly longer.
- There was an initial assessment unit (IAU) operating in the adult emergency department 24 hours a day, seven days a week. All patients arriving by ambulance, except those going straight to the resuscitation area were seen in the IAU. All patients arriving independently and assessed as having a major injury or illness were also sent to the IAU by streaming nurses. Nurse led investigations took place immediately and an advanced nurse practitioner (ANP) or middle grade doctor was available in the area between 10am and 2am to support decisions. The introduction of the IAU had improved initial assessment times for patients. Data provided by the trust showed initial time to assessment was consistently better than the 15 minutes standard from January 2015.It also meant that once patients saw a doctor all the necessary information was available to make a diagnosis and treatment plan.
- The children's emergency department had a nurse based at the reception desk between 10:30 am and 11pm. They were responsible for an initial visual assessment of the child within 10 minutes of arrival. They would reassure parents as well as indicate waiting times and provide pain relief if appropriate. They assessed whether the patient had an injury or an illness and if they needed to be prioritised for care. Outside of these times patients were taken straight into the department for assessment.
- There had been seven black breaches in the 18 months prior to our inspection. This is where a patient has waited on a trolley for more than 60 minutes to be handed over from the care of an ambulance crew to hospital staff.
- Patients attending the eye casualty were initially assessed using a standard triage tool. The same tool was used in the eye ward, and on the children's emergency department where patients were sent out of hours. The tool indicated how quickly patients needed to be seen and by whom. This meant all patients were consistently assessed and referred.
- Escalation procedures were in place for the adult emergency department, children's emergency department and the LJU. These were available to the nurse in charge and displayed in the IAU.
- The adult emergency department had a system for alerting staff to patients who were at risk of falling. Seven bays in the major injuries and illness area were designated as safe bays for these patients where they could be observed from the nursing desk.
- It is usual for patients with mental health conditions to receive psychiatric assessment once they have been assessed as medically fit. However, the adult emergency department had an agreement for fast track 'parallel assessment' (at the same time) if patients were considered at risk of suicide or unlikely to be admitted to hospital.
- Walking assessments for patients awaiting discharge from the department were carried out by nurses rather than physiotherapists, which would normally be the case. At the time of our announced inspection nurses had not received any training to carry out these assessments. We discussed this with the matron who immediately organised a schedule of training to commence that same evening. We spoke with a patient later that day who was aware they were waiting for a walking assessment but that it had to be completed by a nurse who had been trained. When we returned to the department for an unannounced inspection 10 days later staff had received training and we were given a copy of the notes provided to them

Nursing staffing

- There were 40 nurse vacancies in the emergency department which was equivalent to 25%.Staff told us they were short of nurses including senior nursing staff. Nurses had been recruited to fill some of these vacancies but they would not be in post until December 2015. Staff retention had been an issue but managers were aware of this and had taken action to address the

reasons for this including overcrowding in the department, support to staff dealing with challenging patient behaviours and a review of training opportunities.

- The electronic rota system used in the emergency department listed the skills of all nurses on duty. This would alert department leaders to any shortfall in skill mix.
- The department used an average of 17% agency nursing staff for the period January 2014 to June 2015. All agency staff in the emergency department and LJU received an induction and orientation. A member of the DREEAM team attended roll call (nursing handover) and worked through an induction folder with all new agency nurses which they then signed. Electronic records were maintained indicating which agency staff had completed the induction so that clinical educators could identify new staff on the rotas and ensure they received appropriate induction.
- There were 13 advanced nurse practitioners (ANP's) working in the adult department providing 24 hour cover. Thirteen emergency nurse practitioners (ENP's) were employed to treat patients in the minor injuries area.
- There were 30 registered children's nurses employed in the children's department. Nurses working in the children's emergency department had all received paediatric training.
- Receptionist and clerical duties in the emergency department were completed by emergency department assistants (EDAs) who also carried out patient observations and supported trained nurses in caring for patients.
- Care support workers (CSW's) were also employed in the emergency department to carry out observations and other clinical tasks, basic nursing care and the preparation of documentation for discharge.
- Nurse staffing levels and skill mix on the observation ward were appropriate. The ward was staffed with one sister, four registered nurses and two EDA's. Handovers took place twice daily in the morning and evening. These were accountability handovers where each nurse took individual accountability for the patient and the accuracy of their records.
- Nurse staffing levels and skill mix on the major trauma ward (C30) were appropriate. Between April 2015 and July 2015 the use of agency nursing staff was minimal.
- There were four whole time equivalent trauma case managers (qualified nurses) employed on the major trauma ward. The trust had advertised for a fifth. They were available on the ward and to newly arrived adult trauma patients in the emergency department between 8am and 9pm seven days a week.
- Nurse practitioner staffing levels in the eye casualty unit were insufficient Staff told us they were frequently short staffed. During our inspection this was the case on each of the days we visited. One consultant working in the department had completed an incident form on one day of our inspection because of the lack of nurse staffing availability. Staff told us, and managers confirmed it was not possible to supplement nurse absence or vacancies in this department with agency staff. This was because of the specialist skill set and competencies required. Nurses from the eye ward would assist at busy times but they were unable to see patients only suitable for nurse practitioner review. A nurse staffing review had been completed 24 months prior to our inspection. We asked to see a copy of this but the trust confirmed there was no baseline nurse staffing assessment for the eye casualty. The department had advertised for nurses at band five level who would then require ophthalmic competency training to band six level before they could work independently in the department.
- Although nurses in eye casualty reported being well supported by the paediatric and children's emergency departments they had not received any formal training in the recognition and treatment of sick children. One part time nurse was paediatric trained. All nurses had received paediatric life support training.
- Nursing handovers on LJU took place around the patient's bed and a handover sheet was completed each time.
- Nursing handovers, called 'roll call' took place in the emergency department at 7am and 7pm.All qualified and unqualified nursing staff attended. They were shown an electronic presentation of information including themes of complaints and any changes to

practice. The outgoing nurse in charge gave information about the previous shift, patients in the department, cleaning and stock levels. Handover of individual patients took place after roll call on a one to one basis.

- Nursing handovers on the major trauma unit were safe, well-structured and comprehensively documented.
- Uniform colours in the department caused some confusion for locum and agency staff, as well as for patients. It was difficult to differentiate between the colours for CSWs and staff nurses and also between ANPs and Doctors. One patient told us they had asked a CSW for pain relief and had been told they were not able to give it as they were not a nurse. Senior managers were aware of this and had considered possible solutions but had yet to find a cost effective solution.

Medical staffing

- The emergency department employed a higher proportion of consultants and specialist registrar doctors than the England average. The proportion of junior doctors was equivalent to the England average, but the percentage of middle grade doctors was significantly lower.
- Consultants were present in the department 24 hours most days. There were between one and six consultants present depending on the time of day and this was matched to demand as far as possible. Middle grade doctors told us consultants were always available for advice and could easily be contacted by telephone, day and night. However, there was at least one occasion when a consultant was not available overnight because the shift had not been covered.
- The department used an average of 22% locum staff between January 2014 and June 2015, with increased usage during the winter months of December 2014 and January 2015. This meant that some staff were less familiar with the department and processes during busy periods. However, the majority of locum staff were in-house staff working additional shifts.
- The major trauma unit had one consultant available 24 hours a day, seven days a week. A consultant was on site between 8am and 9pm. One of six trauma fellows was on the unit until 11pm and then on call off site from 11pm until 8am.
- All doctors on shift participated in a daily handover at 7:30amDuring this handover they discussed learning from incidents and complaints. They watched a presentation reminding them about clinical trials and shared general information regarding the previous shift. Doctors then handed over information individually regarding the patients they were caring for.

Major incident awareness and training

- The emergency department had suitable major incident and business continuity plans in place. These had been tested recently when a gas leak required evacuation of a specific area in the department.
- Medical and nursing staff told us they had never participated in exercises to practice the plans and these had not been widely disseminated. The training team confirmed there had been no emergency simulated exercise in the department for the past six years. However, a desktop exercise had taken place in July 2014.
- An external provider's security team allocated at least one team member to the emergency department covering a 24 hour period. Nursing staff told us the security team were highly effective and supportive. All staff were issued with personal alarms and they told us, when activated, support was available. We observed this to be the case during our inspection.
- Police officers were often in the department and there was a plan for an officer to be permanently based in a room there to provide support to the whole hospital. This was due to commence the week following our inspection.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

Overall we judged the effectiveness of the service as good.

People's care and treatment supported good outcomes for patients and was based on the best available evidence. There was regular effective monitoring of outcomes for

patients. There was a multi-disciplinary approach to care and treatment and staff worked with other health care providers to assess, coordinate and plan patients' care and treatment.

Staff were appropriately qualified and received excellent training and regular appraisal. Effective and consistent levels of care were available 24 hours a day, seven days a week.

Evidence-based care and treatment

- The department had a robust pathway for the care of patients with sepsis which complied with best practice guidelines. These are patients who have a severe infection which has spread via the bloodstream.
- Patients with suspected hip fractures were treated in line with best practice.
- Care and treatment pathways for stroke patients were consistent with approved guidelines. Thrombolysis took place at the City Hospital site, but patients suffering from a bleed came to the emergency department for initial assessment and computerised tomography (CT) scanning 24 hours a day.
- Doctors and nurses in the emergency department carried out dementia screening according to best practice guidelines. Their performance was audited locally by the health care of the elderly doctors.
- There were clear criteria for the admission of patients to the Lyn Jarrett Unit (LJU) from the emergency department. These were available to staff and included information on the appropriate management of the patient including what to do if their condition deteriorated. We observed these pathways were consistently followed for patients.
- A consultant in the emergency department took the lead role for audits. They told us audit was open to everyone in the department including nurses. Following audits, action plans were developed by the local team and shared with the local clinical governance and trust wide teams.
- The major trauma centre followed best practice guidelines. We noted there was not a category on the pre-alert trauma activation form for falls of less than 20 feet; however, a number of patients who arrived during our inspection met this category. This form was completed when ambulance crews telephoned the department to advise they were bringing in a trauma patient. Based on the information provided the membership of the trauma team for that patient was decided. Patients falling from a height of less than 20 feet would potentially require different treatment to those falling from a greater height. As this category was missing from the form there was a potential that staff could be called into the department unnecessarily.
- The major trauma centre did not meet the national standard which required that a consultant trauma team leader is available within five minutes 24 hours a day. Data submitted to the Trauma Audit and research Network (TARN) showed compliance with this requirement varied between 65% and 71% depending on the time of day. The risk register for the major trauma centre identified this risk and listed appropriate mitigating action. Data submitted to TARN for quarter one 2105-16 showed improved compliance between 85% and 97%. The major trauma centre had re-audited chest drain activity in 2015 and reported improvements from the previous 2014 audit as well as actions for further improvement.
- Peer review of the major trauma centre showed the trust was one of the best in England for definitive care and rehabilitation, but one of the worst for the reception phase of the patient journey. There was an action plan for improvement in this phase which included increased consultant cover 24 hours per day and monthly simulation training for all trauma team leaders from November 2015

Pain relief

- The Initial Assessment Unit (IAU) was staffed by qualified nurses and an Advanced Nurse Practitioner (ANP) who could prescribe pain relief.
- The department scored similar to the England average in the 2014 Care Quality Commission A&E survey for questions about the management of pain relief.
- Patients were asked about their pain and given pain relief where appropriate.
- Nurses on the major trauma unit attended a pain study day within the first three months of working there. They had a pain assessment tool for use with patients living with dementia.

- The pain team visited the major trauma unit every day to support patients with their pain.

Nutrition and hydration

- The department scored similar to the England average in the 2014 Care Quality Commission A&E survey for questions about suitable food and drink.
- Water fountains and vending machines were available in the emergency department.
- During our observations we saw staff offer food and drink to patients where appropriate and this was noted in their records. Patients told us their dietary needs had been taken into account and they received plenty to drink.
- Patients told us they were given food which met their religious and cultural needs and that it was of a high standard.
- At the time of our inspection two volunteers worked in the emergency department helping to provide patients with food and drinks.

Patient outcomes

- There was a programme of local audit in the emergency department where the effectiveness of care and treatment was reviewed. Recent audit activity had included an audit of conscious sedation and one of dementia screening for older patients in the emergency department. Action plans had been produced.
- The department participated in the RCEM audit programme.
- In the RCEM consultant sign off audit of 2013 the department scored better than the England average for three out of eight indicators, but worse than the England average for four out of eight. These indicators related to whether the consultant or senior doctor had discussed the patient and reviewed their notes after they were discharged. A local re-audit had been completed in 2015 with improved results and a further action plan was in place for on-going improvement.
- In the RCEM renal colic audit of 2012/13 the majority of questions were within, or better than, the normal range, with four worse than the England average.
- In the RCEM audit of fractured neck of femur from 2012/13 the department performed worse than the England average. The department audit lead told us this was a top priority for the department and a schedule of audits had been agreed to 2015/16 to monitor the impact of the 2014 action plan.
- The RCEM audit for severe sepsis and septic shock from 2013/14 showed the trust performed worse than the England average for nine out of thirteen questions. Results for a departmental re-audit in December 2014 showed an improvement in all areas audited. There was a plan to re-audit between October and December 2015 to ensure performance continued to improve.
- The department had participated in three RCEM audits in 2014/15; mental health in the ED, assessing for cognitive impairment in older people and initial management of the fitting child. Action plans had not been completed at the time of our inspection.
- Between January 2013 and March 2015 the number of unplanned re-attendances to A&E within seven days was better than the England average, and only up to two per cent worse than the standard.
- Information about the outcomes of care and treatment for major trauma patients was collected and submitted to the trauma audit and research network (TARN). The trust's major trauma centre (MTC) performed better than the England average in 75% of the indicators measured.
- The National Peer Review Audit for Major Trauma Networks, Centres and Units for 2015 showed that out of 13 provider the Nottingham University Hospitals MTC was the only one to achieve 100% compliance with two of the measures; definitive care and rehabilitation. They were also one of four out of ten to achieve the highest score of 92% compliance for rehabilitation of children post traumatic injury.

Competent staff

- Medical and nursing staff received appraisals. Trust records showed 78% of nurses and more than 95% of doctors had received an appraisal between April 2014 and March 2015 against a trust target of 95%.
- Nursing staff told us they received good 'on the job' training. During our inspection we observed an impromptu training session taking place during a quiet period. An ANP was leading a group of nurses in a reflective practice session to review how to treat patients with sepsis. Staff were thoroughly engaged and

it was apparent that learning was taking place. We saw a student nurse on their first day in the department participating in a major trauma call and receiving training from a qualified nurse throughout.

- Newly qualified or appointed nursing staff wore an orange lanyard so they were easily recognised by other staff who could offer them extra support in the department. Several new staff told us how helpful they found this.
- Junior doctors told us they were always released from the department to attend training.
- Medical staff in the major trauma unit told us they did not receive teaching days or simulation training. However the lead trauma consultant did send emails with podcasts attached for training purposes. They told us the ethos of the department was to get decent 'on the job' training. The DREEAM team who provided education and training to the emergency department were not funded to train the major trauma centre staff.
- Trained volunteer simulated patients took part in clinical training. These 'patients' were able to give feedback to staff about how it felt to be their patient. Their feedback included views on values and behaviours so staff could develop their approach to patients as well as their clinical skills.

Multidisciplinary working

- Orthopaedic practitioner staff were available to plaster fractures. Out of hours staff from the emergency department performed this role. These staff were trained in house by two orthopaedic practitioners.
- X ray and CT scanning diagnostic services were available next to the emergency department.
- An urgent care centre (UCC) operated by another provider was situated next to the emergency department from 8am to midnight, with a GP present from 7pm onwards. Emergency nurse practitioners working in the streaming area of minor injuries and illness could refer patients to this service if their condition was appropriate for review by a GP. Staff in the UCC told us communication between the services was good. They were able to admit adult patients to the hospital directly if necessary, but children had to be reassessed in the children's emergency department.
- A supported transfer of care team (STOC) worked in the emergency department to support patient discharge or transfer. The team, including one physiotherapist and one community nurse, were available between 07:30am and 9pm. They attended the emergency department roll call.
- A cardiac specialist nurse was available to support review of patients in the emergency department and LJU between 7am and 9pm seven days a week.
- A domestic abuse specialist nurse was linked to the emergency department and available between 7am and 3pm Monday to Friday. This nurse reviewed all referrals each morning, Monday to Friday and followed up with patients, as well as offering support and training to staff in dealing with cases of domestic abuse. Staff were trained to support these patients at a weekend when the specialist nurse was not available.
- A specialist external alcohol / substance misuse team worked within the department for patients who chose to self-refer. Their support could be requested by telephone.
- Psychiatric assessment services were available to the emergency department, generally within 60 minutes of a request. This service was provided by the hospital's department of psychological medicine. The psychiatric liaison team met with emergency department representatives twice a month to discuss improving services for patients with mental health conditions. We saw action notes from these meetings. Patients transferred to LJU could wait up to four hours for a psychiatric assessment. This was because the LJU was an inpatient area and the target for inpatient areas was four hours.
- A high volume service user specialist nurse worked in the emergency department. They reviewed the care and treatment of patients, who for medical or social reasons, frequently attended the department. They worked closely with a wide range of external partners such as the homeless health team, supported housing and drug and alcohol support services. Multidisciplinary working had proved invaluable in finding solutions for this patient group.
- An internal multi-disciplinary team were working on improving the flow of patients through the hospital

which was improving access to emergency care for patients. However, a number of staff told us links with site managers could be improved if they attended the department more than once per day.

- During busy periods acute medical and surgical physicians would attend the department to review patients and support the emergency department doctors.
- Police officers who attended the department with patients told us the staff worked well with them to enable them to do their job while they were in attendance.
- A multi-disciplinary team meeting took place on the LJU each morning attended by the alcohol liaison team, and the discharge liaison team (STOC). A health care of the elderly consultant was available to support the unit seven days per week on request and also attended twice weekly.
- There was a multi-disciplinary team meeting every morning on the major trauma ward (C30) where the plan for patients with complex injuries was discussed. This was followed by a board round where the trauma case manager presented the plan, treatment, and therapy progress of each patient. The board round was attended by a major trauma consultant, the trauma fellow, the nurse in charge, the trauma case manager, an occupational therapist, a physiotherapist, and a pharmacist. After this, the team went on a ward round visiting C30, the intensive care unit, the high dependency unit, and paediatric intensive care to review all major trauma inpatients. One patient told us how pleased they were with the seven day a week physiotherapy service on C30.
- A psychologist visited C30 twice a week to support patients during their stay in hospital, a dietitian three times a week, a rehabilitation consultant, and health care of the elderly doctors twice weekly to support patient recovery .During a trauma call in the emergency department the trauma case manager would attend from C30 and act as scribe and senior nurse. They would also incorporate teaching of junior nurses into their role. They told us they would quality assure the process, make sure procedures had been followed and appropriate clinicians had been involved.
- One hospital play specialist worked in the children's emergency department. Although they worked a varied shift pattern, this meant that play specialists were not consistently available.

Seven-day services

- The eye casualty department was open from 7am to 10pm, seven days a week. Outside of those hours patients were able to visit the eye ward for emergency care and treatment. Nursing staff told us they had no problems getting support from medical staff if required for emergency patients. Children were sent to the paediatric department out of hours. If their condition was urgent the paediatric team could access the help of an ophthalmic on call doctor.
- Medical staff on the LJU told us the discharge of patients at a weekend could be delayed because of a lack of senior doctors working.
- X ray and CT scanning diagnostic services were available in the emergency department 24 hours a day.

Access to information

- The Urgent Care Centre used the same electronic systems as the emergency departments so when a patient was referred to them all patient information was available immediately.
- Staff had access to information about policy, pathways, and available support services on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical and nursing staff were aware of their responsibilities under the Mental Capacity Act 2005.
- Staff sought consent from patients before treating them, and patient consent was recorded in the records we reviewed. Where patients could not give consent, treatment was provided under best interest guidance and this was recorded in patient notes.
- Staff in the children's emergency department were aware of consent requirements in relation to children and we saw training scenarios for staff around parent / legal guardian consent simulation.

Urgent and emergency services

Are urgent and emergency services caring?

Good

Overall we judged the care afforded to patients to be good.

Staff treated people with compassion, kindness, dignity, and respect. All patients were positive about the care they received. Staff responded to patients' and relatives' anxiety with compassion, and were seen to offer emotional support.

Staff involved patients in decisions about their care and their choices, and where possible these decisions were acted on. They understood the impact of their care, treatment, or condition of their wellbeing, and those close to them.

Compassionate care

- Without exception patients were positive about the care and treatment they had received in the emergency department. They told us staff treated them with respect and listened to their concerns and those of their relatives. Another patient told us staff were professional, knowledgeable, and caring.
- For October 2015 friends and family test response rates were ten percent better than the England average and 93% of patients would recommend the service.
- In the Care Quality Commission Accident and Emergency Patient Survey of 2014 the department scored similar to other emergency departments in England for levels of care. This showed that patient experiences of care were in line with current performance of care across England.However the department scored better than other trusts in relation to privacy afforded to patients when discussing their condition with the receptionist.
- Patients told us staff were kind and patient, "Very attentive", "Generous and lovely".One said, "I give the care here 11 out of 10", another said, "I can't fault the care I've had here". A patient in eye casualty told us, "It's my first time here and they've been absolutely wonderful; I can't praise them enough".
- During our inspection we saw numerous examples of staff responding to patients with kindness and compassion. We heard about an occasion where nursing staff went above and beyond their role to secure the safety of a vulnerable patient and child. We saw one staff member in the eye casualty researching train times for a patient who did not live locally and had been bought in by ambulance but needed to make their own way home.
- Staff introduced themselves to patients before treating them. A patient told us, "Staff always introduce themselves and listen to you".
- Staff consistently closed curtains and doors to maintain patients' privacy and dignity during examinations, and they knocked before entering patient treatment areas. However, parents bringing their children to the emergency department had to explain their concerns in the main entrance corridor where other patients and relatives could overhear their conversation with the nurse.
- Patients told us staff came quickly if they pressed the buzzer and we saw this during our observations.
- Staff made sure the inspection team were aware of any specific patient needs during our inspection so patients were treated compassionately. For example, we were advised when patients were nearing the end of their life, or had passed away, so we could be mindful of patients' circumstances.
- Relatives of a patient already in the resuscitation area of the emergency department were taken to an alternative waiting area when a new and seriously injured patient arrived. This reduced the distress to the relatives, and ensured privacy and dignity for the arriving patient. As soon as the new patient was settled we saw the nurse fetch the relatives back to be with their loved one.

Understanding and involvement of patients and those close to them

- Patients told us they were kept informed about the plan for their care and treatment and staff explained things well.
- One patient on the major trauma unit (C30) told us, "People in A&E were waiting for me. They were calm and reassuring. I felt confident they'd sort it".

Urgent and emergency services

- On the Lyn Jarrett Unit (LJU) patients were involved in the handover of their care from one shift to another and their plan of care and discharge was discussed with them.
- Trauma case managers on C30 attended the emergency department between 8am and 9pm as soon as seriously injured patients arrived at the hospital. They met the patient and their relatives and remained their contact for the duration of the patient's stay in hospital. Patients on the major trauma ward told us they felt involved in their care and knew everything they needed to know.
- A patient on the major trauma ward told us, "The way nurses and doctors explain things here is really good; even to people who can't communicate". Another patient told us that doctors always checked if they had understood the plan for their care and treatment.
- Staff understood the impact of treatment on patients' wellbeing and social circumstances. One patient in the emergency department told us staff had shown consideration for their responsibilities as a carer; and had ensured that a family member was making arrangements for a dependent relative at home.

Emotional support

- During our inspection we observed staff streamline a patient with learning difficulties through the department in order to minimise their distress and reduce the risk of challenging behaviours.
- We observed staff providing emotional support to a patient with a serious mental health condition prior to their planned discharge. They did this in a way which maintained the wellbeing and independence of the patient.
- Staff frequently treated patients who were challenging, and at times aggressive and abusive. They consistently provided appropriate emotional support in a respectful way. One inpatient told us, "There are some demanding patients here. Staff are very polite. I have never heard a raised voice". Another said, "Staff are great with people with challenging behaviour".
- We observed bereaved relatives being supported emotionally by staff. Staff also considered the impact of bad news of a young relative and took appropriate steps for them to be supported.
- One patient who had an allergy to a preferred pain medication told us, "They really listened to me and found me some good pain relief."
- The hospital had a chaplaincy service and staff told us they could request support if necessary.

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

Good

Overall we judged the responsiveness of the service to be good.

Services were planned, organised, and delivered to meet peoples' needs, taking account of individual needs and those in vulnerable circumstances. Patients access to timely care and treatment was improving.

However, signage in the emergency department was poor, and the eye casualty did not always have sufficient chairs for waiting patients.

Systems were in place to receive, review, and learn from complaints and compliments. Staff listened to patients and took action to improve the quality of care. However, information about making complaints or offering compliments was not always easily available to patients.

Service planning and delivery to meet the needs of local people

- Department leaders made good use of audits and data to understand the population groups accessing their service and to develop appropriate pathways.
- The resuscitation area of the emergency department had nine bays for adults, two of which contained appropriate equipment for the treatment of children. During busy periods it was possible to increase capacity to 14 bays.
- An ambulance and two crew members were based at the emergency department in order to speed up transfers for patients being admitted to the Nottingham City hospital site.

- General accident prevention and first aid information was available to parents in the children's emergency department including details of first aid workshops for parents.
- The trust was delivering an Injury Minimisation Programme for Schools (IMPS) in partnership with local schools and the city council. The aim was to educate children aged 10 and 11 to recognise potentially dangerous situations and prevent injuries. Small groups of children from Nottingham city schools attended the children's emergency department each morning to learn first aid and resuscitation skills, helping them to respond effectively to accidents and take safe risks. More than 2,300 children received health education through this programme each year.
- A high volume service user specialist nurse worked in the emergency department. Their role was to support patients in this category to improve their health and wellbeing, and reduce inappropriate hospital attendances and admissions.

Meeting people's individual needs

- A telephone interpreter service was available for patients and staff knew how to access this. Many staff in the emergency department spoke more than one language and would act as interpreter if required.
- Some staff were able to use British sign language for patients with hearing impairments. A signing service was available but staff told us it was not timely.
- Staff in the department used the 'This is me' tool for patients living with dementia. The departmental plan for 2015-16 included actions to improve safety and experience for patients living with dementia. This was to be achieved through working with the health care of the older person's team to introduce an ED dementia tool and deliver training to staff.
- There was a learning disability nurse folder in the emergency department for staff to refer to. They told us they involved carers as much as possible with this group of patients. Parents of a child with learning disabilities told us, "I like the way they talk to him and not to me. They treat him the way he likes to be treated. Everything went like clockwork".
- Where patients came into the emergency department leaving pets home alone, the nursing team held contact details for organisations that could assist.
- Patient information leaflets were not readily available in the emergency departments, however, the matron told us staff had access to them if required. Staff were able to provide us with a selection of leaflets when asked.
- Informative signs and posters were displayed in the children's emergency waiting area giving advice on health topics such as hay fever, sepsis, and asthma. There was also a pictorial display entitled 'Why am I waiting?' so children could understand their care and treatment pathway.
- There were systems and processes in place to support patients living with dementia.
- Trauma case managers worked on the major trauma unit (C30) from 8am to 9pm seven days a week. They attended the emergency department when a trauma patient was brought in, introduced themselves to the patient (if possible) and their relatives as soon as practicable, and became the point of contact for the patient's journey to recovery.
- When major trauma patients were discharged the trauma case managers gave them a business card with their contact number for any queries of concerns. They also received a booklet, "Going home after a serious injury". This contained lots of useful information and contact details and was available in other languages and formats.
- There was a range of patient information displayed in the eye casualty department; however, information about staff and waiting times was not completed at any time during our inspection visits.
- Where patients had died in the emergency department their relatives were offered an appointment with the bereavement team at a later date.
- Friends and family feedback cards in the eye casualty department were available in large print. In the children's department they were available in a pictorial format.

Facilities

- Signage in the main entrance to the department was poor with no official welcome or clearly visible

information about what to expect. However, there were signs warning that staff would not tolerate violence and aggression. At the entrance there was an amnesty bin for weapons. In other areas of the department these signs were repeated. These signs may make the environment feel threatening for some patients and their relatives.

- Vending machines were available in the main entrance and information provided about the availability of refreshments elsewhere in the hospital.
- There was an absence of signage in the ambulatory (green) area. Patients were sent through from the streaming area but it was not clear what they were expected to do upon arrival. We brought this to the attention of the matron who immediately organised for signs to be produced and displayed.
- Information about facilities was not accessible to patients for whom English was not their first language, or to patients with cognitive impairments who would benefit from more pictorial information.
- Televisions were available in the minors area and also in the ambulatory area. However, the latter was not operational during our inspection.
- Call bells were not available in the majors cubicles. However, all bays were visible from the nurses' desk with the exception of three. Staff told us they would only put mobile or accompanied patients in these bays. We observed this was the case during our inspection.
- The children's emergency waiting area was bright and equipped with toys and a television. There were two areas; one for injuries and one for illness; however, patients were able to move between the areas if they wished. There was a small separate young person's waiting area equipped with a games console.
- The LJU only had a small kitchen for food preparation. Staff told us this sometimes provided a challenge especially during the winter when hot food was served to patients. Televisions were not available on the unit and there were no windows. As patients were expected to stay for a maximum of 24 hours staff provided them with DVD players and DVDs if they wanted them.
- The eye casualty unit was very busy during our inspection. At times there were no available chairs for patients who were waiting.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer, or discharge 95% of patients within four hours of arrival at A&E. Between April 2014 and April 2015 the emergency department consistently performed below the standard and below the England average. However between April and July 2015 the department met the four hour standard in 10 of the 18 weeks. We asked senior managers how this had been achieved and they told us about an emergency pathway taskforce set up to look at the four hour standard as a trust wide target. We looked at the minutes of the meetings of this group, these showed how the trust had focused on the 'front door' of A&E, discharge processes, and transfers within the hospital. This had led to improvement in the flow of patients, and timely access to emergency care.
- For the same period the eye casualty achieved 99% or 100% compliance with this target. However, at the time of our inspection four patients had been waiting more than one hour for initial assessment. Staff told us this was due to nurse practitioner shortages in the department. Much of the negative feedback about the service related to waiting times and lack of information about this.
- The percentage of patients leaving the department before being seen varied between a high of over three and a half percent in September 2014 to a low of one percent in January 2015. The England average was less than three percent.
- Total time spent in the emergency department on average per patient was longer than the England average.
- Between April 2014 and April 2015 the percentage of patients waiting four to 12 hours from decision to admit until being admitted was similar to the England average and had more recently been better than the England Average.
- There was an ambulatory care unit in the department where patients could be seen without hospital admission.
- For the period January to March 2015 data provided showed only one percent of patients waited longer than 60 minutes to be handed over from the care of the

ambulance crews to nursing staff. The target time set for handover of patients was 15 minutes. For this period 46% of patients were transferred to the care of hospital staff within the target time. The majority of patients were transferred within 30 minutes.

Learning from complaints and concerns

- Systems and processes were in place to enable patients and relatives to make a complaint. However, information about how to complain was not readily available to patients or displayed in all areas of the emergency department, eye casualty, or LJU. Learning from complaints was shared with all staff at every roll call in the emergency department.
- We saw evidence of actions taken as a result of complaints. For example, the emergency department had received complaints about staff using mobile phones at work. There were now posters displayed explaining these were not mobile phones but hand held devices for work purposes.

Are urgent and emergency services well-led?

Outstanding ☆

Overall we judged the leadership in the emergency and urgent service to be outstanding.

The leadership, governance and culture were used to drive and improve the delivery of high quality, person centred care.

There was a systematic approach to working with other partner organisations to improve care outcomes, tackle health inequalities and obtain best value for money. The trust was part of the South Nottinghamshire urgent and emergency care vanguard. Successful initiatives using GPs in the emergency department had improved waiting times for patients at busy times.

Staff were proud of the organisation as a place to work and spoke highly of the team culture. There was an ethos of continuous learning in the department and there was an innovative use of trained 'simulated' patients. There was a proactive approach to seeking out and embedding more sustainable models of care.

Vision and strategy for this service

- The department had an annual plan with quality and safety as the top priority. There were actions identified and outcomes were measurable. Individuals were clear about their responsibilities for the plan, and dates were set for review and completion of actions.
- The head of service and matron for the emergency department were passionate about their vision for the future and excited to share their plans which included extensive partnership working in the local health community.
- Advanced Nurse Practitioners (ANPs) told us the head of service kept them up to date on trust and departmental strategy at their monthly continuous professional development days and via the intranet and emails.
- The vision for the children's emergency department was displayed and staff were aware of it.

Governance, risk management and quality measurement

- One of the doctors in the adult and one in the children's department were identified as governance leads. Two ANPs also led on clinical governance attending monthly meetings and sharing learning in monthly ANP teaching meetings.
- One of the consultants in the emergency department was the audit lead. There was a programme of national and local audits including Royal College of Emergency Medicine (CEM) audits. All audits had been reviewed, learning identified and actions taken to improve the quality of the service. The audit lead showed us the programme for the following 12 months and told us about plans to include nursing staff in the data gathering phase of audit as they had indicated they would like to be involved. A clinical audit review took place after each audit and was submitted to the trust clinical audit officer indicating what improvements had been made as a result of audit.
- The department maintained a risk register for the adult and children's emergency department and for the Lyn Jarrett Unit (LJU). Senior managers were able to identify and discuss these risks including a shortage of experienced nursing staff, and delayed discharges affecting patient flow. Suitable strategies were in place to address these risks.

- There was a risk register for the eye casualty which identified risks we had recognised and mitigating actions were recorded.
- Unannounced audits took place on LJU. These were led by matrons from another area of the hospital. Results of these audits were displayed for staff and patients to see and changes had been made for improvement.
- The trust had a programme of shared governance where staff were encouraged to solve problems in their areas themselves rather than looking to managers to do so. Shared governance meetings had begun in the emergency department in June 2015 and staff were positive about the impact of these. We reviewed agendas and saw actions had been agreed and taken from these meetings.

Leadership of service

- Service leaders understood the challenges to good quality care and they could identify actions needed to address them. They also understood the broader need to work with other partner agencies to improve health outcomes for patients. Leaders were proactive in seeking out new models of care.
- Junior doctors and nursing staff told us they enjoyed working in the emergency department, and consultants were very approachable and supportive. We observed consultants discussing treatment plans and sharing learning with junior medical staff.
- Staff told us during busy periods of internal escalation in the emergency department the chief executive and other members of the board worked alongside them to support patients.

Culture within the service

- Staff were passionate about learning and without exception they told us education in the emergency department was excellent. They told us even at very busy times they were able to be released for training.
- Agency nursing staff told us the department was well organised and they enjoyed working there.
- Student nurses and newly appointed staff told us they were made very welcome and felt well supported in the emergency department and LJU.
- Staff were proud of the emergency department and proud to work there. They told us staff in the department were friendly and helpful, and the management did not feel remote or hierarchical. They told us they were sometimes concerned about staffing levels and felt that senior managers could do more to retain staff by being flexible and protecting them from verbal abuse.

Public engagement

- The trust had a patient public involvement group with an emergency department staff representative.
- The department was working with other partners in the local health economy to support a 'mostly healthy' group of patients to access the right care at the right time.
- The DREEAM team were working in partnership with community organisations to provide free first aid workshops in the community for parents.

Staff engagement

- Staff told us they would be confident to take concerns to the consultant or nurse in charge.
- Computer screens, when locked, displayed rolling messages about important information for staff including reminders about patient privacy.
- Leaders prioritised the participation and involvement of staff in improvement work, for example staff could take lead roles and had the opportunity to contribute to audits.
- Staff, including agency staff told us their views were considered, and when appropriate reflected in the way services were designed and delivered.
- The acute medicine directorate had conducted a staff survey for the period April to June 2015. Of those who responded 75% said they would recommend the organisation to friends and family as a good place to work.

Innovation, improvement and sustainability

- There was an ethos of continuous learning in the emergency departments and leaders were committed to an integration of services with community providers and external stakeholders.

Urgent and emergency services

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

Medical care (including older people's care)

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

Information about the service

Nottingham University Hospitals NHS Trust provides medical services at the Queen's Medical Centre (QMC). All of the medical wards at the QMC come under the directorate of acute medicine with the exception of ward F21 which comes under the directorate of digestive diseases and thoracics and D55 which comes under the directorate of cardio-respiratory and stroke.

There are 16 medical wards, which include eight healthcare of older people (HCOP) wards, an acute HCOP ward, two diabetic medicine wards, two gastroenterology wards, a cardiology ward, an acute medical ward, a level one monitoring unit and a rheumatology ward.

Between January 2014 and December 2014 there were 95,071 admissions to the medical wards. 20% of all admissions, including day case were planned, whilst 80% of admissions were emergency admissions.

We used a variety of methods to help us gather evidence in order to assess and judge the medical care services based at the QMC. During our inspection, we visited 15 wards, the endoscopy unit and the discharge lounge. We spoke with 44 patients or their relatives and 60 staff, including junior and senior nurses, health care assistants, junior and senior doctors, allied health professionals, nursing and medical students, bank and agency nursing staff, pharmacy staff, administrative and clerical staff, and volunteers. As part of our inspection, we used the Short Observational framework for Inspection (SOFI) which is a specific way of observing care to help us understand the experience of people who could not speak with us. We observed interactions between patients, their relatives, and staff, considered the environment and looked at 28 medical and nursing care records. Before our inspection we reviewed performance information from and about the hospital.

Medical care (including older people's care)

Summary of findings

Patients were protected from avoidable harm, and staff were encouraged to report incidents and monitor risks. Staff understood their responsibilities to raise concerns, to report and record safety incidents and near misses, and there was appropriate investigation of incidents.

There was a good culture around reducing the risk of falls for patients who were identified as being at high risk. There was good engagement with the falls team, and continual assessments were completed to identify any changes to the risk of these patients.

Staff mostly demonstrated a good understanding of infection prevention and control. However, we saw isolated incidents where staff did not adhere to the appropriate procedures.

Staffing levels were set to meet patients' needs and shortfalls had been filled by agency nurses and staff from other wards. However, there were high numbers of nurse vacancies across all of the medical wards.

Risks to patients were assessed, monitored, and managed appropriately, including patients with signs of deteriorating health. Where patient conditions deteriorated concerns were appropriately escalated to the responsible clinician.

We saw numerous examples of staff responding to patients with kindness and compassion. However, we also saw isolated examples where meaningful conversation could have taken place between staff and patients but did not. We also saw isolated incidents where staff did not use person-centred or appropriate language when referring to patients.

Patients and those important to them were positive about their experience of care and the kindness that staff showed towards them.

The trust used an electronic system to capture information for all patients who were over the age of 75 years and were admitted as an emergency. This enabled them to screen these patients for dementia as required by NHS England.

On ward B47 we saw there was an activities board which detailed activities available for patients each day of the week. Throughout our announced inspection we observed activities taking place which were led by a physiotherapist and a health care assistant. However this level of activity support was not offered on the other healthcare of older people's wards.

Systems were in place to receive, review and learn from complaints and compliments. Staff listened to patients and took action to improve the quality of care.

The leadership, management and governance of acute medical services formed a good basis for the delivery of the services it provided. Annual plans were in place for each of the specialities within the directorate of acute medicine, and quality, performance and risks were understood. There were effective governance frameworks in place to support the delivery of the division's plan.

There was good evidence of public and staff engagement and most staff told us they felt proud to work at the trust. There was evidence of good leadership at a local level and there was good communication to and from the Board.

Medical care (including older people's care)

Are medical care services safe?

Good

Overall, we found the safety of medical care services at the Queen's Medical Centre to be good.

Patients were protected from avoidable harm and staff were encouraged to report incidents and monitor risks. Staff understood their responsibilities to raise concerns, to report and record safety incidents and near misses. There was appropriate investigation of incidents. Staff were able to tell us where practices had changed as a result of incident reporting.

There was a positive culture around reducing the risk of falls for patients who were identified as being at high risk. There was good engagement with the falls team and continual assessments were completed to identify any changes to the risk of these patients.

Staff mostly demonstrated a good understanding of infection prevention and control. However, we saw isolated incidents where staff did not adhere to infection prevention and control procedures.

Equipment was checked regularly to ensure it continued to be safe to use. Staff could access equipment such as pressure relieving mattresses as they were required. There were daily checks of resuscitation equipment in all of the medical wards and these checks were documented.

Staffing levels were set to meet patients' needs, and shortfalls had been filled by agency nurses and staff from other wards. However, there were high numbers of nurse vacancies across all of the medical wards.

Risks to patients were assessed, monitored and managed appropriately, including patients with signs of deteriorating health. Where patients health deteriorated, concerns were appropriately escalated to the appropriate clinician.

Incidents

- The division for medicine, including older people's care at the Queen's Medical Centre (QMC) reported 115 serious incidents requiring investigation through the National Reporting and Learning System (NRLS) between May 2014 and April 2015. Of these incidents, slips, trips and falls, followed by infection control incidents, and the development of grade three pressure ulcers accounted for the highest number of incidents.
- The trust's policy described that incidents could be reported through the trust's electronic reporting system or by using the trust's paper incident reporting form. We spoke with a range of staff across the service and all were aware of how to report incidents. All of the staff we spoke with told us they were encouraged to report incidents.
- Staff provided us with examples of when they had reported incidents, and understood what constituted an incident. This included reportable incidents such as pressure ulcers, medication errors, slips, trips and falls.
- The electronic incident form contained a tick box that staff could complete if they wished to receive feedback from incidents they had reported. Most staff we spoke with told us they received feedback on the incidents they had reported.
- Learning from incidents took place throughout the medical wards including the care of older people's wards. For example staff told us, and we saw that action had been taken to reduce the risk of patient falls. Each ward had one or more cohort bays where patients who were identified as being at risk of falling were cared for in the same bay. A member of staff stayed in the bay at all times to constantly supervise patients.
- Each medical division held monthly mortality and morbidity meetings. We saw evidence that deaths were discussed and any issues were actioned. Information was displayed within ward areas explaining responsibilities relating to Duty of Candour. (The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology).
- Duty of Candour processes had been written into the trust's incident reporting and management policy and senior staff were aware of their responsibilities relating to Duty of Candour and were able to give us examples of when Duty of Candour would apply.
- A baseline audit of 25 incidents undertaken by the trust showed that where incidents had resulted in harm they were discussed with patients and those who were important to them. The audit also highlighted that in

70% of cases, a follow up letter was recorded as being sent to patients, however these letters were not always sent in a timely manner, with only one letter being sent within 45 days. The trust was addressing this and was planning to re-audit in January 2016.

Safety thermometer

- The medical care services at the Queen's Medical Centre took part in the national safety thermometer scheme. Data for this was collected from each area on an identified day each month to indicate performance in key safety areas. This included four key areas, pressure ulcers, falls, urine and urinary catheter infections and blood clots.
- Data from the safety thermometer was clearly displayed in ward areas for staff and public to view.
- From June 2014 to June 2015 safety thermometer data showed there had been 57 pressure ulcers with an increase in numbers since January 2015. Whilst falls were on the decrease, the majority of falls took place after December 2015 and the number of CUTIs had been fairly consistent across the year with a decrease in March 2015.

Cleanliness, infection control and hygiene

- The Department of Health's Code of Practice on the prevention and control of infections and related guidance was mostly adhered to within the wards providing medical care.
- Staff told us that they had completed infection control training, and were able to tell us about precautions taken to prevent and control the spread of infection in the hospital. Staff undertook infection control training and hand hygiene on an annual basis. In addition, nursing staff and health care assistants were required to undertake competency based training to learn how to effectively clean commodes. Information provided by the trust indicated training figures for July 2015 to be between 76% and 97% across the acute medical wards and the health care of older people's wards.
- We observed the management of sharps complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.
- There had been three cases of Methicillin Resistant Staphylococcus Aureus (MRSA) at the Queen's Medical Centre between May 2014 and April 2015. (MRSA is an infection that can cause problems if it gets into wounds or into the bloodstream). For the same time period there had been 86 cases of Clostridium Difficile (C-Diff) infections. (C-Diff is an infection that causes diarrhoea.)Equipment was cleaned and marked as ready for use with 'I am clean' stickers.
- Staff were compliant with the trust's infection control policies and protocols such as hand hygiene and bare below elbows policies.
- Staff mostly demonstrated a good understanding of infection prevention and control. There were supplies of personal protective equipment such as gloves and aprons available in clinical areas and we observed staff using them appropriately. Staff wore visibly clean uniforms, and colour coded disposable aprons were used by staff when serving meals. However on one ward we observed a health care assistant assisting a patient with personal hygiene without wearing an apron. We also observed this member of staff going to a trolley to get a bed sheet without taking off the gloves they had worn to assist with personal hygiene. These practices increase the risk of the spread of infection.
- All wards had antibacterial hand gel dispensers inside their entrances and by each patient bed space. Appropriate signage regarding hand washing for staff and visitors was on display. Side rooms were used where possible as isolation rooms for patients at increased infection control risk (for example, those with diarrhoea). There was clear signage outside the rooms to ensure staff were aware of the increased precautions they must take when entering and leaving the room. However, on one ward, we saw a member of staff who was responsible for clearing away crockery and cutlery following mealtimes enter these rooms without using an apron and without changing their gloves or washing their hands. This member of staff was not directly employed by the trust but was contracted as part of the catering team. We told the nurse in charge of the ward about this at the time of our inspection.
- On ward D57 the staff toilet did not have a hand washing facility. Staff using this toilet had to go into a separate washroom to wash their hands. This could increase the risk of indirect cross contamination as staff were required to touch door handles without having washed their hands when they had used the toilet.
- Hand wipes were available to all patients at meal times so they could clean their hands prior to eating.
- Standards of cleanliness were monitored. All of the medical and the healthcare of older people (HCOP) wards participated in weekly infection control audits.

There was an action plan to address where improvements were required. For example; the infection control audit in July 2015 identified on-going concerns around the insertion and continuing care of cannulas and urinary catheter care on ward F19, and hand hygiene on ward D58. A clear action plan was put in place to address the findings and there were plans to follow up on this in the next audit cycle.

- At the time of our inspection ward F21 had been moved to the trusts decant ward to allow for deep cleaning and general maintenance to take place. (A decant ward is a ward which supports a planned move of an entire ward to enable deep cleaning and general maintenance to take place).
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps in clinical environment.

Environment and equipment

- In order to maintain the security of patients, visitors were required to use the intercom system outside the wards to identify themselves before they were able to access the ward. Staff had swipe cards to open doors.
- The wards we visited were mostly well maintained. Although some wards were cluttered due to a lack of space for larger items such as moving and handling equipment. On one ward we saw that moving and handling equipment was being stored in a toilet.
- There were systems to maintain and service equipment as required. Equipment was maintained and checked regularly to ensure it continued to be safe to use. Hoists had been serviced regularly. Where electrical testing had been completed, we saw labelling on equipment to show when testing had been undertaken. All of the equipment we looked at was in date for its testing period.
- Each ward had resuscitation equipment readily available. There were systems in place for staff to record the daily checks made to ensure it was complete and ready for use.
- There was an equipment library for stocks of mattresses and other equipment that patients required. Staff told us they had no problems accessing equipment from the equipment library.

Medicines

- The hospital used paper prescription and medication administration record charts for patients. Medicines were checked by a pharmacist, and the checks were recorded in green ink on the prescription charts to help guide staff in the safe administration of medicines.
- We saw appropriate arrangements were in place for recording the administration of medicines. The records were clear and fully completed. The records showed patients were getting medicines when they needed them, and any reasons for not giving patients their medicines were recorded. This meant people were receiving their medicines as prescribed.
- The trust's medication policy stated that oxygen should be prescribed in the designated section of the inpatient prescription chart. However, we saw that where patients required medical oxygen, this was not prescribed on the prescription chart. Because medical oxygen was not prescribed or signed for on the medication chart, there was no audit trail to evidence it had been given and there was an increased risk that it might not be administered.
- If people were allergic to any medicines this was recorded on their prescription chart.
- Medicines, including those requiring cool storage, were stored appropriately. The medicine refrigerators we checked were locked and at the correct temperature.
- Controlled drugs (CDs) were stored appropriately on the wards we inspected. (CDs are medicines which have extra security controls over them. They are stored in a separate cupboard and their use recorded in a CD register). . However, on the endoscopy unit we saw that staff had left the keys to the CD cupboard in the lock. This meant the CDs could have been accessed by people who were unauthorised to access them. We alerted the nurse on the unit who removed them immediately. Staff carried out daily checks of CDs to ensure they were correctly checked and accounted for. We checked the balance of controlled drugs in the cupboards and found what was being stored matched the CD registers.
- There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis. This meant that patients had access to medicines when they needed them.
- Staff told us the normal practice was for two nurses to check the drawing up and administering of intravenous medication. On one ward, a nurse told us that although they would get a second nurse to check the medication

they would sometimes check the patient's details before administering the medication alone, especially at busy times. This was not in line with the trusts policy and increased the risk of medication errors.
- Emergency medicines were available for use, and there was evidence that these were regularly checked and were in tamper-evident containers.
- A pharmacist visited all wards each weekday. Pharmacy staff checked that the medicines patients were taking when they were admitted were correct and that records were up to date. We saw where pharmacy staff had reviewed prescription charts they had been signed and dated in green ink.
- Pharmacy staff were readily available on the wards to provide medicines to patients on discharge. This meant that patients were not kept waiting for their medicines.

Records

- Patient care records were in a paper format and included pre-printed core care plans and various risk assessments such as venous thromboembolism (VTE), falls, malnutrition, moving and handling, bedrails, and pressure ulcers.
- We reviewed 28 sets of patient care records across the acute medical and healthcare of older people's wards. Patient records were not always well maintained as we found some contained loose leaf pages that had not been filed. This meant that some records were difficult to navigate and there was a risk that some records could be misplaced or lost.
- All of the medical records we looked at were legible, clear, and all entries were dated and signed by the appropriate doctor.
- Records were stored in notes trolleys in ward areas. Although these trolleys had the facility to be locked, we observed unlocked and unsupervised trolleys of patient records throughout the entire medical and HCOP wards. Although nursing and medical staff were usually around, these trolleys were at times left unsupervised and this increased the risk of them being accessed by unauthorised persons. However, this system ensured health care professionals could access the records at all times.
- Locked confidential waste bins were available to dispose of confidential records.

Safeguarding

- We spoke with staff about protecting patients from harm. All the staff we spoke with were able to describe types of what constituted abuse and were confident in how to escalate any concerns they had. Staff told us they would not normally raise patient to patient harm or abuse as a safeguarding concern. This meant staff were raising safeguarding concerns appropriately.
- There was a safeguarding lead for the trust and all staff we spoke with could tell us who the safeguarding lead was, and how they would escalate safeguarding concerns to this person.
- Staff told us they had received training in safeguarding adults and children and were aware of the trust's safeguarding policy.
- Staff told us safeguarding concerns would be discussed in handover meetings and shared across the team.

Mandatory training

- Mandatory training included topics such as health and safety, infection control, information governance, safeguarding adults, safeguarding children, moving and handling, and resuscitation. Equality and diversity training was not mandatory and was not offered as ongoing training. There was however an optional online training session, staff told us they did not consider this was effective in educating staff.
- Mandatory training was undertaken the month of staff members' birthdays, and was linked to their annual appraisals.
- Mandatory training involved two and a half hours of face to face lectures plus the viewing of a digital visual disc (DVD) with discussions.
- Staff we spoke with were aware of the mandatory training they were required to undertake and they told us they were up to date with their mandatory training.
- Information provided by the trust showed that 95% to 100% of staff across the acute medicine and care of the older person wards had completed their mandatory training against the trust's target of 90%.

Assessing and responding to patient risk

- Nursing handovers occurred at every shift change, during which staff communicated any changes to ensure that actions were taken to minimise any potential risk to patients.
- Risk assessments for patients for venous thromboembolism (VTE), pressure ulcers, and falls, were

undertaken appropriately, and were reviewed at the required frequency. Risk assessments identified required actions to minimise any potential risk to patients.

- Patients who were identified at high risk of falling were placed on a high-risk care checklist. This required nurses to check patients for changes in condition every two hours. Patients who were at high risk of falling were also placed in a cohort bay where a member of staff was required to supervise the bay at all times.
- On admission to the wards all patients were assessed for their risk of developing pressure ulcers. This was done using a nationally recognised risk assessment tool. Where patients had understanding they were given leaflets which explained about pressure ulcers and how they could be avoided. In addition, each ward had a tissue viability link nurse who was responsible for checking that risk assessments were completed and acted upon.
- All of the acute medical and healthcare of the older person's (HCOP) wards used an electronic system to monitor patients' physiological observations, for example; patients temperature, blood pressure, pulse rate, respiratory rate, and pain score. Each member of staff had a hand held device to record the observations. Each observation was scored and this was used to calculate an early warning score which gave an indication of whether a patient was deteriorating. The system tracked the observations and triggered an alert to doctors and the critical care outreach team when there were significant changes in a patient's observations. The electronic system also gave the ward sisters an overview of all the patients on their ward. This enabled them to check that appropriate action was being taken should a patient's condition deteriorate.
- Staff demonstrated a good knowledge of the risks associated with sepsis (Sepsis is a life-threatening condition that happens when the body's response to an infection injures its own tissues and organs).Staff recognised sepsis as a clinical emergency and could tell us the actions they would take if they suspected a patient was deteriorating and showed signs of sepsis. If not recognised and treated early it can lead to death. The trust used a 'sepsis six' tool to detect whether a patient was experiencing sepsis. The tool outlined the steps that should be followed in the event of a patient developing sepsis.
- A critical care outreach team (CCOT) was available seven days a week from 8am to 8pm to support staff with patients who were at risk of deteriorating. The hospital at night team was available overnight and could access specialist support from staff on the critical care unit.
- Some patients on the HCOP wards had limited communication due to their dementia. Sometimes they communicated through their behaviour, for example, some patients might become aggressive and frustrated. We looked at patient records and found there were no specific care plans to document why these patients might present with challenging behaviours, what triggered them, and how staff should deal with these sorts of situations.

Nursing staffing

- In July 2014 the National Institute for Health and Care Excellence (NICE) issued clinical guidelines to support Safe Staffing for nursing in adult inpatient wards in acute hospitals. The trust used the safer nursing care tool (SNCT) to assess the nursing skill mix and the number of staff required for each ward using the (NICE) guidance of a minimum of one registered nurse caring for eight patients. Where patient acuity (dependency) was higher, for example, those patients who were at increased risk of falling; staff from the falls team supplemented the nursing establishment on the wards.
- All the wards we visited displayed the number of staff (registered nurses and healthcare assistants) that were planned, and the number that were actually present on each shift. During our visit there was generally the planned number of staff on duty.
- Where planned staffing levels had not been met shifts were filled by ward staff working extra shifts, by staff who were moved from other wards, or by bank or agency staff. Staff across the HCOP wards told us they helped each other out across the ward areas when shortages were identified. On some wards, for example D57 staff had been moved from other areas such as from surgical wards for a period of three months.
- All of the HCOP and acute medical wards had staff vacancies with significant staff vacancy levels on some wards, for example ward D57 had a 50% vacancy rate for band five nurses. Staff recruitment was on-going and had included initiatives such as recruiting from other countries and ward staff being involved in job fairs.
- There was a clear escalation plan for nurses to follow if they were concerned about shortfalls in staffing levels or

skill mix. The trust used a 'Red Flag' system which was used to formally identify and alert senior staff when staffing levels were compromised. Red flag events were reported to the trust Board on a monthly basis.

- Agency use varied on each ward. They covered both nursing and healthcare assistant shifts. Agency staff had orientation and induction on the wards. Information provided by the trust showed that between July 2014 and June 2015, agency use for the HCOP wards was between 15% and 26%, and on acute medicine was between 21% and 45%. Where possible, the trust tried to book agency staff that were known to them.
- We observed an evening nurse handover on one of the HCOP wards. Sensitive information such as the resuscitation status of patients was handed over in private, nurses then gave a handover on the ward area at the entrance to each of the bays. Nurses handed over using their electronic hand held devices. Nurses receiving handover made additional notes on pieces of paper.
- Information was handed over to the relevant nurse who was supporting patients in a particular bay. As nurses only received handover for their bay this meant they had not received a handover for the other patients on the ward. As there were only two registered nurses on night shift, this meant the nurses may not have full details relating to other patients on the ward.
- Staff on ward B49 told us they didn't get breaks at night. There would be two registered nurses and one health care assistant. The acuity of patients was high which meant they needed to be supported to reposition and to use the toilet regularly. Staff on this ward felt there were insufficient planned staffing levels to meet the needs of patients at night.
- Agency staff told us they received orientation and local induction on the wards they were working.

Medical staffing

- Medical staff skill mix was similar to the England average with slightly more registrar and junior doctor levels and slightly less middle career and consultant doctors at this trust than the England average.
- Overall, the acute medicine doctor vacancy rate was approximately 24%. Information provided by the trust indicated that approximately 2% of these vacancies were in the HCOP wards. Work was on-going to fill the vacancy rates. .
- Junior doctors told us they were able to access consultant support out of hours.
- Ward D57 was an acute elderly medical admissions ward. Ward rounds took place twice a day with a safety huddle (a safety huddle is a short meeting between those involved in patient care where key information that could affect patient or staff safety is exchanged) at 9am. At the weekend there were three consultant shifts covering from 8am to 10pm. A ward round took place to see new patients. Sick patients were seen as required throughout the day.
- Between January 2014 and June 2015, the use of locum staff on the HCOP wards averaged at 13% per month. Whilst throughout the general medical wards the use of locum staff averaged at 36% per month. Locum doctors were provided with an induction booklet when they started working at the trust. This included information relating to behavioural standards, health and safety and major incident planning. We saw a copy of this booklet but we did not see evidence of completion.

Major incident awareness and training

- The trust had an emergency planning team who were responsible for ensuring the trust was adequately prepared for major incidents and emergencies. In addition, the trust had a major incident response policy which provided comprehensive guidance for staff to follow in the event of a major incident. Staff we spoke with were aware of the procedure they should follow if they needed to escalate incident concerns and were able to tell us about the command and control function should a major incident be declared.
- The trust had planned for seasonal bed pressures in the winter of 2015/2016 arranging additional bed capacity where this was appropriate to be able to increase the demand for patients.

Are medical care services effective?

Good

Overall we rated the effectiveness of this service as good.

Patients' care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation. There were specific pathways and protocols for a range of conditions, including heart failure, respiratory conditions, diabetes,

sepsis, and acute kidney injury to enable early recognition, prompt treatment and clinical stabilisation. We also saw care pathways were in place for patients with delirium and those at risk of falls. The trust had a dementia strategy that acknowledged the importance of services working together and following a pathway from identifying early signs of dementia, to specialist assessment, to formal diagnosis and liaison with primary care and adult social services.

There was participation in relevant national and local audits. When people received care from multidisciplinary teams this was coordinated and staff worked collaboratively to meet the patients' needs.

The service mostly operated a seven day week and consultants' reviews took place over the weekend period.

We saw elements of good practice. We saw where patient's symptoms of pain were suitably managed. Staff used a pain behaviour tool to assess pain in older adults who had dementia or other cognitive impairment and were unable to reliably communicate their pain. However on ward B49 we found the monitoring of patients food and fluid intake was not always accurately recorded, and we found that patients were not always referred to the dietitian in a timely manner.

Staff were qualified and had the skills they needed to carry out their roles effectively and were supported to maintain and further develop their professional skills and experience.

Medical and nursing staff were aware of their responsibilities under the Mental Capacity Act 2005.Patients were asked for their consent appropriately and correctly, where people were able to give their consent to care and treatment and staff carried out mental capacity assessments when they were needed. Capacity assessments were however sometimes difficult to locate because they had not always been filed correctly.

Evidence-based care and treatment

- The medical specialties provided care and treatment in line with guidelines from the National Institute for Health and Care Excellence (NICE) and Royal College guidelines. Local policies were written in line with these guidelines. A clinical effectiveness committee reviewed the list of guidelines where NICE had produced guidance for the previous quarter.
- NHS England interventional guidelines were met and practices were reviewed regularly. For example, there was a recent alert concerning the use of chlorhexidine and so staff practice was reviewed by senior members of staff to ensure it was used appropriately and safely. Chlorhexidine is an antibacterial liquid commonly used as an antiseptic.
- There were specific pathways and protocols for a range of conditions, including heart failure, respiratory conditions, diabetes, sepsis and acute kidney injury to enable early recognition, prompt treatment and clinical stabilisation. We also saw care pathways were in place for patients with delirium and those at risk of falls. The trust had a dementia strategy that acknowledged the importance of services working together and following a pathway. This included identifying early signs of dementia, to specialist assessment, to formal diagnosis and liaison with primary care and adult social services.
- We did not however see pathways in place for the management of those patients with long-term conditions, for example, those with Parkinson's disease.
- Generic care plans were in use on wards. These contained general instructions on care delivery but most did not reflect patients' individual needs and preferences. The lack of personalisation meant that it was not possible to establish the care needs of each patient from the care plans in place.
- The acute medical services participated in all national clinical audits that it was eligible for, to measure the effectiveness of care and treatment provided. The audits included a heart failure audit, the Myocardial Ischaemia National Audit Project, the Sentinel Stroke National Audit Programme, and the National Diabetes Inpatient Audit.
- Across the acute medicines directorate staff followed NICE guidance (CG92) in the assessment and management of venous thromboembolism (VTE).
- Local audits were taking place in the acute medicines directorate. We saw where the directorate had an audit plan that included audits such as the notification of death throughout HCOP, diagnosis and treatment of urinary tract infections and catheter associated infections and stop/start medications.

- On ward B3 a sepsis audit had been undertaken which indicated good compliance with the trust's sepsis six resuscitation bundle.
- An occupational therapist on ward F20 had undertaken a six month pilot project called 'Playlist for life'. The project involved asking patients about songs that were personal to them that they would like to listen to. Where patients were unable to list songs that were personal to them, their family or carers were encouraged to create a playlist on the patients behalf. The playlists were then created using hand held devices and provided to patients free of charge. An observation tool was created to monitor patient's mood, engagement, responses and communication before, during and after listening to their playlists. Twelve patients took part in the pilot and the results were then analysed and found to be overwhelmingly positive. At the time of our inspection a meeting was taking place to discuss how the experience could be continued throughout the ward.

Pain relief

- We observed nurses monitoring the pain levels of patients, recording the information, and taking appropriate action to control patient's pain. Pain levels were assessed as nurses and health care assistants were undertaking physiological observations. Pain scores were recorded on the trust's electronic observation system.
- Staff used a Pain Assessment in Advanced Dementia (PAINAD) tool to aid their assessment. This pain behaviour tool was developed to assess pain in older adults who had dementia or other cognitive impairment so were unable to reliably communicate their pain.
- Pain relief was prescribed for patients who required it, and patients we spoke with told us they were given pain relief when they needed it.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used throughout the acute medical and HCOP wards.
- Patients were only placed on food and fluid balance charts if their risk assessment indicated they required them.
- With the support of nursing staff, a consultant on ward F20 had started an ice cream project in order to support patients who were nutritionally at risk. A business case was submitted and supported by the League of Friends for funding to buy a freezer and a supply of high quality, high calorie ice cream. Patients who were nutritionally at risk had an ice cream sign placed on the board above their bed, this prompted staff to ensure these patients were supported to eat ice cream. The project had come to an end and the consultant was working on applying for more funding to continue the ice cream project.
- We looked at the nutritional assessment records of a patient on ward B49 and found them to be incomplete. The food chart that we looked at for this patient was also found to be incomplete and inaccurate. This meant that staff were not accurately monitoring how much the patient had eaten. We looked at the nutritional care plan for the patient and found it to be incomplete. The care plan did not give any indication of whether the patient required supplements or fortified meals. The patient had been on the ward for six weeks, and in this time had lost 7.7kg. We spoke with the ward dietitian who told us the patient had just been referred to them. The dietitian raised concerns that staff on ward B49 did not always fully complete food charts and this made it difficult for them to fully assess patients' nutritional intake. We raised our concerns with a senior member of staff. When we returned to the ward at our unannounced inspection, we saw that action had been taken and there was a marked improvement in the completion of food and fluid charts.
- We looked at another nutritional record of a patient on ward F21. We found that complete nutritional screening had been undertaken and the patient was receiving nutrition via a naso-gastric tube. (A naso-gastric tube is a tube that is passed via the nose and enters the patient's stomach. This allows specially adapted liquid nutrition to be administered to patients who are nutritionally at risk). The patient was receiving their feed overnight. We found that documentation had been completed and the position of the tube was checked daily prior to the feed commencing. We found the patient had also been prescribed nutritional supplements throughout the day. The supplements were being given as prescribed, and had been accurately recorded on the patient's fluid intake chart.
- On ward F18 we looked at the nutritional records of two patients and found them to be fully completed, the MUST screening tool had been completed for both patients. One of the patients was identified as being at high risk of malnutrition and we found the monitoring of their nutritional intake was being fully recorded.

- A colour-coded tray and water jug system was used on all medical and care of elderly wards and units to identify patients who needed help with eating and drinking. Patients who were nutritionally at risk or required support with eating had their meals served on a red tray. Patients who were at risk of dehydration or required support with drinking should have their water in a red lidded water jug. However, we found this was not consistently happening across the HCOP wards. The only ward that consistently used red jugs for patients identified as being at risk of dehydration was ward F20.
- Protected meal times were used to allow time for patients to eat sufficiently. However, where relatives or visitors supported people to eat, they were encouraged to continue this. In addition we noticed on one ward that a ward round was taking place as patients were eating their breakfast, so this protected time was not always respected.
- The trust ran a sustainable food programme that was provided by an external contractor. The service had been awarded a gold award from the Soil Association Food for LIFE Catering Programme. The gold award meant at least 15% of the food came from organic sources.
- Catering staff visited wards each morning and afternoon to collect menu orders from patients. Patients told us there was enough choice of food. We saw that food options included special diets. We heard mixed comments about the quality of the food. Some patients told us they were satisfied with the quality, but others felt the meals could be improved.
- We spoke with a patient who was Muslim. They confirmed the trust provided a choice Halal or vegetarian food for them.

Patient outcomes

- The National Diabetes Inpatient Audit (NaDIA) 2013 participation showed that the Queen's Medical Centre had performed better than the England average in 11 of the 21 measures and worse in a further nine of the measures. The trust had developed an action plan which included making the safe use of insulin training mandatory for all trained nurses, pharmacists and junior doctors and developing hypoglycaemia guidelines (hypoglycaemia is a medical term used to describe low blood sugar). We asked staff about the findings of the audit on the diabetic medicine wards C51 and C54. Staff we spoke with were not aware of the audit or its findings, or of any actions that were to be taken at ward level to address the shortfalls.
- The 2013 heart failure audit showed the Queen's Medical Centre scored worse than the national average for three out of four of the in-hospital measures and five out of seven of the discharge measures.
- The trust participated in the Myocardial Ischaemia National Audit Project (MINAP) 2013/14. This is a national clinical audit of the management of patients experiencing a heart attack. MINAP provides hospitals with information about their management of patients experiencing a heart attack and compares the information with nationally and internationally agreed standards. The MINAP audit showed that patients experiencing a heart attack and seen by a cardiologist or member of the team was lower than the national average however patients admitted to the cardiac unit or ward, and those referred for, or had, angiography was higher than the national average.
- Monitoring by the CQC had not identified any areas where medical care services at the Queen's Medical Centre would be considered a statistical outlier for the number of deaths when compared with other hospitals.
- The endoscopy unit at the Queen's medical centre was not Joint Advisory Group (JAG) accredited. JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards. A mock visit was undertaken in August 2015 to evaluate how the endoscopy unit would perform. The report identified concerns relating to the environment, privacy of patients and the cleaning of equipment. The report was to be discussed at a meeting with a view to developing an action plan to get the endoscopy unit at the QMC accredited. The concerns were identified on the directorate's risk register. Action to address the areas needing improvement was underway.
- Between January 2014 and December 2014, the average length of stay at the Queen's Medical Centre for elective neurology, gastroenterology, rehabilitation services, and elective geriatric and diabetic medicines were longer than the England average. The length of stay for elective rehabilitation was significantly higher (227 days) than the England average (30 days).

- Between December 2014 and February 2015, non-elective emergency readmission rates were mostly in line with the national benchmark range of 100, with the exception of diabetic medicine which was slightly above national rate at 118. For the same timeframe, elective emergency admission rates were significantly higher than the national benchmark range of 100. Gastroenterology was the highest with a rate of 199.

Competent staff

- All new staff attended an induction. Staff we spoke with confirmed they received adequate inductions. Newly appointed staff said that their inductions had been planned and delivered well.
- The trust had practice development matrons (PDMs) who delivered training and undertook competency based assessments throughout the ward areas. We saw clinical educators and preceptorship teams working with newly qualified staff nurses on the ward areas we visited.
- The trust employed a dementia specialist nurse. The nurse offered training for new health care assistants as part of their induction. Training was also delivered to a range of staff and volunteers including chaplains, radiographers, and non-clinical staff.
- There was a preceptorship programme for newly qualified nurses which included competencies relating to the ward they were working in.
- All newly qualified nurses undertook an acute care skills foundation programme. Information provided by the trust indicated that 177 newly qualified nurses starting employment in acute medicine had undertaken the training since it started in 2013. The acute care skills foundation programme was undertaken over a period of seven days. Throughout this training staff covered a wide variety of clinical topics related to nursing acutely unwell patients.
- Because of staff shortages across the acute medical wards, staff rotated between AMRU, B3, D57 and the Lyn Jarrett Unit (LJU) to ensure they were skilled in all areas. The LJU was a short stay admissions area adjacent to the emergency department. The unit was supported by acute medicine and emergency department consultants.
- Staff we spoke with told us they received annual appraisals and their appraisals included discussion about their learning and development needs.
- Medical and nursing staff told us they had sufficient support relating to revalidation. Revalidation is a process by which doctors and nurses can demonstrate they practice safely.
- Ward staff were supported by their managers to develop skills and experience specific to their role. Some health care assistants had undertaken training to enable them to become falls specialists; some had also undertaken training to become end of life care champions. However, unlike most link roles, end of life care champions did not receive protected time to deliver any teaching throughout their ward areas.
- Psychiatric support was available on ward B47 where the ward staffing and skill mix had been enhanced with mental health trained nurses, doctors, and allied health professionals. This was because ward B47 was a specialist mental health ward for older people who had complex needs due to dementia.
- At the start of each shift and once handover had taken place, registered nurses signed an accountability handover sheet. This demonstrated that incoming staff took responsibility for the information that had been handed over to them.
- Staff told us they received training to care for people living with dementia. Staff told us they did not feel this training was enough. Staff told us they had not received any training in dealing with challenging behaviour.
- There were six advanced Nurse Practitioners (ANPs) across the HCOP wards. Two of these were qualified and four were still receiving training.

Multidisciplinary working

- Ward teams had access to the full range of allied health professionals and team members described good, collaborative working practices. There was generally a joined-up and thorough approach to assessing the range of people's needs, and a consistent approach to ensuring assessments were regularly reviewed and kept up to date.
- Multidisciplinary team working was well established throughout the acute medical wards and the HCOP wards. There was daily communication between members of the multidisciplinary team with daily board rounds taking place.
- We saw evidence of multidisciplinary team work within patient records where we saw patients were referred to and seen by allied healthcare professionals and specialist nurses as required.

- There was a wide range of specialist nurses, for example the palliative care team and safeguarding leads, and we noted their presence on the wards. Staff told us they knew how to contact these specialists and felt supported by them.

Seven-day services

- There were daily consultant ward rounds, including weekends. Medical and nursing staff told us there were no problems with getting consultant advice and support if needed out of hours.
- Physiotherapists and occupational therapists were on-call out of hours and at weekends. Nursing staff told us that physiotherapists would come in at weekends to see patients who required acute treatment, for example, chest physiotherapy.
- There was an on-call pharmacy team available out of hours including weekends.
- Radiography and computerised tomography (CT) staff were on call out of hours and at weekends to provide urgent CT scans and X rays.

Access to information

- Staff could access information about the trust's policies, pathways, and available support services on the trust's intranet.
- Clinical staff had access to patient's test results such as blood tests, and diagnostic imaging, for example, x-rays, to support them to care for patients safely. These were available via the trust's electronic recording system. Patients medical and nursing records were kept in trolleys for each bay on the wards so they were easily accessible for staff to use.
- An 'About Me' document was used throughout the trust for patients who were cognitively impaired. This was completed by the patient's family or carer as soon after admission as possible. It included information about the person's life history, their likes, dislikes, hobbies, and interests. The quality of the information provided was dependent on the information shared by family and carers and we saw variations in the information that had been shared.
- Ward doctors communicated with patient's doctors in the community and produced an electronic summary of the patient's treatment and care when they were discharged.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date Mental Capacity Act 2005 (MCA) policy which included the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 aims to empower and protect people who may not be able to make some decisions for themselves. It also enables people to make advance decisions and statements to plan ahead in case they are unable to make important decisions in the future. DoLS are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals, and supported living are looked after in a way that does not restrict their freedom inappropriately).
- Ward staff referred applications for DoLS to the trust safeguarding team who carried out assessments to ensure the deprivation was in the patient's best interests.
- Medical and nursing staff were aware of their responsibilities under the MCA.
- Patients were asked for consent appropriately and correctly, where people were able to give consent to care and treatment. Where necessary, for example if a patient required an invasive procedure, risks were explained and consent forms were completed appropriately.
- When care was being delivered to patients in their 'best interest', we saw that decision specific mental capacity assessments were recorded. However, mental capacity assessments were at times difficult to locate as there was no consistency in where the assessments were filed. Some had been filed in the medical notes whilst some were filed in the patient's nursing care records.
- The trust had a process to apply for a DoLS where it was considered a patient may need to be deprived of their liberty in order to receive essential treatment. On Ward B49, we were told of a patient who was being deprived of their liberty. However, when we checked the patients care records we saw that an urgent authorisation had been obtained and had expired. We could not see that an extension had been granted to the urgent authorisation. At the time of our inspection however, the patient was not attempting to leave the ward. We spoke about this with one of the ward sisters who told us they thought the extension had been applied for and would contact the adult safeguarding team to clarify the situation. This meant that staff had not been given the

most up-to-date information concerning the patient's DoLS status and may have unlawfully deprived the patient of their liberty if the patient had attempted to leave the ward.

Are medical care services caring?

Good

Overall, the care provided to patients using this service was good.

We saw numerous examples of staff responding to patients with kindness and compassion, for example on most wards we saw positive interactions between staff and patients. We heard staff using person centred language and taking time to explain things to patients in an unhurried manner.

Throughout all of the wards, patients and those important to them were positive about their experience of care and the kindness that staff showed towards them. We did however observe some isolated examples where individual staff could have done more to interact with patients while delivering basic care such as personal hygiene or assistance with eating and drinking. On one ward we observed one member of staff using language that was not person-centred or respectful when referring to patients.

We also observed that two out of six patients who wanted to get up and walk around this ward were told to sit down as soon as they stood up. This meant that some patients within this ward were not always cared for in a person-centred way and whilst staff were intent on ensuring patients sat down they were not always supportive of the reasons patients might want to get up and walk about. In the same ward however, we also saw positive and caring interactions with patients.

Where possible, patients and those who were important to them were involved in their treatment and care. Staff talked through what was happening with patients whilst undertaking care and treatment ensuring wherever possible, that patients were aware of what was happening to them.

Compassionate care

- Without exception patients and those who were important to them were positive about the care and treatment they had received on all of the medical and HCOP wards we visited.
- Throughout our inspection we saw numerous examples of staff responding to patients with kindness and compassion. However, we also saw isolated examples where care was less compassionate.
- We undertook a Short Observational Framework for Inspection (SOFI) on ward B49. (SOFI is a specific way of observing care to help us understand the experience of people who use the service, including those who are unable to talk with us). Our observations on the ward were mixed. We observed some positive interactions between patients and staff; however, we also observed one member of staff using language that was not person-centred or respectful when referring to patients. In another bay we also observed that two out of six patients who wanted to get up and walk around this ward were told to sit down as soon as they stood up. This meant that some patients within this ward were not always cared for in a person-centred way and whilst staff were intent on ensuring patients sat down they were not always supportive of the reasons patients might want to get up and walk about. In the same bay however, we also saw positive and caring interactions with patients. We saw a health care assistant covering a patient up who was laid in bed and reassuring another patient who was becoming agitated. We saw another member of staff show empathy and kindness to a patient
- On ward B47, we saw a member of staff supporting patients with limited interaction between them and the patient. We observed one patient who was not eating their breakfast. A member of staff was making the patient's bed and tidying up, but there was no attempt to make conversation or encourage the patient to eat. Later, the patient's breakfast was removed by a housekeeper with no attempt to make conversation or to find out whether the patient had finished their breakfast. On the same ward, staff were supporting patients with their personal hygiene. Staff were respectful in maintaining patient's dignity by drawing the curtains around the bed space. However, there was very limited interaction between the staff and the patient.
- On other wards, such as F20, we saw some good interactions between staff and patients which were positive, respectful and caring.

- Staff usually answered call buzzers promptly so that patients had help when they needed it. We saw that staff used curtains around beds when helping with personal care.
- The trust used the NHS Friends and Family Test (FFT) to obtain feedback from patients. This was a single question survey which asked patients whether they would recommend the NHS service they had received to friends and family who needed similar care or treatment. The average FFT response rate for the trust was 45% which was better than the England average of 36%.
- The in-patient survey conducted by the Care Quality Commission (CQC) in May 2015 showed the trust scored about the same as other trusts in their experience relating to their care, including doctors, nurses, care and treatment, and leaving hospital. We did not have a breakdown between hospitals or wards.

Understanding and involvement of patients and those close to them

- We observed that staff mostly involved patients and those who were important to them in their treatment and care. Staff talked through what was happening with patients whilst undertaking care and treatment ensuring wherever possible that patients were aware of what was happening to them. We spoke with the family of one patient and we saw the discharge coordinator was explaining why there had been a delay in discharging the patient. The family told us the staff communicated with them and they were kept up-to-date with what was happening.
- Patients and those important to them that we spoke with told us staff gave them enough information about their care and treatment.
- Wards with patients who were living with dementia were using the 'This is Me' document produced by the Alzheimer's Society. It was completed by those who knew the patient, such as their family, and was being used to help staff to get to know patients and facilitate the provision of person-centred care. It included items such as social history, care preferences, and any special memories the person may have. Staff told us they found them useful but we saw instances where the booklets had not been completed.
- Staff and visitors told us about a 'password' system for relatives of patients to telephone wards to receive detailed information about the patient's condition and care. This could be used once they had given the staff member a password that had been set up previously. This ensured patient confidentiality was not breached.

Emotional support

- Patients and those close to them told us that staff were approachable and they were able to talk to them if they needed to. Staff told us they would initially provide emotional support for patients and those who were close to them.
- Patients could access a range of specialist nurses, for example in palliative care and diabetes care and these staff could offer appropriate specialist support to patients and those close to them in relation to their psychological needs.
- The hospital had a chaplaincy service and staff told us they could request support from the chaplaincy team if this was necessary.
- Staff we spoke with told us if they were worried about a patient's mental health they would refer them to the appropriate doctor for clinical assessment to determine whether they were suffering from anxiety or depression.

Are medical care services responsive?

Good

Overall, we judged the responsiveness of this service as good.

The average length of stay trust wide was similar to the England average. However, the Queen's Medical Centre had a longer length of stay for elective neurology, gastroenterology, rehabilitation services, non-elective geriatric, and diabetic medicine.

Bed occupancy levels throughout the trust were generally below the national average and bed capacity plans were presented to the trust board.

The trust used an electronic system to capture information for all patients who were over the age of 75 years and were admitted as an emergency. This enabled them to screen these patients for dementia as required by NHS England.

On ward B47 we saw there was an activities board which detailed activities available for patients each day of the

week. We observed some activities taking place which were led by a physiotherapist and a health care assistant. However, this level of activity support was not presently offered on the other healthcare of older people's wards.

Systems were in place to receive, review and learn from complaints and compliments. Staff listened to patients and took action to improve the quality of care.

Service planning and delivery to meet the needs of local people

- The trust had expanded Healthcare of Older People (HCOP) beds to meet the needs of local people. These were spread over nine wards. Ward B47 provided specialist mental health care to patients with complex needs due to dementia and delirium.
- The trust had relaxed visiting hours on the HCOP wards to enable families to come into the wards at times including when meals were being served where those close to patients supported patients to eat.
- The trust had a 30 bedded admissions ward for patients who were likely to stay in hospital for less than 48 hours. This ward was supported by dedicated older person's doctors who had a focus on frail elderly patients.
- The trust had an Acute Medicine Receiving Unit (AMRU) for the assessment of adult patients who required medical admission or ambulatory emergency care. Patients were referred to AMRU via their GP. The unit provided a dedicated ambulatory care area and aimed to discharge patients within 12 hours. Patients requiring further care were assessed to ensure they were sign posted to the right clinical environment first time.

Access and flow

- Patients access the acute medical services including HCOP services via their GP or through the emergency department.
- The trust had a patient flow and bed escalation policy. Site matrons and bed managers met three times each day. These meetings looked at how to safely and quickly manage the flow of patients through the hospital. Staff matched up patients waiting for beds on the wards with the beds available, and made suitable arrangements for patients waiting to go home.
- The average length of stay trust wide was similar to the England average. However, the Queen's Medical Centre had a longer length of stay for elective neurology, gastroenterology, rehabilitation services, non-elective geriatric, and diabetic medicine.
- Bed occupancy levels throughout the trust were generally below the national average. It is generally accepted that when bed occupancy rises above 85% it can start to affect the quality of care provided to patients and the orderly running of the hospital. We looked at information provided by the trust for the HCOP wards. Between September 2014 and August 2015, the bed occupancy level averaged at 95%. This was above the trust's threshold of 90%. However, throughout the acute medical wards bed occupancy rates averaged at 81% which was below the trust's threshold of 90%.
- Bed capacity plans were presented to the trust board and detailed actions the trust had taken to deal with bed capacity issues and further actions the trust was planning to take to lower the risk of future bed capacity issues.
- On ward B3, the short stay acute medical admissions unit, consultants provided a GP referral triage service from Monday to Friday between the hours of 9am to 5pm. This enabled consultants to provide advice to GPs and determine whether the patient's condition required admission to hospital, or whether they could be managed at home, therefore avoiding an unnecessary hospital admission.
- The wards had discharge co-ordinators to support the ward teams. Discharge co-ordinators had responsibility for patient flow and discharges in their ward areas. We saw discharge co-ordinators on the wards we visited.
- The discharge lounge was open Monday to Friday between the hours of 8am and 7pm. There were separate seating areas for males and females, and a cohort room for patients who were living with dementia. Meaningful activities were offered to patients who were waiting to be discharged in the cohort room. There was also a clinical room that could be used if a patient's condition deteriorated. There was a cut off time of 4.30pm for patients to be transferred to the discharge lounge. The discharge team did not work at weekends but the trust's electronic communication system monitored discharges in their absence.
- Most staff we spoke with told us discharges did not always happen in a timely way. They told us there were

fewer problems with obtaining medicines to take home but that discharges were often delayed due to suitable placements and care packages not being in place. This was a particular problem when patients had complex cognitive impairment.
- Referral to treatment times were being met across all medical specialities. However, referral to treatment time was not monitored within the HCOP speciality.
- During the period April 2014 to March 2015, 29% of patients experienced one ward move, 14% were moved twice, 5% three times and 3% were moved four or more times. The trust did not monitor the reason for moving patients between wards and could therefore not clarify whether the moves were made for clinical reasons.
- The trust were monitoring out of hours bed moves for patients but the data did not allow the number of bed moves being made for non-medical reasons.

Information provided by the trust indicated that from 1 April until 2 October 2015 the trust had 1,882 outliers. (Outliers are patients under the care of medical consultants but placed on other wards due to a shortage of bed space). Of those, 1,572 had been medical outliers across both the QMC and City sites. This data relates to both Queen's Medical Centre and City Hospital. On the week of our inspection we received information relating to medical outliers at the Queen's Medical Centre. This showed two types of outliers; one related to medical patients outlying on surgical wards and the other medical patients outlying on a medical ward but not of their speciality, for example a respiratory patient being placed on a diabetes ward. On 16 September 2015 there was a total of 15 outliers at the Queen's Medical centre, six of which were on a different specialty ward. Outliers were followed up by their consultant following their consultant's ward rounds. The trust had undertaken a pilot and was in the process of introducing 'specialty tagging' of patients admitted via the emergency department to facilitate the correct allocation of beds to specialities throughout the trust.

Meeting people's individual needs

- Patients had their individual needs assessed by both medical and nursing staff and where required we saw input from other members of the multidisciplinary team.
- Staff told us they could access translation services. Some staff spoke other languages and were able to translate. Patients who required a British Sign Language interpreter were required to let staff at the trust know. Staff knew they could access this service but told us they had never needed to.
- The leaflets displayed were all written in English, but staff told us they could order leaflets in different languages if they were required.
- Pictorial menu cards were available for people who had difficulty reading or understanding a menu.
- The trust had access to a learning disability liaison team which consisted of 2.6 full time equivalent nurses. The team was provided by another trust but had a base on the Queen's Medical Centre site and could access the trust's electronic system. This meant they could access up-to-date information about patients.
- There was an audiologist who could be contacted by ward staff. The audiologist would attend patients who had a hearing aid and gave information and support to ensure patients were effectively using their hearing aid. In addition, they checked to ensure patients knew how to change the battery in their hearing aid.
- The trust had a dementia strategy in place. This outlined the care that patient's living with dementia should expect if they were admitted to the hospital.
- The trust used an electronic system to capture information for all patients who were over the age of 75 years and were admitted as an emergency. This enabled them to screen these patients for dementia as required by NHS England.
- Each ward had a staff member who was a 'dementia champion', these were staff who could advise and support other staff in caring for patients living with dementia.
- An 'About Me' document was used throughout the medical wards for patients who were cognitively impaired. The aim of the 'about me' document was to capture essential information about the patient to ensure person-centred care could be provided. This was completed by the patient's family or carer as soon after admission as possible. It included information about the person's life history; their likes, dislikes, hobbies and interests. The quality of the information provided was dependent on the information shared by family and carers and we saw variations in the information that had been shared. There were no specific care plans or

pathways in place for patients with a dementia. If the 'About Me' document had not been completed, staff may not be aware of anything specific that may trigger certain behaviours.

- On ward B47 we saw there was an activities board which detailed activities available for patients each day of the week. We observed activities taking place which were led by a physiotherapist and a health care assistant. We saw patients enjoying diversional therapy in the ward's day room. There was music playing and they were reminiscing about the seaside. They talked about holidays and swimming in the sea and we heard them singing seaside songs. We also saw patients having a tea party, drinking tea from china cups. There were tissues on the table if patients got upset whilst reminiscing. A Pets as Therapy (PaT) dog visited the patients on this ward. We saw that patients enjoyed this and were smiling as the visit took place. These activities had a positive effect on patient's well-being. Although these activities took place on ward B47 the same level of input was not observed on the other HCOP wards. This meant these sorts of activities were not available to patients who were receiving nursing and medical care on other wards providing care for elderly people.
- We found there were arrangements to ensure patients were cared for in single gender facilities and had access to single gender washing and toilet facilities.

Learning from complaints and concerns

- The trust had an up-to-date policy regarding the management of complaints, concerns, comments and compliments (4C's). This set out the responsibilities of staff at all levels who handled concerns and complaints throughout the trust. The policy also set out the procedure for staff to follow to respond to the 4C's
- The trust Board received monthly information on the number of complaints and timeliness of responses through the trust's integrated performance report. Complaints and concerns were also monitored on a quarterly basis by the quality assurance committee.
- We saw posters explaining how to make a complaint within the ward areas throughout the trust. We also observed comment cards where patients and those close to them could give feedback.
- Ward sisters were involved in investigating complaints in their areas. Nursing staff told us they would try to resolve complaints quickly and locally whenever possible.
- Although staff told us that learning from complaints took place at ward level, we were not assured that learning from complaints was shared across the divisions in relation to the medical and HCOP wards.

Are medical care services well-led?

Good

Overall we judged the leadership of this service as good.

The leadership, management and governance of acute medical services formed a good basis for the delivery of the services it provided. Annual plans were in place for each of the specialities within the directorate of acute medicine and quality, performance and risks were understood. There were effective governance frameworks in place to support the delivery of the division's plan.

There was good evidence of public and staff engagement and most staff told us they felt proud to work at the trust. There was evidence of good leadership at a local level and there was good communication to and from the Board.

Vision and strategy for this service

- There was no separate vision or strategy for the acute medical directorate within the trust. However the acute medicines directorate developed annual plans for each specialty within the directorate. There were specialty plans for 2015/16 and these had been developed to support the trust's objectives. Actions were identified and outcomes were measurable. An accountable member of staff had been assigned to each action and dates were set for review and for completion of actions.
- The trust's vision for the future of their hospitals was 'working together to be the best for patients'. Through patient and staff engagement there were three areas the trust had pledged to work on. These were proud people, team work, innovation and continuous improvement.

Governance, risk management and quality measurement

- There was an effective governance framework to support the delivery of the division's annual plan and good quality care.
- The directorate was committed to ensuring good governance processes and this had been prioritised in

the directorate's annual plan. One of the objectives identified in the acute medicine annual plan was to strengthen governance processes within acute medicine and ensure strong, clear governance structures were in place to communicate messages to the front line.

- We reviewed the minutes of the governance meetings and saw that discussions about complaints, audit outcome, risk and incident analysis was occurring. The acute medicine directorate had a risk register and risks were reviewed and discussed at monthly governance meetings.
- The trust had a programme of shared governance. Wards and departments were empowered to set up their own councils where they could discuss issues within their own areas. This gave them the authority and chance to directly influence decision-making as close to patients as possible. The councils then fed into senior teams.
- Each directorate had a risk register which they reviewed at governance meetings. They escalated risks if necessary.
- Key performance data, for example hand hygiene audit and infection rates, and staffing numbers were displayed on every ward. This ensured the results were visible to patients, their visitors as well as staff so they could see how well the ward was performing.
- There was a rolling programme of audits. These included environmental, cleaning, hand washing and medicines. This ensured the trust was monitoring the quality of the provision of care throughout the directorate at the Queen's Medical Centre (QMC).

Leadership of service

- At the QMC all of the medical wards came under the directorate of acute medicine with the exception of ward F21 which came under the directorate of digestive diseases and thoracics and D55 which came under the directorate of cardio-respiratory and stroke. Each directorate had a clinical lead followed by a matron was responsible for a number of wards.
- Staff told us that senior leaders including the Chief Executive Officer (CEO) were visible throughout the trust. Staff at all levels spoke highly of the chief executive.
- Each ward had a manager who provided day-to-day leadership for members of staff on the ward. Ward staff felt well supported by their ward manager, ward sisters and matrons and told us they could raise concerns with them. The matrons we spoke with had good knowledge of the areas for which they were responsible. Staff in all the clinical areas across the medical services spoke highly about and had confidence in their local leaders, who included matrons, ward managers and lead consultants. Staff across medical wards told us the matron was visible and had a regular presence on their ward.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff told us they felt supported by the medical leadership in the division and the trust.
- Student nurses told us they felt supported on the ward and received supervisory training from senior staff.

Culture within the service

- Nursing and medical staff spoke positively about the service they provided for patients. Staff reported positive working relationships and we observed that staff were respectful towards each other, not only within their specialities but across all disciplines. Without exception, staff of all grades told us they were proud to work for the trust. They spoke positively about the culture within their own areas and throughout the trust as a whole.
- There was a culture of flexibility and willingness among all the staff we met. Staff worked well together and would help out on the HCOP wards where there were shortfalls in staffing.
- Patients acknowledged a caring and positive culture and were mostly happy with their experience of care.
- We held a focus group with the lead consultants for each of the medical specialities, including acute medicine and HCOP. All of the consultants were extremely supportive of the development of advanced nurse practitioners throughout the trust and the contribution they made to delivering safe and effective care and treatment.

Public and staff engagement

- All wards used the NHS Friends and Family test to get feedback from patients. Results were displayed on white boards on each ward. We saw many positive comments but one reoccurring theme was noise at night. This was being addressed by the trust and was discussed at the trust's Board meetings. Reducing noise at night was being measured through each patient's response to the question "were you ever bothered by noise at night from

other patients and hospital staff". We saw the results of the survey for March 2015 where the trust had identified they had not met their target. There was an indication that the trust had incorporated further actions and plans into their work plans for 2015. In addition, we saw wards displayed comments made by patients and their carers/families. We also observed appreciative cards that had been given to the wards by patients and their carers/families.

- During 2014/15 the trust held over 400 public involvement events with approximately 8,500 people attending. There were also a number of events called Events in Tents. These were attended by members of the public, staff and other stakeholders. These events assisted the trust in refreshing its vision and values.
- The trust undertook a 'carers of patients with dementia' survey and results were collated on a monthly basis. Between April 2015 and August 2015, 13 carers took part in the survey. At the time of our inspection the outcomes of the survey were not yet available.
- All staff we spoke with told us they felt communication within the trust was good.
- Nottingham University Hospitals introduced the concept of shared governance in 2012. Shared Governance was introduced to give staff the opportunity to create councils for each ward or department and any level of staff could join the council. It was a 'bottom up' model of management which aimed to empower frontline staff to make decisions about patient care at the point of care delivery. It also gave staff the opportunity to discuss any issues in their area. This information was then taken to senior management meetings. Staff we spoke with told us they felt valued, engaged and involved through the shared governance councils. Staff told us they felt confident to raise concerns within the trust and shared governance gave them the opportunity to do that. Staff on ward B3 took pride to tell us they were the first ward to initiate shared governance. They felt it empowered staff to have a voice.
- Staff told us that the Nottingham University Honours awards had helped to boost morale throughout the trust. We saw certificates throughout the wards where staff and teams had won awards.

Innovation, improvement and sustainability

- An occupational therapist on ward F20 had undertaken a six month pilot project called 'Playlist for life'. The project involved asking patients about songs that were personal to them that they would like to listen to. Where patients were unable to list songs that were personal to them, their family or carers were encouraged to create a playlist on the patients behalf. The playlists were then created using hand held devices and provided to patients free of charge. An observation tool was created to monitor patient's mood, engagement, responses and communication before, during and after listening to their playlists. Twelve patients took part in the pilot and the results were then analysed and found to be overwhelmingly positive. At the time of our inspection a meeting was taking place to discuss how the experience could be continued throughout the ward.
- With the support of nursing staff, a consultant on ward F20 had started an ice cream project in order to support patients who were nutritionally at risk. A business case was submitted and supported by the League of Friends for funding to buy a freezer and a supply of high quality, high calorie ice cream. Patients who were nutritionally at risk had an ice cream sign placed on the board above their bed, this prompted staff to ensure these patients were supported to eat ice cream. The project had come to an end and the consultant was working on applying for more funding to continue the ice cream project.
- Patients wore a coloured wrist band to highlight the oxygen rate they were prescribed. This ensured staff could easily identify the patient's required rate to ensure they were receiving safe care.
- On ward C54 a clinical coder was evaluating discharge letters and checking to ensure the coding of patients diagnosis' was correct for all patients who had been discharged from the ward. This was to ensure the trust was paid the correct tariff for the clinical service they had given to patients. This showed the trust was taking steps to ensure the financial stability and sustainability of the service.

Surgery

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

Information about the service

Nottingham University Hospitals NHS Trust provides a range of planned and emergency surgery at Queen's Medical Centre. Surgical specialities include neurology and neurosurgery, spinal surgery, ophthalmic surgery, orthopaedic surgery, vascular surgery and ear, nose and throat surgery. There are 337 beds for surgical patients, including inpatient and day case surgery, (but not including gynaecology). There are 23 operating theatres, (not including children's and obstetric theatres).

There were 36,939 admissions for surgery in 2014. More than half of all admissions were for planned surgery, including day case surgery. Emergency surgery accounted for 42% of admissions.

During our inspection we visited ten surgical wards, surgical triage unit, pre-operative assessment unit, day case unit, and discharge lounge. We visited the operating theatres, including pre and post anaesthetic care areas. We spoke with 33 patients, or their relatives / carers, and 50 members of staff. These included all grades of nursing staff, healthcare assistants, domestic staff, consultant surgeons, consultant anaesthetists, junior doctors, therapists, administration staff and managers.

We observed care and treatment and looked at 29 patient records. We received comments from people at our listening events, and from people who contacted us to tell us about their experiences. We reviewed performance information from, and about, the hospital.

Summary of findings

Overall, we rated surgery services at Queen's Medical Centre as good. Safety, effectiveness, caring and responsiveness of the service were all good and the leadership was rated as outstanding.

Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. Lessons were learnt from incidents and shared widely to support improvement in all areas.

Systems, processes and practices in place to keep patients safe were mostly reliable. The exception to this was the system for ensuring equipment was maintained in line with manufacturers and other guidance. Many items of equipment on the wards had not been checked or tested for over a year.

Staffing levels were generally maintained as planned. There was safe and effective management of infection control measures, medicines and patient records.

Risks to patients were assessed, monitored, and managed appropriately. This included patients with signs of deteriorating health.

Care and treatment achieved good outcomes for patients, were evidence based and in line with local and national guidance. Outcomes for patients were generally in line with or better than national averages.

Surgery

Patients' pain relief, and their nutritional and hydration needs were generally well managed. Consent to care and treatment was not always in line with legislation and guidance.

Surgery services were planned and delivered to meet the needs of local people and those from further afield requiring specialist services. Multidisciplinary team working was well established and effective in ensuring patients' needs were met.

Staff treated patients with compassion, kindness, dignity and respect. Most patients we spoke with or had feedback from were positive about the care they had received.

Surgery services had a clear vision for enhancing the patient experience which was translated into measurable achievements by speciality action plans.

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

Governance arrangements were strong and quality, performance and risk management promoted continuous improvement.

Staff were proud of working for the trust and felt valued and respected. They actively sought patient feedback and worked collaboratively to provide new solutions for patients.

Are surgery services safe?

Good

The safety of surgery services was good.

Patients were protected from avoidable harm and abuse. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them. There was appropriate investigation of incidents. Lessons were learnt and shared widely to support improvement in all areas.

Systems, processes and practices in place to keep patients safe were reliable. The exception to this was the system for ensuring equipment was maintained in line with manufacturers and other guidance. There were many items of equipment on the wards that had not been checked or tested for over a year. Staffing levels were generally maintained as planned. There was safe and effective management of infection control measures, medicines and patient records.

Risks to patients were assessed, monitored and managed appropriately. This included patients with signs of deteriorating health.

Incidents

- Incidents were reported using the electronic trust wide reporting system. Most of the reported incidents were assessed as causing no harm or low harm to patients.
- There were 18 serious incidents, (those causing significant harm to patients), reported in surgery services at Queen's Medical Centre (QMC) between May 2014 and April 2015. These included pressure ulcers, falls, and healthcare acquired infections. Staff with the appropriate level of seniority reviewed and investigated incidents and took action to improve services. Incident reports showed they investigated appropriately using root cause analysis to identify contributing factors. Actions were planned and assigned to named members of staff. Completion of actions was monitored through regular governance meetings.
- Staff knew the types of incidents to report and could demonstrate how they would report and escalate them to their managers. Staff said they were encouraged and supported to report incidents. 'Patient safety

conversations' had been held with theatre support workers, (those at band two), as it was identified that these staff were less likely to report incidents and near misses.
- Learning from incidents was shared with staff through individual feedback, governance meetings, team meetings and through the trust's intranet.
- Examples of learning from incidents included action taken to prevent patient falls on the wards and to prevent medication errors in theatres. Patients identified as at risk of falls were placed together in one bay of each ward. A member of staff stayed in the bay at all times so that patients had constant supervision. Medication errors had happened in theatres because anaesthetic drugs were not labelled. Standard labels were produced in a universal format for use from a dispenser in every theatre.
- Most staff told us they had feedback from incidents they had reported, or those incidents reported in their local area and in other areas of the trust. Staff in theatres at Queen's Medical Centre were aware of learning from serious incidents in theatres at Nottingham City Hospital.
- Staff were familiar with the 'Duty of Candour 'The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology). Staff told us they would inform patients or their relatives / carers when incidents occurred.
- Mortality and morbidity meetings were held in line with trust policies. Clinicians and managers reviewed deaths and made changes to practice where needed.

Safety thermometer

- The NHS safety thermometer is a tool used to record four common, and largely preventable, harms to patients: pressure ulcers, falls, urinary tract infections in patients with a catheter, and new venous thromboembolisms (blood clots). The safety thermometer provides information for frontline teams to monitor their performance and to make improvements to eliminate patient harms.
- Safety thermometer information showed low numbers of harms recorded for patients using the surgery services at QMC. For the year September 2014 to September 2015, all of the surgical wards recorded high rates of harm free care: between 90% and 100% each month with very few exceptions.
- The wards we visited displayed safety thermometer information clearly and prominently. Staff knew about the results for their ward and were proud of their track record of low numbers of harm to patients.

Cleanliness, infection control and hygiene

- The areas we visited were visibly clean. There were suitable arrangements for the handling, storage, and disposal of waste, including clinical waste and sharps.
- We observed staff following trust policies in relation to infection prevention and control. This included correct hand hygiene and 'bare below the elbow' guidance with appropriate use of protective personal equipment, such as gloves and aprons.
- There were bi-monthly audits of staff hand hygiene, including nurses, doctors and allied healthcare professionals. For June / July 2015, all directorates providing surgical services had achieved scores of more than 90% for staff compliance with hand hygiene procedures. The Specialist Support directorate that included theatres had scored 100%.
- Staff cared for patients with known infections in single rooms. Guidance about the precautions to be taken was displayed on the door to the room. We saw that staff provided care for these patients in line with the guidance and trust policies.
- Theatres staff followed appropriate infection control protocols and gowning procedures in line with trust policies.
- Each ward had an infection control link nurse. Their role included liaison with the trust infection control team, carrying out audits of staff hand hygiene and checks of the cleanliness of equipment. They had six hours each month protected time to carry out their role.
- All patients were checked at pre-operative assessment or on admission for evidence of infection by methicillin resistant staphylococcus aureous (MRSA), clostridium difficile (C. diff) and carbapenem-resistant Enterobacteriaceae (CRE). These are all bacteria that can cause difficult to treat infections because they are highly resistant to antibiotics.
- Surgical site infection rates were available for neurosurgery and for surgery to repair fractured neck of femur. The infection rates for neurosurgery were below

3% in 2014. Causes of infections were investigated and action taken to reduce the risk of recurrence. Infection rates for repair of fractured neck of femur were 0.5% in 2014 and 0% for January to March 2015. This was low when compared with results from other hospitals.
- Each ward we visited displayed information about hospital acquired infections. The information showed low incidence of infections caused by MRSA and C diff.
- There was a regular programme of deep cleaning for wards. Patients were relocated temporarily to another ward, which was kept empty for this purpose.

Environment and equipment

- The wards and areas we visited were mostly well maintained, though there were a few exceptions.
- Not all wards had single rooms. This meant that patients who needed a room on their own because of infection or other reasons had to be moved to another ward.
- There were items of equipment overdue for testing or maintenance on every ward we visited. Examples of this were seven out of 28 beds on one ward which were overdue for annual maintenance checks, and six fans on another ward all overdue for electrical safety checks. We saw an oxygen cylinder regulator with a sticker indicating the next annual check was due in June 2014, but also had another sticker saying it required reconditioning in June 2016. Staff told us they had taken note of the 2016 date when carrying out their daily checks and were not aware the equipment was overdue for the annual inspection.
- Staff told us that when they reported equipment requiring maintenance or repair, this was usually carried out quickly. The ward sisters we spoke with were not aware of a system or plan for routine annual checking and maintenance of equipment.
- There was a comprehensive environmental safety checklist used annually for each ward. This included guidance on the action to take for any issues found. The checklist prompted staff to check the date of the annual safety test for portable electrical equipment. However, on one ward we found fans last tested more than a year previously and one fan with no sticker to show when it was last tested. Staff had not noted these items on the ward's annual checklist and this represented a risk to patients.
- Staff told us there were no issues with obtaining equipment for use on the wards. They said that equipment was usually available quickly when needed, such as special mattresses and cushions to help prevent pressure ulcers.
- Equipment for emergencies, including resuscitation equipment, was available in all the wards and theatres we visited. Records showed staff had signed when they had checked equipment every day.
- The sterile services department on the QMC site was responsible for cleaning, disinfecting and sterilising all reusable equipment and instruments for the operating theatres. The sterile services department was fully accredited to recognised national and international safety and quality standards.
- The 'Well Organised Theatres' initiative was started in 2012 with the aim of keeping theatre areas uncluttered and in an orderly layout. Staff used the 'three second rule' to ensure that the right equipment was available at the right time. The initiative was ongoing and resulted in a better working environment for staff and more efficient storage of equipment.
- Central Alerting System (CAS) reports were noted at monthly governance meetings and appropriate action taken. CAS is an online system issuing safety alerts about medical devices and other equipment to NHS and other healthcare providers.

Medicines

- Medicines, including controlled drugs and intravenous fluids, were appropriately and safely stored on the wards we visited and in theatres.
- Staff followed trust policies to ensure medicines were ordered, handled, administered and disposed of appropriately and safely. Pharmacy staff carried out regular reviews to maintain minimum stock levels and to ensure medicines were within their expiry date.
- Staff carried out daily checks of controlled drugs to ensure these were correctly reconciled and accounted for. We checked the balance of controlled drugs in the cupboards; this was correct and matched the controlled drug registers.

Records

- We looked at 29 patient records on the wards and records of operations which were kept in theatres. Records were kept in lockable trolleys on the wards. The trolleys were closed when not in use, though not locked as staff needed frequent access to records.
- The majority of records we saw were accurate and all were up to date. We found inaccuracies and lack of detail in the 'do not attempt resuscitation' forms for two patients, (reported on in the End of life care section of this report)..
- There were daily records of each patient's care and treatment. Some wards adapted the format for daily records to ensure specific patient needs were included, such as for patients recovering from neurosurgery.
- Staff completed appropriate risk assessments including the patient's risk of falls and pressure damage and the risks associated with moving and handling. Risk assessments were appropriately reviewed and kept up to date.

Safeguarding

- Staff we spoke with knew how to report any safeguarding concerns and how to contact the trust's safeguarding team. Staff told us they were up to date with training in safeguarding adults and children.
- The trust provided information about safeguarding training completed by staff working in the directorates delivering surgery services at Queen's Medical Centre. Staff in two of these directorates had achieved the trust target of 90% completing level one safeguarding training. The other two directorates had achieved 87% and 89% of staff completing the training. Three of the directorates had achieved 90% of staff completing level two safeguarding training and one had achieved 89%.

Mandatory training

- The trust had a target of 90% of staff completing mandatory training every year. Data provided by the trust showed that most services achieved the trust target, meaning that most staff had completed their mandatory training. Services at QMC not achieving the 90% target included the hepatobiliary service where between 60% and 88% of staff had completed mandatory training, some groups of staff in neurosurgery (75%) and spinal surgery (69%). However, the data provided was for all groups of staff in each speciality and so included those not necessarily working in surgery services, (such as staff in outpatients).
- Staff we spoke with told us they were up to date with mandatory training. Training was due in the month of their birthday and staff said this system worked well.

Assessing and responding to patient risk

- Staff assessed patients pre-operatively, looking at the patient's physical and mental health and checking for any risk factors that could cause complications after surgery. Pre-operative assessment was in line with local and national guidance, including for emergency surgery.
- All operating theatres at QMC used the '5 steps to safer surgery' World Health Organisation (WHO) surgical checklist. Correct use of the WHO checklist should ensure that common and avoidable risks to patient safety are minimised or prevented. Theatres carried out robust annual audits of their compliance.The audit comprised ninety seven patients at City Hospital and a hundred and ninety three patients at QMC and results were fully compliant in 90% of cases at QMC. The audit had become more rigorous since 2013 and showed an improvement in compliance, although this is difficult to track as 2015 was the first year results were aggregated by site. Theatres developed an action plan to strengthen signing in, signing out and time out procedures.
- Annual audits were carried out of the '5 steps to safer surgery' World Health Organisation (WHO) surgical checklist. The latest audit report in July 2015 showed actions were planned in specialities where performance had fallen below 100%, such as neurosurgery and ophthalmic theatres at QMC. These included staff training and a repeat of the audit in January 2016.
- Eye cataract surgery clinicians adapted the WHO checklist to include checks of the lens implant to be used. This was to stop the wrong lens implant being inserted by mistake.
- The trust developed the 'Safer Surgery' programme, initially in response to the WHO checklist in 2009. The programme included a patient safety lead for theatres and a patient safety champion in each speciality theatre team. The patient safety lead and champions provided a network of communication across the trust.
- The trust standardised theatre practices and processes at QMC and Nottingham City Hospital to ensure safe

ways of working and reduce inconsistencies. An example of this was the re-design of the swab record boards to meet the needs of all surgical specialities. Magnetic headings were used to allow surgical teams to set up their board for each case so that the swabs, sharps and instrument counts were safe and consistent.
- Staff assessed all patients on admission to the wards for their risk of developing pressure ulcers. Each ward had a link tissue viability nurse who checked that staff completed and acted on risk assessments. Staff gave patients a leaflet to explain the risks of pressure damage and how it could be prevented.
- All of the surgical wards used an electronic system to monitor patients' physiological observations, such as body temperature, pulse rate and blood pressure. Staff used hand-held devices to record observations. There was a track and trigger system to alert staff to any changes or deterioration in the patient's condition. The system automatically alerted doctors and the critical care outreach team when there were significant changes.
- Ward sisters used the electronic devices to give them an overview of all patients on their ward. This meant they could easily check if staff were taking appropriate action in response to changes in patients' observations.
- Staff demonstrated their awareness of the risks of sepsis and the action to take if they suspected sepsis. Sepsis is a potentially life-threatening response to an infection. Early identification and specific treatment is essential to reduce the risk to patients. We saw that nurses took appropriate action if monitoring of physiological observations showed possible symptoms of sepsis.
- Medical input was available when required for surgical patients. This included input from an ortho-geriatrician, (a specialist in the care of older people undergoing orthopaedic surgery).

Nursing staffing

- Nursing staffing levels were measured against the National Institute for Health and Care Excellence (NICE) guidance of a minimum of one qualified nurse caring for eight patients. The trust had recently reviewed and increased staffing levels on the surgical wards.
- The Association of UK University Hospitals acuity tool was in use to help decide staffing levels. Teams discussed the level of patients' needs at shift handovers and there was a scoring system to show this. We saw the scoring system used on two out of the 10 wards we visited. Not all staff we spoke with knew how to use the scoring system. However, we saw that staff were able to react quickly when changes in patients' needs required a higher level of staffing.
- There were significant staff vacancy levels on some wards. There were vacancies for four nurses (whole time equivalent posts) on one of the neurosurgical and spinal wards. This was included on the directorate risk register.
- Staff recruitment was on-going and had included initiatives such as recruiting from other countries and ward staff being involved in job fairs.
- Agency nurses covered nursing and healthcare assistant shifts. Agency staff had orientation and induction on the wards.
- Agency use varied on each ward. There was particularly high use of agency nurses on the colorectal surgery wards – up to 37% in June 2015. To address this, there was on-going recruitment of permanent staff.
- Wards used specialist agency staff for patients with neurological problems because of the specific expertise required.
- Despite the staff vacancy levels, most staff told us staffing was usually sufficient to meet patients' needs. Nurses told us they could escalate any concerns about staffing levels and they found the ward sisters and matrons supportive in obtaining more staff when needed. Staff told us that gaps were usually filled by ward staff working extra shifts, staff moved from other wards, or by bank or agency staff.
- The trust had recently reviewed nurse staffing in the neurosurgery post-operative unit and changes had been made to meet patient needs. There was an additional 'twilight' shift on two days each week to coincide with the neurosurgery theatre lists.
- Staffing levels in the surgical triage unit had been increased in the afternoons as this was a busy time. Staffing of the unit was under review, looking at further increasing the staffing for peak times.
- The nursing staffing on wards caring for patients with neurological problems included nurses with expertise in mental health and learning disabilities. These nurses were able to use their skills and knowledge to provide the specialist care and support needed.

Surgical staffing

- Medical staff skill mix was similar to the England average with slightly more registrars at this trust than the average.

- The surgical triage unit had a consultant based there 8.30am to 5.30pm, Monday to Friday. Outside these hours, a registrar provided cover.
- A consultant anaesthetics was resident from 8:00 am to 9 pm seven days per week. There were three consultant anaesthetists on call every night, seven days a week.
- Nurses on some wards said that medical cover at night could be a problem. They described long waits for doctors to come to the ward to prescribe medicines and intravenous fluids. The doctors covering at night did not always have surgical experience, but they could get advice from on-call surgical doctors.
- Use of locum doctors was high in some specialities, such as neurosurgery and ophthalmology. Long-term locums were used for difficult to recruit to vacancies to provide continuity.

Major incident awareness and training

- The trust major incident response policy provided comprehensive guidance for staff in the event of a major incident. This included guidance for specific surgery staff at QMC, such as senior nurses on duty and consultant surgeons on duty or on call.
- The trust had business continuity plans to provide guidance for staff in the event of incidents such as loss of communication systems, flood damage, or widespread illness among staff.
- The surgical wards managed under the trust's Musculoskeletal and Neurosciences (MSKN) directorate kept the major incident policy and business continuity plans easily available on emergency planning boards. These boards were displayed prominently on the wards and had information immediately to hand for staff to use. Other surgical wards did not have the same system and staff could not always find the information quickly or easily. Staff working on MSKN wards told us they understood all wards across the trust were to have the boards. However, staff on other wards were not aware of this.
- The sterile services department had business continuity arrangements in place with an external provider. The department tested these arrangements successfully in 2015 when it shut down for five weeks for maintenance and refurbishment.

Are surgery services effective?

Good

The effectiveness of surgery services was good.

Care and treatment were evidence based and in line with local and national guidance. Outcomes for patients were generally in line with or better than national averages.

Patients' pain relief, nutritional and hydration needs were generally well managed. Consent to care and treatment was not always fully in line with legislation and guidance.

Staff were supported to maintain and further develop their skills and experience. Multidisciplinary team working was well established and effective in ensuring patients' needs were met.

Evidence-based care and treatment

- Care and treatment was in line with local policies and national guidance. Staff followed trust policies, for example, in the care and treatment of patients with an infection. National Institute for Health and Care Excellence (NICE) guidance was followed, including the care of acutely ill patients. Staff acted on recommendations from the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), including the use of a system to identify patients at risk of postoperative mortality and morbidity more rapidly and easily.
- Monthly governance meetings included discussion of new NICE guidelines and compliance with existing guidelines.
- Patients' pre-operative assessment for planned surgery was in line with NICE guidance. Staff assessed patients, looking at any known risk factors and ensuring unnecessary tests were not carried out.
- Elective (planned) surgery accounted for 57% of all surgery carried out at Queen's Medical Centre (QMC). Most of this was carried out as day case surgery. This was in line with national guidance and research based evidence. There are recognised benefits of day case surgery, rather than inpatient admission, for patients, staff and NHS trusts.
- There was an Enhanced Recovery After Surgery (ERAS) programme for some patients having planned surgery. Staff identified patients suitable for ERAS through pre-operative assessment. The aim of enhanced

recovery was to improve the patient's recovery from surgery so that they were able to return to their normal activities sooner. Using ERAS had led to shorter stays in hospital for those patients.

- Staff offered acupuncture to patients to relieve post-operative nausea and vomiting. This was based on research studies that showed acupuncture to be at least as good as anti-sickness medication. Acupuncture could also be used safely alongside medication if needed. The use of acupuncture at QMC was in the early stages and so there was little data available to show its effectiveness. Staff told us that in the first six months 60% of patients using acupuncture had found it beneficial.
- Surgery services participated in a range of local and national audits. The audit plan for 2015 / 2016 included local audits in response to patient and staff concerns, and national audits, such as the National Inflammatory Bowel Disease Audit. Managers and clinicians at monthly governance meetings reviewed audit reports and planned action in response to findings.

Pain relief

- Nurses discussed pain relief with patients at their pre-operative assessment for elective surgery. Post-operatively, staff asked patients about their level of pain when they carried out regular monitoring of physiological observations.
- There was a specialist pain management team providing a service to assess and treat patients on the wards. Each patient had a care plan about how their pain should be managed and this included details of how to contact the pain team for support and advice. Treatments used for chronic pain included transcutaneous electrical nerve stimulation (TENS), acupuncture, nerve blocks and counselling in pain management.
- Most patients we spoke with told us their pain was well managed. Three patients, (on different wards), commented that there were often delays at night in getting pain relief if they had to wait for a doctor to prescribe medication.

Nutrition and hydration

- Staff assessed all patients for their risk of inadequate nutrition and dehydration. Patients at risk had appropriate care plans in place including monitoring of their food and fluid intake. Staff referred patients at higher risk to the dietitian and / or speech and language therapists.
- Catering at QMC was provided by an outside contractor. Catering staff came onto the wards morning and afternoon to collect menu orders from patients. Patients told us they had sufficient choice of food, including special diets. There were mixed comments about the quality of food: some patients were satisfied with the quality but others felt the meals could be improved.
- At mealtimes, patients needing help to eat and drink were served their meals on red trays. We saw that staff knew which patients needed help and assisted them. Volunteers were available on some days to assist patients with their meals.
- We observed the lunchtime meal being served on one ward and saw that the first course and pudding were served to patients at the same time. This meant that a hot pudding may be cold by the time the patient had finished their first course, or ice cream may be melted. One patient commented that there was, "Too much food" and they may have found it off-putting being presented with the whole meal.
- If patients had missed a mealtime, meals could be ordered or there were sandwiches and snack boxes available.
- Water jugs were available for every patient and were refreshed during the day. We saw that water jugs and drinks were within patients' reach.
- Theatre staff had initiated the 'Think Drink' project in response to feedback from patients who felt dehydrated whilst waiting for their operation. Before the project started, many patients were 'nil by mouth' from midnight on the day of their operation. This meant they did not have anything to drink for at least eight hours before surgery, often longer. The project aimed to prevent dehydration by promoting appropriate fasting for pre-operative patients. This resulted in new guidance for staff to identify which patients could have a drink up to two hours before their operation. Patients had information about when they must stop eating and drinking before their operation.

Patient outcomes

- Emergency surgery accounted for around 42% of all surgery carried out at QMC. Patients who have emergency surgery are generally known to be at higher

risk of adverse outcomes, including death. Patients who have an emergency laparotomy, (where the abdomen is opened), have a particularly high risk of poor outcomes. A team at the trust led by two consultants had launched an emergency surgery safety improvement programme in 2014. The programme looked at the whole pathway for patients coming into the hospital with abdominal pain. One focus of the programme was to ensure these patients had a thorough and rapid assessment to identify those at high risk of death as early as possible. The Emergency Laparotomy Audit led to an action plan of emergency laparotomy improvements for completion in February 2016. Since the programme had started, the overall mortality in emergency laparotomy surgery had dropped from 14% to 11%, which was in line with the national average.

- Day case surgery accounted for 38% of all surgery carried out at QMC and made up more than 66% of elective surgery.
- The trust's performance in the national bowel cancer audit 2014 was mostly in line with or better than the England average.
- Patient Reported Outcome Measures (PROMs) for hip and knee replacements showed the trust had improved and were in line with the England average. PROMs are the results of questionnaires completed by patients before and after surgery about their perceived health improvement
- The Anaesthesia Clinical Services Accreditation Scheme (ACSA) is a voluntary scheme for NHS and independent hospitals that offers quality improvement through peer review. The consultant anaesthetic group at QMC had agreed to participate in ACSA and had recently submitted the registration process. The trust had appointed an ACSA lead and there were some ACSA accredited reviews as part of the consultant body.
- 61.5% of patients with a hip fracture were admitted to an orthopaedic ward within four hours of arriving in the emergency department. This was in line with the best performing hospitals in England.
- For patients admitted to wards for planned surgery, the length of stay was slightly worse overall than the England average. Managers and leads of surgery services said the case mix of patients at QMC had an adverse effect on length of stay data. This was because a significant number of patients had their planned surgery at an independent treatment centre on the QMC campus. These were usually patients with less complex needs who were at lower risk of complications following surgery. The patients having planned surgery at QMC tended to have more complex needs and often needed a longer stay in hospital to recover from surgery. (The length of stay data for patients in the treatment centre was not included in the data for QMC).
- The average length of stay for patients having emergency surgery was worse than the England average overall, though some individual specialities were better than the England average.
- The risk of readmission rates for planned and emergency surgery at QMC were about the same as the England average.
- Local trust wide audits included audits of patient observations, infection prevention and control measures, and patient records. Staff had feedback from audits and they took action to address any issues.
- Audits carried out by the sterile service department showed improvements in their service. The incidence of unavailability of equipment, failure of decontamination and damage to equipment had all reduced in the last two years. This had contributed to a reduction in cancellation of operations for non-clinical reasons.

Competent staff

- There was a preceptorship programme for newly qualified nurses that included specific competencies for the ward or area they were working in.
- Newly qualified nurses had the opportunity to work across different specialities in rotation. This gave nurses a range of experience and skills and helped with staff recruitment and retention.
- There was a specialist preceptorship programme in theatres for newly appointed band five theatre practitioners and band two theatre support workers. This supported new staff, regardless of their previous theatre experience, to ensure they were trained to correct standards.
- Staff working in theatres attended a training and education day every two months. There were no planned operations scheduled for that day to allow as many staff as possible to attend. Topics covered included dementia awareness, radiation protection, and learning from serious incidents.
- Ward staff were encouraged and supported by their managers to gain skills and experience specific to their role. Examples of this were leadership courses for band six nurses and head and neck foundation courses for

nurses working in this speciality. Some healthcare assistants had additional training to carry out tasks such as taking blood or removing catheters. This meant less waiting for patients and results of tests were available more quickly.

- Medical staff we spoke with were generally happy with the training provided. They said there were sufficient opportunities to carry out or assist with operations, including opportunities to go to other local NHS hospitals.
- Staff we spoke with told us they had annual appraisals. They said the appraisals included discussion of their learning and development needs.
- We requested information from the trust to show how many staff in surgery services had received an annual appraisal. The information provided was for four of the seven directorates providing surgery services and showed that between 88% and 92% of their staff had received an appraisal in the last 12 months.
- Medical and nursing staff told us they had sufficient support for revalidation. Revalidation is the process used to ensure doctors and nurses are practising safely.

Multidisciplinary working

- Multidisciplinary team working was well established and effective with daily communication between all teams within the surgical wards and theatres.
- Multidisciplinary working was evident from patients' records. We saw that patients were referred appropriately for advice and support from allied healthcare professionals and specialist nurses.
- Ward staff used the electronic monitoring system to make referrals to allied healthcare professionals. Staff told us this system worked well, allowing patients to be seen more quickly and saving time for staff.
- Ward staff spoke highly of the specialist nurse teams. Specialist advice and support available included pain relief, tissue viability (treatment of wounds and pressure ulcers), and caring for acutely ill patients.
- Speech and language therapists were provided by another NHS trust. There were different levels of service available for some groups of surgical patients. There was a dedicated speech and language therapist for patients having neurological surgery, but not for patients having spinal surgery. This meant that the spinal patients could wait longer to be seen by a speech and language therapist.
- There was a standard operating procedure etiquette for the theatre team to guide them on appropriate behaviour. This included respect, professionalism and effective communication in multidisciplinary team working.
- There was a weekly meeting to review patients waiting for discharge and look at solutions to delays in discharging patients. This meeting included local authority social services staff.

Seven-day services

- Emergency surgery and the surgical triage unit were available 24 hours a day, seven days a week.
- Planned surgery was usually carried out Monday to Friday.
- There were daily consultant ward rounds, including at weekends. Medical and nursing staff told us there were no problems with getting consultant advice and support out of hours if needed.
- There was an on-call pharmacy team available out of hours and at weekends.
- Physiotherapists and occupational therapists were available on-call out of hours and at weekends.

Access to information

- Patient medical records were kept in trolleys for each bay on the wards so they were easily accessible for staff to use. Nursing care records were kept at the end of patient beds or with the medical records.
- Diagnostic test and x ray results were available electronically. This meant staff had quick and easy access to test results and appropriate treatment for patients could be given promptly.
- The surgical triage unit had 24 hour administrative support so patient's medical records could always be obtained when needed.
- GPs had direct access by telephone to the consultant on the surgical triage unit so they could get timely advice about patients.
- Summaries of the patient's care and treatment were sent to their GP on discharge from hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us that staff asked them for their consent to care and treatment. We saw in the medical records that patients had signed consent forms before treatment and surgery.

Surgery

- For planned operations, we saw that staff gave patients information about the risks and benefits of surgery when they attended for pre-operative assessment.
- Nursing and medical staff we spoke with were aware of the Mental Capacity Act 2005 (MCA) regarding those patients who may not be able to give informed consent. Staff routinely considered patients' capacity to give consent and to make decisions about their care and treatment
- However, staff did not always understand or correctly apply the principles of the MCA. The MCA says that assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general. The MCA is clear that staff must make every effort to provide information in a way that is most appropriate to help the person to understand. We looked at the records of the assessment of mental capacity of eight patients. Only one record had details of the specific decision for the patient; the other forms either did not note the decision to be made, or gave a general decision. None of the assessments noted what efforts were made to help the patient to understand the decision to be made.
- Nursing and medical staff showed an understanding of the Deprivation of Liberty Safeguards (DoLS). Ward staff referred applications for DoLS to the trust safeguarding team who carried out assessments to ensure the deprivation was in the patient's best interests. However, as noted above, the assessments of capacity did not always follow the principles of the MCA.

Are surgery services caring?

Good

The standard of patient care provided by surgery services was good.

Staff treated patients with compassion, kindness, dignity and respect. Most patients we spoke with or had feedback from were positive about the care they had received. Most patients felt that they had sufficient information about their care. Patients were involved in their care and treatment and had opportunities to ask questions, although some patients felt there could be better communication about how long they had to wait for scan results.

Friends and Family survey results showed that 90 – 100% of patients would recommend the service.

Clinical nurse specialists were available to help patients with specific emotional needs, for example patients with cancer.

Volunteer visitors from the chaplaincy came to see the patients on request.

Compassionate care

- Most patients we spoke with were positive about the care they received. Patients told us they felt well looked after and that staff were helpful and kind.
- We saw staff responding with compassion to patients who were in pain, discomfort or emotional distress. One patient told us they had been in the hospital several times in the last year and they felt the attitude of staff and the care provided had improved during that time. Two other patients told us they felt staff were not always as caring and compassionate when they were very busy.
- Patients told us their dignity and privacy were respected. Staff usually answered call buzzers promptly so that patients had help when they needed it. We saw that staff used curtains around beds when helping with personal care.
- A survey of patient experiences by Healthwatch showed that most of the 31 patients who responded had a positive experience of surgery services at Queen's Medical Centre. Most of the positive comments received were about the staff. There were two negative comments about lack of compassion for emotionally distressed patients.
- All surgical wards used the Friends and Family Test. This is a survey which asks patients whether they would recommend the NHS service they have used to friends and family who need similar treatment or care. The response rate for QMC and for the trust overall was better than the England average. Most surgical wards at QMC scored between 90% and 100% for the number of people who would recommend the service.

Understanding and involvement of patients and those close to them

- Most patients and their relatives / carers we spoke with told us staff gave them enough information about their care and treatment. One patient told us they had plenty of opportunity to ask questions and said, "What I asked, they have answered." A relative told us about the positive and appropriate efforts made by medical staff to explain treatment to a person with a learning disability.
- Three patients on one ward were waiting for scan results and felt there could be better communication about how long they could expect to wait. One of the patients said, "I don't like to keep asking as I don't want to be a nuisance."

Emotional support

- Clinical nurse specialists were available to provide emotional support for patients, for example, patients with cancer or patients having stoma surgery.
- Some wards had quiet rooms and day rooms that were suitable for difficult discussions and emotional support in private surroundings.
- Volunteer visitors from the chaplaincy came to see patients on request. One patient told us these visits gave them support and reassurance.

Are surgery services responsive?

Good

The responsiveness of surgery services was good.

Surgery services were planned and delivered to meet the needs of local people and those from further afield requiring specialist services.

Patients had timely access to the care and treatment they needed with priority given to those in most urgent need.

Complaints and concerns were listened and responded to and used to improve the quality of care for patients.

Service planning and delivery to meet the needs of local people

- Queen's Medical Centre (QMC) provided a wide range of planned surgery, such as treatment for eye, ear, nose and throat conditions, spinal surgery, and treatment of bladder and bowel conditions. The trust worked with commissioners, other NHS trusts and independent providers to ensure surgery services were available and accessible for patients locally and further afield.
- There were two dedicated general emergency theatres at QMC, plus shared use of a third theatre. There was dedicated emergency theatre time for specialities within their theatre timetable, plus 24/7 emergency surgical cover for neurosurgery and spinal surgery.
- The neurosurgery services at QMC accepted adult referrals from hospitals in a wide catchment area, including Derby, Burton, Leicester and Boston.
- The neuro-spinal post-operative unit (NSPU) was set up in November 2011 to provide care for patients following surgery for up to 48 hours. Staff identified the need for this unit because they found patients did not always recover well immediately post-operatively on the neurosurgical or spinal wards. The NSPU was able to provide a higher level of staffing and support for patients.
- The surgical triage unit (STU) was set up in January 2015 to assess patients with acute general surgical problems. Patients came into the STU from the emergency department or directly from home after seeing their GP. Protocols were in place with the East Midlands Ambulance Service to bring some patients directly to STU, bypassing the emergency department. Children were not seen in the STU; though young people aged 16 to 18 were given the choice of being seen in the STU or the children's ward.
- Ultrasound scans were available in the STU Monday to Friday. This cut down waiting time for scans and meant patients did not have to go elsewhere in the hospital.
- Facilities did not always support patient centred care. A toilet was out of order with a notice to say it would be repaired by 7 September 2015, (the week before our visit). We also saw two shower rooms out of order on one ward. Staff told us these needed major repairs and this was planned as part of the rolling programme of refurbishing all the wards. Other bathroom facilities were available to patients on the ward.
- Most wards we visited lacked storage space, particularly for larger items of equipment such as lifting hoists. This meant that areas were sometimes cluttered with equipment, or equipment was stored in rooms intended for other purposes.

Access and flow

Surgery

- Referral to treatment times, (waiting list time for an operation), were consistently better than the national operational standard and better than the England average. The national operational standard is for 90% of patients to start their treatment within 18 weeks of referral. Surgical specialities across the trust achieved 92% to 100% of patients starting treatment within 18 weeks of referral. The one exception to this was trauma and orthopaedics where just over 89% of patients started their treatment in the 18 week period.
- Site matrons and bed managers met three times a day. These meetings looked at the quick and safe management of the flow of patients through the hospital. Staff matched up patients waiting for beds on the wards with the beds available and made suitable arrangements for patients waiting to go home.
- There were weekly meetings to discuss all patients who had been in hospital more than seven days. The meetings were multidisciplinary, including local authority social services staff, and looked at how to safely discharge the patients from hospital.
- There was an ongoing project to improve theatre productivity so that more operations could be completed in the same theatre time. The project started in April 2012 and the overall use of theatres at QMC had increased from 76% to 95% by the end of March 2014. This had resulted in more than 1000 additional operations taking place in the same theatre time in 2013 / 2014 as compared with the previous year. Theatre staff told us and showed us that the improvement in use and productivity of theatres had continued into 2015.
- Use of the STU reduced patient overall waiting time and reduced the number of admissions to surgical wards. A doctor saw patients within 10 minutes of arrival in the STU for an initial triage assessment. Patients then waited around 30 minutes on average during the day, longer at night, for a full assessment of their condition and a plan of care and treatment. Patients moved onto the adjacent surgical admissions ward or on to other wards or were discharged home. Some patients went home with arrangements to return for an outpatient appointment. The overall waiting time for patients was an average of four hours from coming into the STU to transferring to a ward or going home. This compared well with the situation before the STU was set up when patients could have an overall wait of up to 22 hours.
- GPs could phone the consultant on duty in the STU for advice before sending in patients. This cut down on unnecessary admissions.
- Bed occupancy rates were between 80% and 88% in 2015. This was in line with the England average.
- The rate of planned operations cancelled on the day of surgery in 2014 / 2015 met the national standard of less than 0.8% and was lower than the previous year. The top three reasons for cancellation were emergency patients taking priority, over-running of the theatre list, and equipment not available.
- When a patient's operation is cancelled on the day of surgery by the hospital for non-clinical reasons, patients should be offered another date within the next 28 days. The percentage of patients at QMC whose operation was cancelled and who were not treated within 28 days had been below the England average since January 2013. The number of patients affected was very low: 10 patients in 2014 and three patients from January to March 2015.
- Around 75% of patients with a fractured hip had surgery within 48 hours of admission. This was in the middle range of performance when compared with other hospitals in England.

Meeting people's individual needs

- There was a Learning Disability Liaison team with staff provided by another NHS trust. The team had an office base on the QMC site with access to the trust's electronic systems. Staff alerted the team when they were caring for a person with a learning disability.
- We spoke with a small group of parents and carers of people with a learning disability who said they were pleased with this service. The parents and carers said the team supported them well. However, they felt there was a gap in the service as it was not available at weekends.
- The trust had a dementia strategy in place outlining the care that people living with dementia could expect when admitted to the hospital. This included an assessment of patients over the age of 75 to check for possible signs of dementia. We saw that staff assessed patients as required.
- The staff on one ward participated in a project to improve the outcomes for patients with hip fractures

who were also living with dementia. The improved outcomes included reduced length of stay in hospital, fewer post-operative complications and a reduction in the number of re-admissions.
- Staff from another NHS trust provided the Rapid Response Liaison team for patients who needed mental health support. This included assessing patients for anxiety and depression . Ward staff spoke positively of the response and support provided by this team.
- The Friends and Family test was available in alternative formats, such as large print or with pictures and symbols as well as words. These formats may be easier to use for patients with a learning disability or those living with dementia.
- There was an interpreter service available by telephone or in person for patients who did not have English as their first language. Some staff spoke other languages and were able to interpret. Staff we spoke with were aware they could use a British Sign Language interpreter if required for deaf people, though they could not recall ever needing to do this.
- Photo menu cards were available to help patients choose meals. This helped patients who may be unable to read a menu or understand the choices available.
- Some wards had a quiet room for use by patients or relatives. Staff told us these rooms were useful for difficult conversations with patients and relatives. Relatives used the rooms to have a break if they were staying with the patient for prolonged periods.
- Staff working in the surgical pre-admission unit made a short film giving advice and instructions to patients. The film included many members of staff so that patients would see familiar faces on admission. The film was available on the trust's website.

Learning from complaints and concerns

- There were displays of information about how to make a complaint on all the wards we visited. Two of the patients we spoke with had previously made a complaint about the service. Both were satisfied with the response from the trust and the action taken to address their concerns.
- Staff told us they would try to resolve complaints quickly and locally whenever possible. Ward sisters were involved in investigating complaints.
- Complaints were discussed at governance meetings and action planned to address issues raised. Staff gave us examples of learning from complaints and concerns. One example was a complaint made about the level of care provided by an agency nurse to a patient. Action was taken to ensure the competency of agency nurses to carry out the care required following certain operations.

Are surgery services well-led?

Outstanding ☆

The leadership and management of surgery services were outstanding.

Surgery services had a clear vision for enhancing the patient experience which was translated into measurable achievements by speciality action plans.

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

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

Staff were proud of working for the trust and spoke highly of the culture, communication and team working. Staff felt valued and respected. Staff worked collaboratively to improve patient care and experience.

Feedback was actively sought from people using the service. Staff used complaints, comments and other feedback to improve surgery services.

Vision and strategy for this service

- Surgery services had a clear vision. Staff at all levels understood how they contributed to the vision, values and service plan objectives which applied to them, especially the key priority which was 'Enhancing Patient Experience.'
- Strategic planning reflected best practice. Surgery speciality action plans interpreted the full range of corporate objectives, providing staff with a 'golden thread' to see how their work contributed to the organisation as a whole. Action plans also integrated

actions resulting from clinical audits such as the Emergency Laparotomy Audit and the WHO theatre checklist. Progress against these action plans was reviewed at directorate level on a monthly basis and half yearly on a corporate basis.

- Clinical Directors and other managers of surgical services were clear and open when discussing the vision and strategy for their specialities. They understood challenges to achieving the strategies, including relevant local health economy factors, and considered them in planning and delivering services. They worked systematically with partner organisations to improve care outcomes, tackle health inequalities and obtain value for money. A key trust priority was to 'develop new integrated models of care in partnership with other organisations' and each speciality contributed to this. For example, audiology was delivered in fourteen community settings. In the colorectal speciality, leaders were having discussion with neighbouring trusts to expand and develop outpatients services for patients with colorectal issues. This would lead to more day treatment for patients, without the inconvenience of an overnight stay and better value for money for the trust.

Governance, risk management and quality measurement

- Surgery services had an effective governance framework which supported improvement and innovation. Directorates held governance meetings monthly. Governance meeting had clear terms of reference and included discussions of performance, clinical effectiveness and risk management. These meetings fed into directorate and corporate governance meetings which enabled effective communication up and down the organisation..
- At the same time, management arrangements were strengthened by themed trust-wide groups, such as the Infection Control Group or the Falls Operational Group. This meant that leadership was effective across the range of surgical specialities and across both City and QMC sites. These themed groups enabled learning to be shared across the trust, and information was fed back to speciality level meetings. They also contributed to the strong collaboration between services.
- There was effective two way communication between senior leadership and ward staff. Staff representatives from each ward attended joint staff and management governance council meetings held monthly. Staff discussed issues such as learning from incidents, and presented ideas for improvements. Speciality plans were discussed at these meetings, giving staff an opportunity to contribute. The meetings fed into a trust wide meeting attended by the chairperson of each council.
- Staff were positive and enthusiastic about the joint governance arrangements they shared with management. One member of staff told us, "It really works well. It makes us feel involved and listened to." Staff gave us examples of changes made through shared governance, such as a more robust and standardised system for checking suction equipment on the trauma and orthopaedic wards. The trust planned to make this standard practice in all its wards.
- Managers and clinicians discussed performance, clinical effectiveness and risk management at speciality level governance meetings. If there was a shortfall in performance, ward based teams produced an action plan to rectify the situation. Risk management was effective with actions given out to escalate or mitigate risks. Leaders also discussed feedback from patients and planned innovations at governance meetings, along with information on best practice elsewhere..

Leadership of service

- Clinical directors and leaders showed an inspiring shared purpose. This was demonstrated through the successful initiative to improve and standardise theatre processes across QMC and City sites. They encouraged staff at all levels to develop skills, especially leadership skills, and to aim for promotion. This meant that staff were motivated and had the skills to contribute fully to continuous improvement projects.
- Ward staff were positive about leadership in their ward or area. Health care assistants and nurses said the ward sisters / managers and matrons were supportive, visible and approachable. Ward sisters told us they felt well supported and had good leadership from their managers.
- Nearly all the staff we spoke with had met the trust's chief executive and spoke positively about his leadership.

Culture within the service

- Staff felt respected and valued. Staff at all levels were involved in continuous improvement work, and

managers and peers gave them recognition. Staff were proud of achievements in their ward or area, such as significant reductions in patient falls and hospital acquired infections.
- Without exception, the staff we spoke with told us they were proud to work for the trust. They spoke positively of the culture within their own areas and of the wider organisation.
- Staff in all wards and theatres spoke highly of the communication and team working including staff of all levels and disciplines. We saw staff working collaboratively to improve patient care and experience, for example when receiving patients in theatres, and at the bed managers meeting.
- Staff were supported and actively encouraged by their peers and managers to report concerns and to present ideas for improvements. A healthcare assistant told us how their observations of care given to patients had led to them producing a presentation to the shared governance council. The presentation was aimed at nurses and healthcare assistants, reminding them to focus on the patient as an individual.
- Medical and nursing staff recruited from other countries spoke of the welcoming atmosphere at the trust. They were pleased with the support from colleagues and managers to help them to settle in.
- We observed an open, considerate culture with staff showing respect for their colleagues and demonstrating the values of the organisation.

Public engagement

- All wards used the NHS Friends and Family test to get feedback from patients. They also used an innovative approach to obtaining feedback. This involved collecting feedback on an electronic system on a hand held device. Results were prominently displayed on each ward.
- Staff displayed details of action taken in response to comments from patients. This included the creation of rooms on two wards to give patients and relatives a quiet, calm space to use.
- Theatre patient champions collected feedback from patients and visited patients on the wards post-operatively. Between April 2014 and June 2015, they collected feedback from over 1500 patients, (at both QMC and Nottingham City Hospital). Information collected was discussed at regular theatre patient and public involvement (PPI) meetings. Staff took action to address issues raised by patients. This included reducing waiting times for patients in theatre reception and providing food and drink to patients when their return from theatre was delayed.
- The 'Think Drink' project resulted from feedback from patients who felt dehydrated whilst waiting for their operation. The project made improvements in maintaining patients' hydration pre-operatively.
- People could watch a short film on the trust's website giving information and advice about coming into the hospital for an operation.

Staff engagement

- Staff we spoke with said that staff morale was good in their own areas and in the wider organisation.
- Staff felt engaged and involved through the shared governance councils. As well as improvements in patient care, staff could bring other ideas. Staff from one ward had asked for improvements to their staff room. They were pleased when the room was redecorated and a new kettle and microwave provided.
- Staff working in surgery services were supported to attend an annual patient safety conference in January 2015. There was no planned surgery scheduled on this day to enable as many staff as possible to attend the conference.
- Medical staff had come to work in spinal surgery because of national and international recognition of the spinal unit at QMC. One of these staff told us, "I had high expectations of the training here and I feel I have got what I came here for."
- Staff were involved in recruiting new staff through job fairs and going to Portugal to speak with nurses there wanting to work in the UK. A ward sister spoke positively of their involvement in recruiting staff. They had produced a montage of photographs of ward staff holding placards with their reason for enjoying working on the ward. This was displayed at a job fair and had attracted new staff.

Innovation, improvement and sustainability

- There was a strong focus on continuous learning and improvement for all staff in surgery services. This included a development programme for staff working in theatres. Support workers, (band four staff), in theatre were supported and provided with training to develop and improve their skills and experience. Staff working at bands five and six had support and training to develop

competency within their role and their leadership skills. This meant these staff were able to move more easily into more senior roles and were able to support the service in the absence of team leaders.

- Theatre staff had successfully standardised practices and processes at QMC and Nottingham City Hospital to ensure safe ways of working and reduce cultural differences. The theatres safety improvement programme implemented a variety of safety projects. It ensured that all theatre staff were trained on team etiquette. This emphasised safety, mutual respect, effective communication, accountability and situational awareness. As a result, theatres ran more safely and efficiently.
- One orthopaedic ward was identified as having a high number of incident reports for stage two pressure ulcers within a short period. Staff on the ward undertook a review of the reports of pressure damage. They found various issues that were contributing to the high number of reports, including staff incorrectly assessing pressure ulcers and making duplicate reports. Action taken included teaching sessions and displays of advice for staff. The outcome of the project was a significant reduction in reported stage two pressure ulcers. Information about the project was displayed on the ward for patients and visitors to see.
- There was a 'Dragons Den' project where staff could present their ideas for service improvements. Theatre staff had been successful in presenting their ideas for improvements in equipment used in vascular surgery at QMC.
- The theatre PPI group had been shortlisted for a Nursing Times Award for Enhancing Patient Dignity and were due to present their work in September 2015.
- Theatre patient safety leads were invited to present their work at a conference in Columbia in May 2015.
- The theatre PPI group were working on a DVD to show to patients before their operation. The DVD will show patients what to expect when coming to theatres to help reduce fear and anxiety.

Critical care

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

Information about the service

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

This location report refers primarily to the adult critical care provision at the QMC, however the adult critical care provision at the City Hospital Campus is under the same management team and the two sites work together. City hospital critical care provision is referred to within this location report where applicable.

The critical care service provides level three (L3) intensive care for patients requiring support for two or more vital organs, and level two (L2) high dependency care for patients requiring support for one or two vital organs.

L3 patients require one to one nursing care and L2 patients require one nurse to two patients.

The QMC adult critical care service comprised of three units :-

- Adult Critical Care Unit (AICU) which has 21 beds for patients requiring L3 care.
- Surgical High Dependency Unit (SHDU) which had 21 beds for patients requiring L2 care.
- Medical High Dependency Unit (MHDU) which had 12 beds, eight of which were designated as L2. This unit was managed by intensive care nurses but clinical management was provided by the patients' medical consultant.

The service runs 24 hours 365 days and provides high levels of care for emergency, trauma and elective surgical patients.

Additionally there is a Critical Care Outreach Team (CCOT) that supports the identification of the deteriorating patient through staff education, direct referral and by following up patients following transfer to the ward from critical care.

NUH critical care is a member of the Mid Trent Critical Care Network (MTCCN). This is a group of geographically close critical care units which work together to promote consistency of patient care and share expertise in improving standards of care.

Between April 2014 and March 2015 there was 95% bed occupancy at L3, which was equivalent to 813 bed days per month and 70% bed occupancy at L2, which was equivalent to 1,265 bed days per month.

During our inspection we visited AICU, SHDU and MHDU at the QMC and met with the senior management team. We also met the senior nurse within CCOT and a consultant with a particular interest in recognising and rescuing the deteriorating patient.

During our visit also spoke with three senior nurses, fourteen nurses, six consultants, eight junior grade doctors, two physiotherapists two receptionists, three patients and eight relatives/visitors. Seven sets of patient records were reviewed.

Critical care

Summary of findings

We found the adult critical care services at QMC to be good for safe, effective, caring and responsive, and outstanding for well led.

Patients and visitors consistently expressed satisfaction with the care and treatment they received, stating that staff went out of their way to support them during a difficult time.

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

Training and support for staff development was established, however we did have concerns that there was limited access to the post registration critical care module for registered nurses.

Care was patient centred and focussed on continual assessment, including an outstanding approach to safeguarding and the application of Deprivation of liberty when required.

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

The service had a comprehensive annual plan with clear actions, measurable outcomes, named responsibility and targets.

There was a systematic approach to working across the trust to improve care and outcomes for patients and provide best value for money.

Staff worked very well together across hospital sites and across departments. There was a collective enthusiasm across all staff groups and a clear knowledge of the vision, values and strategic goals for critical care. Staff told us they were proud to work in the department.

Governance processes were established across adult critical care with active involvement from all staff groups. Staff unanimously spoke highly of the local leadership and said they felt supported and able to raise concerns or challenge decisions about patient care.

There was a positive culture of innovation and service development which was not only shared within the critical care and across the trust but also extended to other trusts through training within the departments clinical simulation centre.

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

Critical care

Are critical care services safe?

Good

The safety of the critical care services was good.

There was an openness and transparency about safety, with people receiving a sincere and timely apology when things went wrong. Staff were encouraged to report incidents, and lessons learnt were communicated widely to support service improvement. There was good examples of how sharing and learning from incidents had improved safety for patients within critical care.

There was a low level of hospital acquired infection reported on the safety thermometer and local infection control procedures were followed.

Equipment was maintained and readily available as required.

Medical staffing numbers met the critical care core standard levels for the bed capacity within AICU and SHDU critical care areas however; MHDU medical cover was provided by the medical directorate and did not meet the minimum core standard for L2 care of one consultant to 15 patients. Plans were in place for critical care to take over the medical management of MHDU patients from December 2015, which would address this. The service was in a period of transition with planning in place for this expansion, patient safety was a priority with nursing and medical staff working together to support this.

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

Medicine storage was safe with access being through electronic fingerprint recognition. However, there were concerns relating to the safe checking and administering of medication at the bedside within the adult critical care areas.

Entry to the critical care units was by a secure intercom system.

Incidents

- Incident management within the QMC adult critical care reflected the open and honest approach which was evident across all of the adult critical care units within NUH.
- Staff understood and fulfilled their responsibility to report concerns, near misses, and incidents on the trusts electronic reporting system. New staff were given guidance and supported in this process.
- There was positive reporting culture across critical care with 430 incidents reported in the four months prior to our inspection. Details provided by the trust demonstrated that each incident was appropriately reported and actions taken where required. There were no never events reported.
- Lessons were learnt and communicated widely to support improvement. We observed a recent patient safety incident being shared with staff at the shift handover on the AICU, changes were made immediately to prevent a further occurrence and staff were reminded to be extra vigilant with labelling of medication administration lines.
- Another example of sharing and learning was a revised documentation relating to skin assessments that had resulted in a fall in avoidable pressure ulcers since July 2015.
- A 14 day handover communication tool, used on all adult critical care units, ensured that staff were informed of the incident within 24 hours. This tool was also used to inform staff of all safety alerts.
- Regular critical care patient safety council / governance meetings were attended by all staff groups. We reviewed four sets of meeting minutes and noted that actions were updated and outcomes shared.
- A quarterly report called 'Sweet Treats' covering patient and non-patient related incidents was issued. The July to September 2015 edition included a range of topics from needle stick injuries to communication problems.
- Duty of candour (A statutory requirement to be open an honest with patients when errors occur) was generally understood by critical care staff. We were told of a patient who had received an apology following an incident. Our review found this was fully documented in the patient's notes, and a follow up letter was sent to the patient explaining that the outcome of any investigation would be shared with them.

- Mortality and morbidity meetings take place across the critical care departments. Intensive Care National Audit and Research (ICNARC) data indicates that mortality rates are in line with those of similar critical care units.

Safety thermometer

- The safety thermometer is a NHS tool used for measuring, monitoring and analysing patient harm. Information about the safety thermometer was clearly displayed for staff and visitors to see.
- A combined adult critical care data sheet entitled 'performance at a glance' was on display in all units. For May / June 2015 there had been no reported incidence of Clostridium difficile (C Diff), Methicillin-resistant Staphylococcus aureus (MRSA) or patient falls. There were three reported pressure ulcers, which had been investigated and action plans were in place, these had been clinically unavoidable.

Cleanliness, infection control and hygiene

- All adult critical care areas appeared visibly clean and uncluttered.
- Staff were observed to be adhering to the trust's policy on infection control, including bare below elbows policy. Personal Protective Equipment (PPE) such as gloves and aprons were readily available. We observed staff changing PPE when moving between patients.
- Sharps boxes were in use throughout the critical care units and were not overfilled.
- There were hand gel dispensers throughout the department, and hand washing facilities were located between bed spaces.
- There had been 29 unit acquired infections in the twelve months May 2014 to May 2015 that had been investigated. A primary cause was cited as an increase in complex bowel patients and patients with chronic infections. This was being monitored with data submitted to ICNARC (Intensive Care National Audit and Research)
- The trust commissioned external cleaning services who undertook cleaning audits at a frequency determined by the risk category of the area. Critical care is designated a high risk area and is scheduled to be audited fortnightly. The cleanliness audit covered a range of areas from floors to cupboards and bathrooms Scores of 91 - 97% compliance were being achieved with no areas of concern highlighted. However, senior staff expressed concerns about the allocated time for cleaning services within some areas. SHDU opened to 20 beds in April2014 following a phased programme of commissioned additional beds, there was no additional cleaning provision for this area.
- Stored equipment appeared clean and was labelled as ready for use. However it was noted that a small number of items were not labelled.

Environment and equipment

- All adult critical care areas appeared clean and well maintained, although some areas of the estate were old and in need of updating. The priority was to replace the flooring in AICU, which had areas of damage with temporary coverings, which was a recognised health and safety risk. There was a plan to replace the flooring and the unit was piloting different surfaces prior to a final decision being made.
- All new and refurbished adult critical care areas met, or exceeded, the standards identified within the Core Standards for Critical Care (2013). Patient hoists were integral at each bed space and facilities were able to support the care of heavier (bariatric) patients.
- Equipment was serviced by the trust's medical electronics department, equipment viewed was labelled as tested with a retest date clearly displayed. Staff told us there was never a problem accessing equipment when needed.
- The risk register included the risk of patient harm through reduced access to monitoring on MHDU. This was due to the monitoring system becoming outdated and unsupportable in the long term. The manufacturer was providing support whilst funding for replacement was identified. Interim arrangements to support MHDU patients' requiring monitoring was in place including transfer of the patient to the AICU if necessary.
- Emergency equipment including resuscitation and airway management trolleys were easily accessible and were checked daily for correct content and use by dates.
- Entry to the critical care units was by secure intercom communication.

Medicines

- There had been 26, no harm, medication incidents reported within adult critical care (across QMC and City Hospital campus) in the four months prior to our inspection. Medication safety was included in the risk register and actions to improve medicines governance and safety was in the adult critical care annual plan for 2015/16.
- Five nurses were observed checking and administering medication but they did not follow trust policy and procedure. This included checking multiple items at once, and checking medicines whilst involved in another activity. No errors in medication administration occurred during these observations.
- Prescription medicines were stored safely in locked rooms which housed a medication storage system. The storage system required electronic finger print recognition to access and monitored stock levels, including controlled drugs; however, a manual check of controlled drug stock was carried out on each shift. These checks were found to be consistently correct.
- There were fridges for temperature sensitive drugs within the locked drug store rooms. Temperature levels were recorded daily and were within an acceptable range.
- A microbiologist attended ward rounds daily to monitor antibiotic prescribing.
- There was an Antimicrobial Stewardship Group and Medicines Education Group which provided prescription guidance.

Records

- Records were stored in a secure way that ensured patient confidentiality. A notice reminding staff not to leave notes unattended was displayed at the nurse's station.
- Seven sets of medical notes were reviewed and found to be correctly completed, legible, dated, and signed. There was a daily sheet outlining the patient's treatment and nursing plan. These were completed and updated throughout the shift.
- Conversations with relatives were recorded in patients' records by nurses and physicians.
- There was work in progress to digitalise medical notes and staff were closely involved in the development of this project.

Safeguarding

- Safeguarding was given a high priority within the adult critical care areas, supported by the matron and lead consultant. Staff understood their responsibilities and knew how to report safeguarding concerns.
- The matron had a special interest in safeguarding and had completed higher education in this area.
- Ninety eight per cent of critical care staff had completed adult safeguarding training to level 2. Level 2 is for staff with professional and organisational responsibility for safeguarding adults.
- Information about safeguarding was displayed in each adult critical care area.
- Staff demonstrated a good knowledge of safeguarding and knew who to raise a concern with. Mental capacity assessment was included in daily patient assessments.
- Adult Safeguard training had been completed by 98% of staff which exceeded the trust target of 90%.
- Information about safeguarding was clearly displayed on each adult critical care area.

Mandatory training

- Mandatory training across all staff groups within critical care was well attended and records showed 98-100% completion. This exceeded the trust target of 90%. Mandatory training included manual handling, fire safety, infection control, health and safety, information governance and safeguarding.

Assessing and responding to patient risk

- Risk assessments were completed daily for patients on the adult critical care units. This included mental capacity assessment, and observations for the development of delirium. Delirium is an acute, reversible, mental disorder which can occur as a result of disordered sleep-wake cycles resulting in a range of symptoms from withdrawal to agitation. Research has identified that this can occur in up to 80% of acutely ill patients and can affect their long term recovery.

Critical care

- Each critical care bed space had a booklet which staff could refer to for current guidance regarding patient assessments.
- Critical care observation charts were completed comprehensively and any signs of deterioration reported to the nurse coordinator or doctor promptly. The modified early warning system (MEWS) was used across all units. MEWS is a nationally recognised patient assessment tool that scores a patient in relation to regular clinical observations such as temperature, pulse, blood pressure, and respiratory rate. The score is an aid to recognising a deteriorating patient and gives clear instructions for escalation from increased frequency of clinical observations, to urgent medical intervention.
- Electronic observation recording (e-obs) was not in use within critical care although this was being considered. The nurse to patient ratio and immediate access to medical staff meant there was no delay in recognising and escalating the deteriorating patient.
- We reviewed notes on the critical care unit and found risk assessments were consistently and comprehensively completed.
- The Critical Care Outreach Team (CCOT) reviewed patients on the wards who had a score of four plus on the modified early warning score (MEWS).The audited response times for CCOT was 58 minutes for patients scoring four and for those scoring four to six was 29 minutes. This met recommended response times.

Nursing staffing – Adult Critical Care

- The total number of nursing staff across the adult critical care areas met the requirements of the critical care core standards. Level three (L3) critical care patients were cared for at a ratio of one nurse to one patient, and Level two (L2) high dependency patients were cared for at a ratio of one nurse to two patients. In addition, a senior nurse, band six or seven, was supernumerary as shift clinical coordinator.
- The workforce development plan identified 308 WTE (whole time equivalent) qualified nurses and 31 WTE nursing assistants were required to safely staff the department. There were 12 WTE vacancies which represented 3.7%.
- Adult critical care staff were actively involved in trust and local recruitment activities, including recruitment fairs and open days.
- Full nursing team handover was carried out at the start of each shift which included use of the 14 day handover tool. The 14 day handover tool was used to inform staff about incidents, complaints, policy changes and news for 14 consecutive days, ensuring all staff received relevant and current information. This was followed by individual patient handover at the bedside.
- The use of bank and agency staff was minimal, with only two shifts being covered by agency across all of the critical care units within NUH for the week prior to our inspection. There was a check list induction sheet for agency staff new to the department.

Critical Care Outreach Team

- The CCOT consisted of a specialist matron, band 8, 11.13 WTE band 7 sisters/charge nurses, 12 WTE band 6 deputy sisters/charge nurses and a 0.9 WTE specialist physiotherapist.
- The critical care outreach team (CCOT) provided support across the trust for patients transferred out of critical care, but who still required high level intervention. The CCOT supported ward staff in recognising and managing deteriorating patients.
- The service was available 8am to 8pm seven days a week. There had been a recent increase in funding to provide a 24 hour service; Friday evening to Monday morning (Phase one). If data identifies benefits to patient outcomes, a phase two was planned to increase funding for 24hr cover, seven days a week. Early indicators to the service expansion has seen a reduction from 6% to 4% in unscheduled ward admissions to critical care.

Medical staffing

- There was a suitably qualified and experienced consultant intensivist / anaesthetist as head of service for adult critical care.
- There were 18 consultants in post at QMC which met the core standard recommended ratio of one consultant to every 14 patients, Monday to Friday. This fell to one consultant to 20 patients at a weekend which does not meet the recommended ratio. However, there were

intermediate / advanced trainees (at registrar level) rostered ensuring senior anaesthetic cover was available at all times. A consultant in intensive care medicine was available 24/7 and able to attend within 30 minutes as required within the core standards.

- There were three consultant vacancies. One consultant had been appointed (starting February 2016), the other two positions were being advertised.
- Nursing staff told us they were well supported by medical staff and there was always medical assistance available when required. Locum consultants were employed at weekends when required.
- Handover between day shift and night shift staff was attended by consultants, junior doctors, physiotherapist, and the bedside nurse. This was followed by allocation of patients to the trainees who undertook a full examination of their allocated patients. There followed a full multidisciplinary round which included medical staff, physiotherapist, nurses, pharmacist and other health professionals at 11:30 when a daily plan was agreed for each patients
- There was an additional weekly multidisciplinary ward round for long term patients to discuss their treatment and rehabilitation planning.
- MHDU medical cover was provided by the medical directorate and did not meet the minimum core standard for L2 care of one consultant to 15 patients. At the time of our inspection, Pplans were in place for critical care to take over the medical management of MHDU. patients from December 2015, which was fully supported by the medical directorate However, following the inspection the trust informed us of alternative plans being put in place.. In the interim consultant anaesthetists were working alongside the physicians to ensure patients had access to appropriate and timely care.

Major incident awareness and training

- QMC was designated as a major trauma centre in April 2015.
- There were up to date policies and procedures available for the admission of single to multiple patients with information displayed in the AICU seminar room.

Are critical care services effective?

Good

We found the services provided within adult critical care were good.

Outcomes for patients were better than expected when compared with other similar services. Care and treatment was planned and delivered in line with current evidence based best practice and there was active and effective audits providing guidance for service improvement.

Staff were proactively encouraged to acquire new skills and share best practice. New staff were well supported and there was a positive culture of personal and professional development. The service did not meet the critical care core standard of a minimum of 50% of nurses with a post registration critical care qualification but there was good use of ward based educators.

Patients had their nutrition, hydration, and pain management needs assessed and appropriately managed.

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

Evidence-based care and treatment

- Patients care and treatment was planned and delivered in line with current evidence based guidance, standards and best practice including those set by the National Institute for Health and Clinical Excellence (NICE).
- There was a booklet for staff kept at each bed space that included guidance and explanation for all risk assessments, this included current policies to ensure best practice was followed. This booklet was reviewed and updated in April 2105.
- The adult critical care service was an active member of the Mid Trent Critical Care Network (MTCCN) and adhered to the agreed policies produced by the network. This included admission and transfer policies.
- There was an awareness of delirium that patients may experience as a result of treatment in a critical care environment. National best practice on the detection and management of delirium in adult critical care was followed.

Critical care

- There was an active audit team led by a critical care consultant along with the critical care clinical governance lead, nursing audit lead, and corporate audit officer.
- The audit report for 2014/15 presented a comprehensive range of national, trust wide, and local audits. We saw evidence that the findings from audits were implemented and practice improved as a result.
- Examples of audits included. Ventilator Associated Pneumonia Audit - which identified infections occurring in long stay patients with an action to look at new methods to protect these patients. Record Keeping Audit – which reported 95% compliance against the NUH record keeping policy and Matching Michigan Audit -(National program of reduction in rate of catheter related infection in critical care – which reported improving outcomes and an agreed action to undertake a root cause analysis on all positive catheter related infections.
- Staff were informed of audit outcomes through presentations, e-mail, governance meetings and newsletters.

Pain relief

- We saw evidence of pain scoring and appropriate administration of analgesia (pain relieving medication); however patients responses to analgesia administration was not always recorded in the daily treatment and evaluation plan.
- A behavioural pain scoring approach was being introduced within adult critical care. A behavioural pain score is a nonverbal assessment based on patients facial expression, upper limb movement and acceptance of mechanical ventilation.
- The pain management team visited daily to assess patients with epidural. An epidural involves an infusion of a local anaesthetic into the spine which numbs the nerves, stops pain and aids patient movement following surgery. Other patients requiring support with pain relief were seen by the pain team on referral.

Nutrition and hydration

- All patients had their nutritional needs assessed by a dietitian within 24 hours of admission to critical care Monday to Friday with an on-call service for advice at the weekend. A dietitian attended the multi-disciplinary team round for patients receiving long term critical care.
- Nutrition and hydration was maintained in a variety of ways. Orally whenever possible.by a naso-gastric tube or intravenously
- We reviewed two sets of patient's notes on MHDU and a food and drink plan was found to be place and completed.
- Fluid balance charts were maintained accurately within the critical care areas.

Patient outcomes

- Intensive Care National Audit and Research Centre (ICNARC) provides comparative data of patient outcomes within critical care. Data was submitted from AICU and SHDU separately, which had caused some data accuracy issues, for example patients who were admitted to AICU, then transferred to SHDU, and subsequently died had their death recorded twice (post AICU and on SHDU). This consequently gave a false mortality rate for the hospital. However, when adjusted locally, the hospital was within expected levels and mortality rates were low compared to national case mix data.
- The incidence of patients being readmitted to critical care within 48 hours of discharge is a measure applied nationally to assess whether patients are discharged from critical care appropriately. QMC data matches that of other units of similar size unit at 0.5 – 4%.This indicates patients were discharged from critical care appropriately.
- Readmissions to the unit post 48 hours were 9% which was within the range for other similar sized units. The reason the rate was at (% was mainly due to the number of patients with complex conditions returning for further planned surgical procedures.
- ICNARC data indicated a greater number of transfers of patients to other critical care units than those recorded for similar critical care units who submitted ICNARC data. This could be viewed as a negative, however it was due to the routine use of the City Hospital critical care unit for the rehabilitation of long term ventilated

patients. The City Hospital critical care unit specialised in the care of long term ventilated patients, such as those with Guillain-Barre (a neurological condition) or recovering from trauma and therefore transfer to this unit was beneficial to the patient.

- The time that transfers of care were undertaken did at times occur late in day. This was due to creating capacity for emergency and trauma admissions.

Competent staff

- Staff within critical care were competent and confident in caring for patients at Level two and three patients and told us they were well supported within their role.
- There was a positive culture of learning and professional development although funding for external post registration critical care awards was limited. One nurse told us of a four year wait to attend the post registration course. Only 26% of qualified nurses had completed a post registration award in critical care nursing. This did not meet the minimum standard of 50% recommended within the core standards for critical care. Discussions were on-going to facilitate this course in-house with affiliation to a local university.
- There was a comprehensive induction process for new staff members who had a seven week supernumerary period and a named mentor. New members of staff with previous critical care experience had a four week supernumerary period. A newly employed staff nurse told us that the support provided had been excellent from nursing and medical staff.
- There was a practice development nurse within critical care who facilitated classroom and one to one bed-side teaching. There was also a clinical educator to train staff in the use of equipment.
- Minimum bank and agency staff were used within adult critical care.; When bank and agency staff were used, an induction and competency check process was in place. A welcome booklet was also provided.
- 93% of nursing staff had received an appraisal for the period 2014/15, which was just below the trust target of 95%.
- Data provided for medical staff appraisal for the same period showed 100% completion.
- Staff were proactively encouraged to acquire new skills and share best practice. There was evidence of innovative staff training, using the trust's simulation centre. We observed a training session aimed at developing the skills required to manage patients and their loved ones through the delicate process of organ donation.

Multidisciplinary working

- Patients received coordinated care from a range of different staff, teams, or services. All relevant staff were involved in assessing, planning, and delivering people's care and treatment. This was evident in the medical and nursing documentation.
- There was a multidisciplinary team (MDT) approach with daily ward rounds and a specific MDT round each week to monitor those patients receiving long term critical care at the hospital of seven days plus.
- There was a close working relationship between the three critical care units at the hospital and the CCU at the City Hospital campus.
- There was an established Critical Care Outreach Team (CCOT) at the hospital which provided follow up on the ward for post critical care patients.

Seven-day services

- All allied professional services were not on site 24 hours seven days a week. Services were available as follows. Physiotherapists offered a seven day service with an out of hours on call. Dietitians reviewed patients within 24 hours of admission Monday to Friday with no dedicated weekend service (this was under review). Pharmacists did daily reviews Monday to Friday, (review of a recent one month weekend provision was underway), Speech and Language and Occupational Therapies were available on an individual referral basis.–The pain team did a daily review of patients with epidural plus provided a referral service.
- CCOT was available seven days a week 8am-8pm. A pilot of 24 hour weekend working was underway at the time of our inspection. Following a review of the pilot the service had plans to extend this to seven day 24 hour service.

Critical care

- The AICU and SHDU were open seven days a week with appropriate levels of medical and nursing staff that met the core standards for critical care.

Access to information

- A unit receptionist told us there was never a problem accessing medical notes.
- Doctors were provided with access to electronic records and patient results following induction to the trust.

Consent and Mental Capacity Act

- Deprivation of Liberty Safeguards (DoLs) was used when patients were unable to give informed consent, or where their personal safety was at risk. This was appropriately documented and discussed with relatives or those close to the patient. The DoLs status of patients was reviewed daily. Deprivation of Liberty Safeguards (DoLS) form part of the Mental Capacity Act 2005. They aim to make sure that people in hospitals are looked after in a way that does not inappropriately restrict their freedom.
- Consent was sought from patients when providing treatment or personal care.
- Seventy five per cent of consultants had completed consent training which did not meet the trust target of 90%.

Are critical care services caring?

Good

Caring within the adult critical care service at the QMC was good.

Feedback from those people using the service was consistently positive about the care and treatment received by both patients and their visitors.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promotes peoples dignity. Relationships between people who use the service, those close to them and staff are strong, caring and supportive. Senior staff within the critical care units supported the patient centred approach.

Staff demonstrated an understanding of people's individual needs and showed determination and creativity to overcome obstacles to delivering care. Staff recognised the totality of people's needs.

We observed staff treating patients and their visitors with great sensitivity and empathy.

Compassionate care

- Feedback from people who use the service, those close to them, and stakeholders was consistently positive. We were approached by a family who described the care their loved one had received as 'above and beyond' with a commitment to ensuring they were informed and involved in every aspect of the care provided.
- There was a strong person centred culture. Staff, including nursing and medical leaders were highly motivated and inspired to offer care that was kind and promoted individuality. We observed patients were treated with kindness and respect throughout our visits to the adult critical care units within QMC.
- All those involved in patient care and treatment approached patients with sensitivity using speech and touch to reassure patients throughout any interventions.
- Patients were given a full explanation of their care and treatment whatever their level of consciousness and where possible consent was requested.
- Families were encouraged to bring in photographs and personal items for patients which were displayed for the patient to see. Staff took time out to read communication received by the patients.
- Medical and nursing staff consistently demonstrated good interactions with patients and their carers, answering questions with empathy and sensitivity.

Understanding and involvement of patients and those close to them

- Visitors were involved in conversation and where appropriate decision making about their loved ones care and treatment. They received continual updates and reassurance. Conversations were recorded within the patients' medical notes to ensure consistency of information provided.

- One visiting family said that the care and consideration towards them had been 'marvellous'. They said that they had been kept fully informed during visits and contacted promptly by telephone of any changes in the' patient's condition.

Emotional support

- Patients and relatives were given emotional support whilst on the critical care units. Family members told us that 'staff always found time to talk 'and that nothing was too much trouble. We observed friendly and open conversations between staff and visitors.
- Multi-denominational spiritual support was available on request.
- Following discharge from critical care patients were visited on the ward by a senior nurse to answer any questions they may have about their time on the units.
- The trust's major trauma centre status included the provision of access to a psychologist to help patients following major trauma who were at risk of post-traumatic stress disorder (PTSD).
- Staff were particularly mindful of the need to protect patient's dignity and were observed talking to patients in a respectful and informative way, whatever their level of consciousness.
- Following discharge from hospital patients are invited to attend a post intensive care clinic. The purpose of this is to discuss their time in critical care and answer any questions about what happened to them and possible long term effects. This service was not financially supported by the commissioners but it does sit within NICE guidelines. The nurse managing this service is passionate about continuing the support of patients who have been into critical care and may have questions that are unanswered.

Are critical care services responsive?

Good

The responsiveness of the service was judged to be good.

Services were provided in a way that met the needs of local people, and innovative action had been taken to prevent cancelled elective surgery. The service was actively seeking ways to continually improve.

Queens Medical Centre (QMC) had been recognised as a major trauma centre in April 2012. The critical care unit had developed and expanded in order to respond to this accreditation.

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

There were minimal complaints made to the service.

Service planning and delivery to meet the needs of local people

- The service included three areas Adult intensive care unit (AICU) providing L3 care for acute admissions, trauma, and elective surgery. Surgical High Dependency Unit (SHDU)for surgical patients requiring L2 care and Medical High Dependency Unit (MHDU) which provided nursing care at level 2 for medical patients.
- Queens Medical Centre (QMC) had been recognised as a major trauma centre in April 2012. The critical care unit had developed and expanded in order to respond to this accreditation by increasing capacity by four L3 beds and two side rooms.
- The adult critical care service met the needs of the local population and was actively seeking ways to continually improve. At the time of the inspection Tthis included plans to integrate the MDHU unit with the SHDU and transfer care of these patients from the medical directorate to the adult critical care, however following the inspection the trust informed us of alternative plans. This integration was planned to take place in December 2015. This will ensure medical L2 patients receive medical input which meets the core standard recommendations.
- AICU was located adjacent to the operating theatres so there was direct access for patients being transferred to AICU following surgery.
- SHDU was two floors above with dedicated lift access to the operating theatres.

- MHDU was located in south block which was some distance from AICU and SHDU. The location of this facility was due move to join SHDU in December 2015.
- The service had adopted a 'just do it' approach to elective surgery management to reduce cancelled surgery on the day. This meant booked elective surgery could go ahead first thing each morning without first establishing that there was a critical care bed available. This has been made possible through an active team approach to bed coordination. Early discussions take place between AICU and SHDU about actions required to create bed capacity. Since adopting this approach in May 2015 there had been no cancelled elective surgery due to a lack of critical care beds.
- There was limited availability of relative's accommodation in AICU with only one overnight room. This was en-suite with one bed and two chairs that could be pulled out into camp beds. Linen and towels were readily available. The room was clean but in need of updating. In addition there was a small interview room.
- As a major trauma centre, admitted patients could be from distant parts of the country. If required critical care could negotiate the use of overnight stay rooms elsewhere in the hospital. However we did note there was ample information about local accommodation on display in visitor areas.
- The general waiting area for AICU had been refurbished. Visitors had been asked for their suggestions during the planning process and the décor and furniture reflected their ideas.

Meeting people's individual needs

- Visiting hours within AICU were set at 11am to 8pm with a recommended quiet period in the afternoon. However in recognition of individual patient's needs and visitors who live greater distances these could be adjusted to meet family needs. However visitors were reminded of the need to respect other patients need for peace and rest.
- Patients living with dementia had a "This is Me" document. This is a document completed by relatives/ carers to tell staff about patient's individual needs, likes, dislikes, and interests. It enables health and social care professionals to see the patient as an individual and deliver person-centred care. The unit had a dementia care champion.
- Translation services were used in the critical care department. Staff we spoke with said they had limited experience of this service but knew how to access it. Additionally, critical care staff came from a wide range of nationalities and were able to utilise their language skills.
- The trust had learning disability nurses who were able to offer support and advice when patients with learning disabilities were admitted to critical care.
- There was a range of communication tools available to assist staff and patients to communicate when physically unable to do so. This included electronic devices and picture boards.

Access and flow

- Data relating to access and flow was provided collectively for the adult critical care service and included AICU, SHDU and MHDU at QMC and the Critical Care Unit (CCD) at City Hospital.
- ICNARC data report for May 2015 shows that there is an on-going increase year on year for critical care admissions. Graphs demonstrated Q3 2013 having approximately 280 admissions and Q3 2014 having approximately 320 admissions.
- Bed occupancy ranged from 80 to 85% which was in line with the national average of 84%. It is recommended by the Royal College of Anaesthetists (2012) that occupancy should average 70% in order to meet the demand for critical care beds, avoiding cancellations and non-clinical transfers.
- The service had recently adopted a 'just do it' policy for elective surgery. This had reduced cancelled surgery due to a lack of critical care beds.
- Out of hours transfers were reported as slightly above the average for units of a similar size although the data included transfers between critical care units in different locations within the hospital. For example from AICU to SHDU or MHDU. However out of hours discharges to the wards was below that of similar units.

- Bed management meetings took place at 09:30am, 11:30am and 3pm to enable discharges and transfers to be facilitated. We attended this meeting and observed a teamwork approach to managing patient flow.
- Elective admissions were booked through a centralised on-line service, giving patients the choice of when surgery took place.

Learning from complaints and concerns

- There were three complaints recorded on the 'Performance at a glance' paper with no reported breach in response times for 2014/2015. Information about complaints was shared at shift handovers using the 14 day handover tool.
- Information about how to make a complaint was available in all visitor areas.
- Staff were unable to recall any written complaints but felt they could deal with any issues brought to them or would escalate to their immediate team leader.

Are critical care services well-led?

Outstanding ☆

We found the adult critical care service demonstrated outstanding leadership.

The service had a comprehensive annual plan with clear actions, measurable outcomes, named responsibility and targets.

There was a systematic approach to working across the trust to improve care and outcomes for patients and provide best value for money.

Staff worked very well together across hospital sites and across departments. There was a collective enthusiasm across all staff groups and a clear knowledge of the vision, values and strategic goals for critical care. Staff told us they were proud to work in the department.

Governance processes were established across adult critical care with active involvement from all staff groups. Staff unanimously spoke highly of the local leadership and said they felt supported and able to raise concerns or challenge decisions about patient care.

There was a positive culture of innovation and service development which was not only shared within the critical care and across the trust but also extended to other trusts through training within the departments clinical simulation centre.

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

Vision and strategy for this service

- There was a clear vision and strategy for adult critical care across the trust.
- The senior management team told us with great enthusiasm of their plans and aspirations for developing the service. Leaders were inspirational and motivational; this was reflected when speaking to staff who spoke positively about their work and the future of critical care provision.
- The medical high dependency unit (MHDU) was partially managed by the critical care service. Nursing staff were employed by adult critic care but patients were managed by their named medical consultant. At the time of our inspection There there was a plan to transfer the care of patients on MHDU into the care of the critical care consultants, however the trust has informed us that since our visit the plan has changed. This would then ensure that the nursing and medical ratio to patient would match that of other L2 areas and meet the core standards for critical care. This plan was fully supported by medical directorate who would continue to see patients in an advisory role relevant to their particular speciality.
- The service had submitted a 60 Million pounds business plan to enable a complete refurbishment of the older, outdated, critical care facilities and expansion of SHDU to accommodate MHDU.
- Information collected through ICNARC and local audits was analysed and used for service development planning. An example of this was the recognition of the need to integrate MDHU into adult critical care, which would provide increased critical care level input for MHDU patients that would be consistent with the provision for SHDU patients.

Governance, risk management and quality measurement

Critical care

- Governance processes were established across adult critical care with active involvement from all staff groups.
- Leaders were committed to ensuring a culture of openness existed within the critical care service and that duty of candour was embedded within practice. This was evident from our conversations with staff and in the handover process.
- The Critical Care Patient Safety Council / Governance Meetings took place fortnightly covering the full range of governance topics including incidents, nursing dashboard, guidelines, performance, and complaints. There were clear actions and names identified throughout. We reviewed four sets of meeting minutes and noted that actions were followed up and outcomes shared. The meetings were held alternately at QMC and City Hospital sites.
- Key information from the governance meetings was included in the 14 day handover tool.
- The critical care risk register was reviewed and actions monitored at governance meetings. Examples of items on the risk register include the outdated monitoring system on MHDU, lack of commissioning support for critical care follow-up clinics and medication errors. There are actions and monitoring in place for each risk.

Leadership of service

- There was strong leadership within adult critical care. The lead consultant and senior nurse were both visible and active in all elements of management.
- Senior staff were drivers of continual improvement, encouraging staff to put forward ideas for improvement and innovation. Staff had made the most of a recent open day, for the opening of additional beds, by having a recruitment stand to attract new staff. This had proved to be successful.
- Staff said they were consulted and informed of plans for critical care and were able to tell us about the expansion plans
- Staff unanimously spoke highly of the local leadership and said they felt supported and able to raise concerns or challenge decisions about patient care.

Culture within the service

- We found the care and service delivered throughout adult critical care demonstrated a strong cohesive team approach. It was clear that an open, transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- Patient safety was promoted throughout the service and we observed staff being vigilant in their observation of patients. Offering assistance without being intrusive and acting in the patients best interest to prevent injury. For example supporting patients when moving or preventing them from inadvertently pulling out intravenous lines.
- There was evidence of collaborative working and positive relationships with other departments within the hospital, offering advice and support to wards on the care of patients requiring higher levels of care. Staff would also advise ward staff to consult CCOT if a patients MEWS indicated this may be beneficial.
- The service was also engaged in sharing expertise with other critical care staff from across the country, utilising their simulated practice centre.
- During our inspection we noted staff being positive and caring towards patients. We also observed a caring and respectful culture towards each other, their immediate teams, and the organisation as a whole.

Public engagement

- One family had returned to the critical care to present a cheque and to thank the department for the care provided to a family member. They told us that they felt that nothing was ever too much trouble and that communication with them was excellent.
- There was active public engagement in the expansion of the critical care services and comments utilised in the planning process. The public were invited to the critical care open day.
- The critical care annual plan includes the need to hold stakeholder events for any further development plans.
- There was public consultation regarding the refurbishment of the public waiting areas and the public's choice for colour and furniture provision was acted upon.

- Staff lanyards had been changed to indicate a person's role as a direct result of concerns raised by members of the public about difficulties identifying who was who.
- There were plans to utilise volunteers within critical care for simple duties included within the annual plan.

Staff engagement

- All of the staff spoken with during our inspection, without exception, were proud to work within critical care and spoke highly of their managers.
- There was open access to any member of staff to attend governance meetings and minutes reflected this with staff of all levels attending meetings.
- Staff reported feeling involved and consulted about changes in the trust and felt very confident that they would be 'listened to' if they had a suggestion or a concern about the service.
- There were plans to introduce Schwartz rounding within critical care. This is a regular open gathering of staff to discuss difficult issues relating to their work in an open and honest way. It would be chaired by a psychologist and has been found to be beneficial in other units across the country for staff who have witnessed traumatic situations in the workplace. This is fully supported by the management team.

Innovation, improvement and sustainability

- Innovative approaches were used to gather feedback from people who used the service through inviting patients and carers to opening of a new bed area and getting their views regarding patient privacy.
- The 'just do it' project to avoid cancelled elective surgery due to lack of critical care beds has been successful. This is also an example of several departments working together to solve a problem.
- There was a project in place preparing for complete digitalisation of patient records.
- The trust completed 'Schwartz rounding' for staff support. Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work.

  Plans to transfer MHDU patients into the care of the critical care team would ensure consistence of care for all level two patients within QMC.

Maternity and gynaecology

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

Information about the service

Maternity and Gynaecology services provided by Nottingham University Hospital are located on two hospital sites, the Queens Medical Centre, and Nottingham City Hospital. Services at Nottingham City Hospital are reported on separately however, services on the two hospital sites are run by one maternity and gynaecology management team. They are regarded within, and reported upon by the trust as one service, with some of the staff working across the two sites. For this reason, it is inevitable that there is some duplication contained in the two reports. Where possible the trust has separated the data for the purpose of inspection.

Maternity services at Queens Medical centre include the antenatal clinic, a fetal medicine unit, the antenatal assessment unit (ABC), the labour suite, the birth sanctuary (midwife led unit), antenatal and postnatal wards. The gynaecology service offer inpatient services, emergency assessment facilities and an early pregnancy assessment unit.

The antenatal baby care (ABC) has six beds providing an assessment and triage service. The induction bay has four beds and the antenatal ward has 18 beds located adjacent to ABC. Six of the antenatal beds are located in side-rooms within the ward area. The labour suite comprises of nine single rooms all with en-suite facilities, a two bedded observation bay, two rooms for close monitoring of women and a two room theatre suite. One of the labour rooms has a water birth pool. The birth sanctuary midwife led care has four rooms, two of which had pools in the rooms. The second maternity ward cares for women after having their baby and includes eight beds for babies who required extra care (transitional care). The transitional care area consists of two four bedded bays. The ward has a further 12 beds and eight side rooms.

Gynaecology services are provided in the ward and treatment area. The ward has two six bedded bays and four side rooms for inpatients. A dedicated treatment area for the early pregnancy unit has three assessment and scanning rooms with two counselling rooms. The gynaecology assessment unit (GP assessment unit) and early pregnancy unit consists of a large waiting area, four examination rooms and a minor procedure room.

There are 79 beds dedicated to women's and maternity services and during June 2014 and May 2015, the hospital had 4430 births.

During our inspection, we visited all ward areas and departments relevant to the service. We spoke with 17 women, five relatives, and 26 members of staff including; senior managers, service leads, managers, midwives, consultants, doctors, nurses, anaesthetists, sonographers, support workers, administrators, and domestics. A further 26 members of staff attended crossed site focus groups. We reviewed 16 sets of medical records.

Maternity and gynaecology

Summary of findings

Overall, we rated the service as good,

There were recently developed local and divisional risk and governance arrangements, staff felt the service had a profile on the trust board agenda. There were processes in place to share lessons learnt from incidents and investigations.

There was a multidisciplinary approach to care and treatment, which involved a range of staff in order to enable services to respond to the needs of women. All staff told us that that working relationships between the professional groups was excellent.

Women using the women's health services received care based on up to date guidelines and national guidance. The guideline for admission of a woman to the midwifery led care unit had been removed from the intranet to be reviewed and ratified by governance staff, leaving staff to admit women to the midwife led unit without a criteria.

The departments were found to be caring and compassionate. Women, families, and visitors were treated with respect and their wishes considered. Support was given to women in their chosen method of feeding their babies.

Services responded well to the needs of the individual, and women were given a choice of where to birth. New methods of sharing information had been introduced with the use of the new maternity phone application.

Maternity care was offered between the two hospital sites, and women's care was occasionally diverted due to staff and bed shortages.

Leadership and culture in the hospital encouraged openness and transparency. Staff all felt very supported and enjoyed their work at the hospital.

Staff worked hard to provide new and innovative projects to improve the service for women.

The midwife led care centre did not fully embrace the 'home from home' values of midwife

Staff had not always documented that essential lifesaving equipment had been checked. Midwives were delivering post-operative care without the required formal training and competency assessments.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

Overall, the safety of the service required improvement.

Maternity staffing ratios were below the recommended levels which was supported by the monitoring tool used on the labour suite. The midwifery and medical vacancy rate was being acted upon, but there were difficulties in recruiting staff which meant they were unable to meet the national standards for safe staffing. There were not enough supervisory midwives to provide support to staff at the recommended level.

Daily checks of essential lifesaving equipment were not consistently documented. Within the midwife led unit (MLU) there were no obvious criteria for which women to admit. This lack of guidance caused staffed to be confused over which women to admit to the MLU.

Staff were not assessed in their competency to care for women post anaesthetic procedures such as caesarean section.

In maternity services, the Maternal Early Warning Score (MEWS) was used to assess the health and wellbeing of women who were identified as being at risk. The unit did not use Neonatal Early Warning scoring charts to assist in the early recognition in deterioration of the newborn, however, there were plans to pilot a system to monitor newborn babies for signs of deterioration. Staff were currently using a paper observational chart system to monitor babies physiological readings. The condition of babies was monitored but the service planned to reinforce the escalation process.

Gynaecology services used electronic patient observation devices to monitor patient's wellbeing. This included appropriate escalation.

Staff reported incidents which were all reviewed, and lessons were learned. There was an effective process for the investigation of serious incidents and a good understanding and use of Duty of Candour.

Staff were aware of safeguarding processes and a female genital mutilation (FGM) specialist midwife supported women and colleagues with identified cases.

Incidents

- The trust had a clear incident reporting policy in place that identified staff responsibilities. Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses. Members of the governance team reviewed all incidents daily. We were able to see evidence of action plans being implemented, reviewed, and updated. Post inspection we requested data by site, however, we were told that this was not possible to review retrospectively.
- At the time of our visit the maternity services had had 303 outstanding incidents. This had been reduced from 616 in June 2015 by targeted work from the governance team. QMC maternity and gynaecology had 174 open incidents. The majority of the incidents were no harm incidents. The trust reported their incidents by site. Closure had been delayed due to investigating staff prioritising serious or moderately serious incidents ahead of these. There was a plan in place to address the backlog, and an improvement could be seen.
- There were 22 serious incidents reported to the NHS strategic executive information system (STEIS) between May 2014 and April 2015. We reviewed summary notes in relation to three reported serious incidents. We saw recommendations and actions demonstrating a culture of learning from such incidents.
- There were monthly multidisciplinary perinatal mortality and morbidity and encephalopathy meetings. Babies that had difficult births, became ill after the birth, or had a poor outcome were discussed. Improvements to care and treatment were shared and actions agreed.
- A maternity and gynaecology governance (MAGG) newsletter was circulated to all staff demonstrating discussion around learning from incidents, and trends in incident reporting. Examples of this were user error for the blood gas analyser, and the labelling of blood bottles. Staff we spoke with were aware of incidents and incident trends.
- All minutes to meetings referred to discussion and Duty of Candour with family members. Staff had an understanding of the Duty of Candour regulation. The Duty of Candour is concerned with openness and transparency and places a responsibility on NHS hospitals to inform patients when things have gone wrong and harm has been caused.

Maternity and gynaecology

Safety thermometer

- The maternity and gynaecology service participated in the NHS safety thermometer and collected and displayed the information in ward areas. The safety thermometer captures information on the number of pressure ulcers, venous thromboembolisms (blood clots), falls and catheter urinary tract infections. We noted that there had not been any incidents in relation to the safety thermometer since October 2014.
- The maternity service monitored their clinical outcomes through a maternity dashboard in accordance with The Royal College of Obstetricians and Gynaecology 2008 guidelines. This would help to identify patient safety issues so that appropriate action can be taken. They did not however submit to the maternity safety thermometer. This meant that they were not able to demonstrate harm free care in the specified areas of the safety thermometer.

Cleanliness, infection control and hygiene

- We found standards of cleanliness to be good in all areas. There were hand gel dispensers on entry to all areas and also at the point of care.
- Staff followed best practice with infection control and prevention principles in relation to management of waste, including sharp items, and clinical waste.
- The hospital's 'bare below the elbow' policy for best hygiene practice was adhered to. Staff had access to, and were seen to use personal protective equipment such as gloves and aprons.
- Information in respect of cleaning audits was displayed on ward areas. These were performed fortnightly in the high risk areas such as labour ward, and monthly in other areas. Audit figures in all areas demonstrated an achievement of 94-98%.
- In maternity, we did not see evidence of a consistent approach to labelling equipment when cleaned. Staff did not have assurance that the equipment was clean and ready for use. In gynaecology, the equipment was labelled when cleaned.

Environment and equipment

- Doors to gain entry to the ward areas were locked and staff gained entry via a swipe card system. CCTV cameras were in use in all areas. Receptionists were employed 24 hours a day to assist in answering the doors. On occasions the receptionists had other administration tasks and women were met by staff as they entered the unit. This was necessary due to the length of theward corridors.
- Resuscitation equipment was readily available in all clinical areas. Adult and neonatal resuscitation trollies were locked and checked monthly.
- Checking and documentation for neonatal resuscitaires (a warming platform used for clinical emergencies and resuscitation) in labour suite were inconsistent. We identified checklists that had signatures missing 30% of the time for July, August and September. Staff told us they checked each resuscitaire before use however the system for recording checks were completed was not robust. No incidents had been reported of resuscitaires being unfit for use.
- Within the ward areas in both maternity and gynaecology, emergency equipment was checked consistently, with items appropriately packaged, stored and ready for use. All patient equipment we looked at had been routinely checked for safety with visible portable appliance testing (PAT) stickers demonstrating when the equipment was next due for service. This included infusion pumps, blood pressure and cardiac monitors as well as patient moving and handling equipment such as hoists.
- Staff were aware of the process for reporting faulty equipment.
- Cardiotocography (CTG) equipment was available in all labour rooms to enable staff to monitor the fetal heart rate in labour. This included one waterproof telemetry monitor for a fetal heart beat to be monitoredwithin the birthing pool.
- In the event of emergencies, equipment was available for urgent birthing pool evacuation.
- Women who required closer monitoring up to level two high dependency care received care on delivery suite in one of the two advanced obstetric care rooms. These rooms contained monitoring equipment and were fit for purpose. Staff accessed the high dependency outreach team for further support.

- The obstetric theatres were within the labour suite, these had a designated recovery area with monitoring equipment.
- Equipment was available within the gynaecology general practitioner assessment and treatment unit. This enabled procedures to take place as an outpatient within the gynaecology and early pregnancy unit.

Medicines

- There were effective arrangements in place for storing medicines, including controlled drugs and refrigerated items. Intravenous fluids were stored in a locked room entered via a keypad.
- Controlled drugs had been checked according to the trust's policy in all areas.

Records

- Records were kept securely in closed but unlocked cupboards in all areas.
- In maternity, the women using the service were provided with their own set of care records to bring to the hospital. The electronic system used in the hospital was not accessible to community midwives and they relied on printed summaries of care from the hospital. The hospital was looking at a new inclusive electronic note system and had employed staff to be part of the planning and implementation process.
- Hospital staff used a combination of electronic and paper records. This caused duplication of records during hospital admissions. A paperless approach was not yet in use.
- We reviewed 16 sets of records; the named midwife or nurse leading the women's care was documented. Records were legible, dated and signed with clear plans of care.
- Patient records were multidisciplinary and we saw where nurses, midwives, doctors and allied health professionals including physiotherapists had made entries.
- Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools.

Safeguarding

- Staff we spoke with knew about the trust's safeguarding process and were clear about their responsibilities. Display boards around the ward areas gave comprehensive information on safeguarding including deprivation of liberty and the Mental Capacity Act 2005 information. Contact numbers were visible to staff for further support.
- We saw evidence of the Whooley depression score in use in the latest edition of the records. The Whooley test is used to determine which patients require further clinical assessment for a risk of depression. The question of female genital mutilation (FGM) was addressed, including postnatal communication to community staff. We saw the child health record distributed and issued to all women, including a body map of the baby after delivery.
- There were two midwives appointed trust wide for maternity safeguarding and each clinical area had safeguarding champions who were given protected time to support their colleagues with safeguarding issues. Within the community, 12 midwives were involved with the many specialist groups including vulnerable, homeless and teenage women, as well as those suffering with drug and alcohol dependency. A dedicated midwife had been appointed to support staff and care for women who had undergone female genital mutilation. Maternity guidelines existed for the screening and care of this group of women.
- All staff in both gynaecology and maternity described an alert system on the inpatient records if a safeguarding concern had been raised.
- Staff within the gynaecology ward described a thorough process for the management of under eighteen year olds undergoing termination of pregnancy. We saw evidence of this in minutes to meetings.
- Community midwives reported having quarterly meetings with supervisor of midwives and the safeguarding team to discuss issues and concerns.
- Within maternity and gynaecology at QMC, 89% of nursing and midwifery staff and 87% of medical staff had received level two adult and level three children safeguarding.

- It was identified that staff may not be asking women about routine safeguarding questions. We saw a completed audit. The highlighted gaps in practice were actioned with a plan to do another audit after the actions were completed.

Mandatory training

- Trust wide mandatory training was described as your 'birthday training' as staff completed this in the month of their birth. Maternity and gynaecology recorded 90% compliance in all compulsory education.
- Maternity staff described attending yearly multidisciplinary skills and drills training. This included maternal and neonatal resuscitation, electronic fetal monitoring, management of obstetric emergencies, recognition of the severely ill pregnant women, manual handling, epidural update, suturing update, perinatal mental health and safeguarding updates, physical examination of the newborn, infant feeding, and bereavement. In addition to this, half yearly maternity forums were held to train staff on these and other topical issues such as completion of patient observations and early warning score charts. The content of these sessions altered according to identified areas of learning. Middle grade doctors and obstetric consultants were 90% compliant, and hospital and community midwives 98% compliant in training, this was better than the trust target of 75%.
- Equipment training in family and health division identified a 67% shortfall in training on the use of medical equipment (August 2015). This meant that the department could not be assured that staff had the appropriate knowledge and competencies to operate the necessary equipment. This data was supplied by the trust and not broken down to ward and site. In all areas we visited staff described local training in the use of equipment.
- Newly qualified staff had a comprehensive training programme to complete in their preceptorship period.
- Cardiotocography (CTG) training compliance was reported in 2015 at 90% for all middle grade doctors (excluding locums) and obstetric consultants. Hospital midwives 78% and community midwives were 98% compliant, this was better than the trust target of 75%.

Assessing and responding to patient risk

- Gynaecology areas used hand held electronic patient observation devices that included an escalation function to senior nurses and medical team of deteriorating patients. The device highlighted when observations had been delayed.
- In maternity services, the Maternal Early Warning Score (MEWS) was used to assess the health and wellbeing of women who were identified as being at risk. We checked 10 sets of notes and found these had been completed and scores were calculated. A neonatal early warning scoring system was not in use at the time of our visit. The service had reviewed two charts, the favoured chart was going to be piloted. Currently observations and the condition of newborns was documented on paper charts. Implementation of a new system would reinforce the escalation process.
- Staff in labour suite had close support from the outreach team for care of the critically ill woman.
- Staff in maternity and gynaecology demonstrated an understanding of the signs and symptoms of sepsis, such as an increased temperature and respiration. Staff were aware of the process to follow which was highlighted on the MEWS chart.
- The World Health Organisation (WHO) Surgical checklist, five steps to safer surgery was in place. We observed completion of the checklists and did not find any concerns.The trusts audits of the WHO checklist demonstrated 100% compliance in July 2015.
- The obstetric anaesthetist and outreach teams supported midwifery and medical staff with critically ill women.
- There were no obvious criteria for giving birth on the Sanctuary birth centre (the midwife led unit MLU).Lack of accessible guidance caused staffed to be confused over which women to admit to the MLU.

Midwifery staffing

- The trust reported a midwife to birth ratio of 1:29, this was similar to the Royal College of Obstetricians and (RCOG: Safer Childbirth Minimum Standards for the Organisation and Delivery of Care in Labour) recommendation of 1:28.
- There were 3.47 WTE midwives vacancies. Offers had been made to three new midwives, leaving a 0.47

vacancy. The unit did not use agency staff, all staff on the nursing bank were employees of Nottingham University Hospital. A closed Facebook group was used for advertising vacant shifts that were filled by the good will of staff.

- The labour suite used the Birth Rate Plus acuity tool to determine retrospective staffing levels in response to the degree of care women needed. This information was added to the system every four hours during the day and every two hours at night. The information was used when the decision to divert women's care was made. Between June and August 2015 audit figures demonstrated that overall, 47% of the time staffing was less than the trust desired requirement (as defined by Birth Rate Plus). This meant that one to one care of labouring women was not possible during busier times. We did not see evidence of shifts where staffing was below the planned level. We were told that this information was analysed weekly and the risk was on the risk register. We saw evidence of actions taken to address concerns including reallocating staff in busier periods, use of bank staff and support from management colleagues. Staff were offered flexible working hours and NHS professional bank staff were used. The QMC managers planned to re-audit the data in six months' time to gain a greater understanding.
- Staff were allocated on a daily basis from the labour suite to the midwife led unit, induction ward and antenatal assessment ward. In times of increased activity, the staff were reallocated to the areas of highest activity. Two community midwives were located in the hospital overnight for homebirths. These staff worked from the community hub and could help during periods of high activity. This included working in the hospital or assessing women at home if it was appropriate.
- The labour suite had senior midwife co-ordinators to manage the ward on a daily basis. The co-ordinator in charge would not be directly responsible for woman in labour due to managerial duties.
- Senior staff could not identify which midwives had received training in the care of the critically ill women. This did not follow the best practice guidance, 'Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman.' (The Royal College of Anaesthetists 2011). The lack of recording competencies prevented staff from rostering the appropriate staff on each shift to care safely for women in the high dependency unit.
- Labour ward matrons told us that staff had the training to provide post anaesthetic care for women, but no formal assessment was made of the competency. This did not comply with the recommendations by the British Anaesthetic and Recovery Nurses Association (2012) to recover women following anaesthesia.
- Staff described appropriate use of clerical and support staff to answer doors, retrieve notes and administration tasks. Each ward manager of maternity and gynaecology had an assistant for administration duties.
- Support workers were on duty in all areas to provide additional support to midwives. Support workers attended a specific training day. They did not undertake extra duties unless trained. The average staff absence rate for maternity and gynaecology at QMC was 2.9%. An innovative text messaging and closed group on Facebook was used to advertise vacant shifts.

Nursing staff

- The gynaecology ward and GP assessment unit were staffed together. The trust had assessed the required staffing levels to meet patient's needs. There was a ratio of one qualified nurse for every eight patients. Flexible working and the use of an evening 'twilight' shift had improved staffing levels.
- There were eight staff vacancies at the time of the visit due to a new business plan for more staff by the ward sister. Employment offers had been made for three staff nurses. Agency staff were not used and the bank staff were normally staff familiar within the service. The ward manager was not counted into the staffing numbers, but was visible during the day for support and advice. During our visit, she was seen to give support to staff and answered an emergency call.

Medical staffing

- Quality clinical outcome data indicated an average of 58 weekly hours of dedicated cover from consultants' presence on the labour ward. This was not in line with national recommendations, for the number of babies born on the unit each year; there should be 98 hours a week. There was a plan to increase the dedicated cover

on the labour suite. Medical staff told us that the appointment of two new consultants would increase presence to 76 hours. Staff of all grades described working extra shifts to cover busy periods and support junior staff. Locum staff were used and completed an induction pack as well as receiving post shift feedback.

- Dedicated anaesthetic cover was provided twenty four hours a day with an on call anaesthetist available to cover for women who needed to go to theatre.
- Consultant ward rounds on the gynaecology ward occurred three times a day. A consultant on call for gynaecology carried a phone termed the 'hot phone' to accept calls directly from GPs concerning patients.
- Medical staff described an excellent working relationship across sites.
- There were two midwifery handovers and three multidisciplinary handovers a day. We observed each handover, but there was no formal paperwork for handover which followed a 'situation, background, assessment, recommendation (SBAR) format, although the midwives signed to identify that it had occurred, confirming receipt and understanding of the unit demands.

Major incident awareness and training

- The hospital had a major incident business plan on the intranet. Staff were aware of the policy and had extra information via booklets and DVDs. It covered processes when there were no beds available, and massive external emergencies.
- Practical obstetrics multi-professional skills drills training was developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the newborn.

Are maternity and gynaecology services effective?

Good

The effectiveness of maternity and gynaecology services was good.

Care and treatment reflected current evidence based guidance, standards and best practice.

Efficient multidisciplinary working was apparent throughout the unit despite non-gynaecology patients being present on the gynaecology ward.

There was evidence of meetings and discussions around outcomes and changes. In all of the records we looked at, risks assessments were completed.

In maternity, staff had made an hourly documented systematic assessment of mother and baby in accordance with national guidelines.

Most of the training appeared comprehensive and appropriate for care within the service.

Assurance could not be given that staff providing high dependency and post-operative care had the required formal training and competency assessment.

Guidelines were not available for women wanting to birth their babies on the midwife led unit.

Evidence-based care and treatment

- Policies and guidelines were based on guidance issued by professional bodies such as the National Institute for Health and Care Excellence (NICE), the Royal College of Obstetricians and Gynaecologists (RCOG) safer childbirth guidelines. Within gynaecology, the care of women requesting induced abortion (RCOG) and the Department of Health, Termination of pregnancy for fetal abnormality guidance were also followed.
- While signed consent was not required for the disposal of fetal remains, guidance states women should be offered a choice of how to manage the remains, and as such the conversation should be recorded. Notes reviewed showed clear written consent was obtained indicating the woman's choice of disposal.
- We reviewed 14 guidelines these were all easily accessible, in date and version controlled
- There were no guidelines for the admission criteria to the midwife led unit (MLU, an area for low risk births). Governance staff had removed the guidelines to review them. When the issue was highlighted by inspectors, staff were not aware that the guidance had been removed. Care of women in labour was covered by other guidelines.

- Some procedures being performed in the MLU, such as continuous fetal heart rate monitoring and instrumental births, were not appropriate for a low risk environment.
- We reviewed 10 labour fetal heart rate monitoring records. In all records, staff had made an hourly documented systematic assessment of mother and baby in accordance with national guidelines.
- Procedures were in place for the care of non-gynaecology patients within the gynaecology ward. This 'way of the day' prompt gave greater assurance that they received appropriate care.

Pain relief

- Labour ward and the nearby MLU had three birthing pools for the women to use as pain relief in labour. Local audits captured the use of water in labour. Aromatherapy was used throughout the maternity unit by trained staff.
- Entonox (a pain relieving gas) was piped in all labour rooms. Pethidine and diamorphine injections were available if women required stronger pain relief.
- Within labour ward, epidurals were available for women in labour 24 hours a day, seven days a week.
- Women were able to access pain relief during birth and post operatively in a timely way. Analgesia was offered regularly, and the women we spoke to felt their pain was managed well. In the gynaecology ward patients told us they were offered pain relief regularly and were not left in pain.

Nutrition and hydration

- Women we spoke with told us that the meals were of an acceptable standard and that snacks were available in a patient fridge. Women could choose whether to eat in the dining area or by their bed.
- Fluid balance charts were completed and legible.
- Women were encouraged to make an informed choice on the best method to feed their baby. The service was awarded UNICEF level three Baby Friendly Initiative in July 2015. The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF to promote breast-feeding.
- Breast-feeding statistics for initiation within 48 hours of birth were mainly between 71% to 73% against a trust target of 73%.
- The infant feeding coordinator was qualified to cut tongue-tie in babies, (a condition that may cause feeding difficulties). This enabled a prompt response to solve any identified feeding problems. Trained breastfeeding volunteers came to the maternity ward to provide extra support for mothers.
- There were sufficient numbers of breast pumps for expressing milk. These were available for women to use when required.
- Expressed breast milk was labelled and stored safely in accordance with trust guidelines.
- The early pregnancy unit ran a rehydration service to women who were suffering with severe early morning sickness (hyperemesis). This enabled them to be treated as day cases if appropriate. We saw evidence of women being offered meals in the early pregnancy unit and GP assessment unit.

Patient outcomes

- The maternity department maintained a trust wide maternity dashboard which reported on clinical outcomes before, during, and after delivery. There was another document of outcome indicators which contained manually collected data. The documents were not displayed for staff to see.
- The number of women who had a normal birth between 2014 and 2015 was 61-65%, which was slightly below the 66% trust target for 11 of the 12 months.
- Between 2014 and 2015, 62.3% of women had a normal delivery; this was below the trust target of 66%. The home birth rate was 1.2%, this was less than the national average of 2.3%.
- The trust wide caesarean section rate was between 19% and 26% (average 24.5%) this was generally lower (better) than the national average of 25.5%, and the trust target of 26%. Staff told us that they thought it was low due to the birthing clinic which supported women with their fear of childbirth, and minimised women choosing caesarean section.
- Between 2014 and 2015, 13.2% of babies were delivered by medically assisted instrumental delivery (forceps and

ventouse extraction). This was above the trust target of 11%. All cases were reviewed by a midwife and medical lead of the governance team to identify trends or practice issues.These were fed back to the member of staff and trends were discussed at the labour ward forum.

- Between January 2015 and March 2015 at QMC 3% of women had a third degree perineal tear following birth, and 0.1% sustained a fourth degree tear. This was in line with the trust's target of 4%. Between July 2014 and June 2015, trustwide the number of women who had third and fourth degree perineal tear following an instrumental birth was 6.7%. Between 2014 and 2015, in four of the 12 months, the figure was worse than the trust's target of 8% (8.6 - 9.8%).All figures were reviewed by a midwife and medical lead the governance team to identify trends or practice issues, this was feedback to the member of staff and trends were discussed at labour ward forum.
- The rate of women who had obstetric haemorrhage (bleeding following birth) greater than two litres was 1.5% and had been just above the trust target of 1.9% for five of the last 12 months.
- At QMC nine women (0.8%) developed sepsis following birth between January 2015 and March 2015. Staff completed MEWS charts to identify cases appropriately.
- National antenatal key performance indicators were reported electronically for screening in pregnancy data.The database identified actions for the any data that did not meet national standards.
- The gynaecology ward regularly had women from other medical and surgical specialities present due to bed capacity issues within the hospital. Policy and processes were available for caring for these medical patients on a gynaecology ward. On the day of our visit, there were four non-gynaecology patients on the 16 bedded gynaecology ward. The medical doctors had reviewed all non-gynaecology patients that day.
- Ward staff performed audits of incident trends, such as babies falling from beds. As a result of this audit a risk assessment for mothers to keep their curtains open and the use of bedside cots was designed. After implementation, a further audit highlighted an improvement, and the results were shared and published nationally.
- The audit and results of maternity notes regarding the routine enquiry into domestic abuse by midwives during pregnancy was shared with the inspection team. The audit identified areas for improvement and a date for re-audit.

Competent staff

- Practical obstetrics, multi-professional skills drills training was developed for the maternity services. This is an accepted format by which healthcare professionals gained and maintained the skills to manage a range of obstetric emergencies, for example haemorrhage, maternal collapse, and resuscitation of the newborn.
- Staff received updates in caring for women whose condition was deteriorating, but had not had anaesthetic recovery training and competency assessment.
- Records confirmed that 90% of gynaecology, 86% of maternity and 90% of medical staff had completed an appraisal in the last 12 months. The staff we spoke to supported this. Completion of the appraisals was linked to advancing to the next salaried increment for maternity staff.
- Newly qualified staff completed a comprehensive competency (preceptorship) pack prior to progressing to the next grade. All staff in clinical areas and the trust clinical educators supported this process.
- The annual Supervisor of Midwives (SOM) report for 2013-2014 showed that the ratio for SOMs to midwives was 1:25 making the trust non-compliant with national expectations. The trust had arranged to employ two midwives as full time SOM's and for two more midwives to complete the SOM training. This would improve the support given to the midwives. Supervisors of midwives (SoMs) help midwives provide safe care and are accountable to the local supervising authority midwifery officer (LSAMO). The national recommendation for a SoM is to have a caseload of 15 midwives. Staff told us they currently had a ratio of 1:22 SoMs.This was supported by the unit data of a ratio of 1:22.6 between June 2014 to April 2015, which, while gradually improving was still worse than the national recommendation. This meant that supervisors had less

time to support individual midwives and reported feeling under greater pressure. However, at the time of our visit a full time supervisor had been employed to reduce the pressure.

- Maternity support workers were trained to work in transitional care ward performing observations and giving advice to new mothers under indirect supervision of a midwife.
- Weekly CTG meetings took place to discuss high risk cases and establish lessons learnt. We were told that these were predominantly attended by medical staff due to maternity department workload.
- Medical staff attended weekly training opportunities, and described a supportive department for training.
- Midwives throughout the hospital were trained in performing the new-born baby checks. We did not see evidence of these skills being formally used. Midwives told us that they were not given dedicated time to perform the checks and maintain the qualification. The qualification was however, maintained as part of their personal professional development.

Multidisciplinary working

- Staff reported that the multidisciplinary working within the department was efficient and effective. We saw minutes of weekly meetings that reinforced this.
- Community staff provided monthly multi-agency pregnancy liaison group meetings for high-risk cases to provide a multidisciplinary approach to care.
- Gynaecology and GP staff worked together to produce community and hospital treatment guidelines to care for women suffering from hyperemesis.
- Hospital and community staff reported a good working relationship between the teams.
- Electronic summaries of care were sent from hospital to community.
- Physiotherapists supported mothers with third and fourth degree tears and after caesarean section.
- The physiotherapists and occupational therapists supported patients after surgery on the gynaecology ward and for assessments prior to discharge home.
- Meetings with the Maternity Service Liaison Committee groups did not take place. The maternity senior team did nothave plans to reform the group at present. The trust participated and we reviewed minutes for Partnership in Maternity meetings. This was a forum for maternity service users, providers and commissioners of maternity services to meet to design services that meet the needs of local women and families. The minutes demonstrated that service users were not often represented at the meetings.

Seven-day services

- Maternity and emergency gynaecology services were available 24 hours a day, seven days a week. The early pregnancy unit was open between 8.30am to 5.30pm Monday to Friday, and 8.30am -12.30pm Saturday and Sunday.
- The antenatal assessment centre (ABC) was open between 7.30am and 8.00pm seven days a week.
- A Supervisor of Midwives (SOM) was available 24 hours a day, seven days a week through an on-call rota. This on-call system provided midwives with access and support at all times.
- A consultant on call and anaesthetist was available 24 hours a day, seven days a week. The gynaecology consultants on call covered both Queens Medical Centre, and the sister site City Hospital. Consultants told us that due to teamwork and the supportive nature of colleagues this had not caused a problem or compromised patient care.

Access to information

- Patient white boards were available throughout the unit mapping patient location. In public areas these were trifold boards that could be closed to maintain patient confidentiality. In gynaecology the electronic patient board had the patient details minimised for patient confidentiality.
- Medical records were accessible and available for both gynaecology and maternity clinics.
- The electronic notes system provided and sent summaries to the GP and community midwives on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Maternity and gynaecology

- Patients gave verbal consent for their care and treatment and this was clearly documented in the women's records. The records we reviewed contained written consent for surgical procedures.
- Training on consent, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLs) and learning disability was part of mandatory training for all staff. 80% of midwives and 90% of nurses had completed their mandatory training. Information was displayed in staff areas on an explanation and definition of MCA and DoLs.
- Booking and consent including Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed for Termination of pregnancy at a central site in the city.

Are maternity and gynaecology services caring?

Good

Overall, the care provided for women using maternity and gynaecology services was good.

The staff were found to be caring and compassionate in all aspects of the division.

Staff treated women, families and visitors with respect and their wishes considered. They felt included in and were informed about the plan of care.

The women we spoke with all expressed that staff had been caring and provided great physical and emotional support.

Women's wishes were considered in the development of the service.

Specialist services throughout the department offered emotional support for women, this included extra clinics.

In maternity, delays in discharge were not always communicated and partners could only stay in exceptional circumstances.

Compassionate care

- We observed ward areas, listened to focus groups and spoke with individual staff who were involved in patient care. We saw good interactions and found that staff responded compassionately, treating people with kindness, dignity and respect.
- Friends and Family Test (FTT) results were generally above the England average for antenatal care, birth, postnatal ward and postnatal community care between April 2014 and May 2015. Staff on labour suite acknowledged that their response rate for FFT was poor with 22 replies. They had not devised a plan to improve response. The feedback they had received was 98% to 100% positive.
- The service performed the same as other trusts in all areas in the CQC Survey of Women's Experiences of Maternity Services 2015.
- All staff we spoke to were very proud of the care they gave to women and their families.
- Women and their partners we spoke to felt that they had been treated with respect and compassion. They felt confident to ask questions and said all staff have "been great", midwives were "amazing" and a partner described staff as "very accommodating".
- We observed staff respecting the women's dignity by knocking and waiting to be invited in to rooms, or behind the curtains around the woman's bed space.

Understanding and involvement of patients and those close to them

- The women we spoke to told us they were well informed and involved in planning their care.
- Women discharged home were provided with detailed information on the signs and symptoms that they should look for, and how to seek advice.
- There were no designated areas for care of women and their families following bereavement. A donation had been made by a family, and talks were in progress with the family to utilise the money to provide the most appropriate facility.
- Women's wishes were considered in the development of the new gynaecology assessment unit.

Emotional support

- The culture on wards was patient focused and attentive to individual needs. Feedback was overwhelmingly positive; women and relatives told us that all staff, from reception through to consultants, had provided exceptional care. Women told us their wishes had been

respected and they had been treated with dignity. Delays in discharge and communication concerning discharge information was highlighted by two women we spoke to.

- Confidential professional counselling from a qualified therapist registered with the British Association of Counselling and Psychotherapy was available for women using the termination of pregnancy services. Consultations were available before and after procedures.
- A midwife from the postnatal ward provided a listening service for women who wished to discuss their labour and birth.
- A specialist midwife ran an 'extra input' antenatal clinic to support women with psychological or significant anxiety issues around childbirth. Midwives in a focus group were able to give examples of providing women centred care during complex situations.

Are maternity and gynaecology services responsive?

Good

The responsiveness of maternity and gynaecology services was good.

Women's needs were met with a range of specialist maternity and gynaecology clinics and fetal medicine service.

General practitioners had direct access to the gynaecology day unit for support and patient review.

The early pregnancy unit provided a one stop service for women.

Babies requiring extra care could be cared for without separation from their mothers in transitional care.

The maternity ward had implemented an initiative to improve the women's experience and early discharge home following a caesarean section.

There were clinics in the community developed with local population in mind, for example a clinic with a dedicated Polish interpreter in an area of high prevalence.

A new maternity phone app had been used to find an alternative method for sharing information with women.

Women were given a choice of where to give birth however the trust were not meeting expected targets for seeing pregnant women by the 14th week of their pregnancy.

Women's care was occasionally diverted to the sister site due to staff and bed shortages.

Elective caesarean sections were delayed due to the demands of labour suite, although very rarely cancelled and rearranged.

The midwife led birth centre did not fully embrace the 'home from home' values of midwife led care.

Service planning and delivery to meet the needs of local people

- Women were given an informed choice of where to give birth dependant on an assessment of clinical needs. The community midwives offered a home birth service.
- Consultant gynaecologists with specialist interests had specialist roles. We saw staff took the lead on different conditions to provide a comprehensive gynaecological service to women.
- Colposcopy and minor procedure services were offered in the gynaecology assessment unit adjoining the ward.
- The co-located midwife led birth centre (the Sanctuary) had for 10 years, been offering women assessed as low risk, a less medicalised birthing option. Women did not call or enter the Sanctuary directly, but liaised with the assessment unit or labour suite
- The Sanctuary was described by the hospital as a more home-from-home environment; however, we observed it to be clinical and medicalised. Some attempts had been made to make the areas more homely with soft lighting and bean bags. We saw equipment in the Sanctuary rooms that would be used for high-risk women such as fetal monitoring equipment, neonatal resuscitation equipment and instruments to assist an instrumental birth. The presence of medical equipment was not following the values of midwife led care. The distinction between the high and low risk areas appeared blurred. During our visit the senior team acknowledged our concerns about the values of the MLU and agreed that they had not got the model of home from home for a MLU implemented. They had discussed options and decided to arrange a working group to change the practises to meet the standards of low risk, home from home care.

- Babies who required extra monitoring and care were cared for on the transitional care ward on the maternity ward. This enabled mothers and babies to stay together during their stay.
- There were clinics in the community developed with local population in mind, for example a clinic with a dedicated Polish interpreter in an area of high prevalence.
- For women whose first language was not English, maternity information was provided in other languages. Staff said interpreters were used regularly to support women in the hospital and community.

Access and flow

- Trust wide maternity services (QMC and City Hospital sites) reported 200 single site closures between January 2014 and June 2015. The closure of one of the maternity units did not stop maternity services at the trust.
- The diversion of maternity services guideline identified the diversion of patients to the sister site as a last resort. This single unit closure (of only one of the two hospitals) occurred on 99 occasions at Queens Medical Centre, during the period of January 2014 to June 2015. Data was not captured to identify how many women this affected.
- Staff prepared women for the possible diversion at their first antenatal appointment. Staff explained that when the labour suite had no beds, or staffing was difficult, women may be transferred to the sister site at City hospital.
- The elective caesarean section (CS) theatre list ran daily Monday to Friday. Routinely three cases a day were booked. The medical theatre team performing the operations were also responsible for emergency care on the labour suite. Staff told us, and we witnessed, that if the labour suite was busy then the elective operations would be delayed. Women who had not eaten or drunk prior to surgery could remain starved for up to 14 hours. A policy was in place to hydrate women if it was considered necessary. We also witnessed one woman attend labour suite at 07.30 in preparation for her caesarean, to be told at 10.00 that it would be delayed due to the lack of availability of neonatal cots. The lack of prior planning had caused the woman unnecessary distress, and an unnecessary attendance to hospital. It was rare (one case in six months) for caesareans to be cancelled or rescheduled.
- Trust wide 79% to 86% of women were seen by 13 weeks of pregnancy, this was consistently lower than the target of 90%. Staff had looked into this and found that it was due to women booking late. The community manager was working to improve the compliance statistics.
- The service implemented the enhanced recovery after surgery programme (ERAS). This promoted early mobilisation and early discharge for women following an elective caesarean section. Audit of the process had highlighted that there had not been an increase in mother or baby readmission. Further audit indicated a 60% day one discharge of women within the ERAS programme.
- Women had been delayed being discharged home due to waiting for medicines from the pharmacy to arrive. Plans were in place to supply training and medicines to the ward staff for dispensing take home medication.
- The gynaecology emergency service allowed general practitioners to refer women directly to the service. This removed the need for women to spend time in the emergency department awaiting triage. The women were treated in the department by gynaecologists and sent home if appropriate reducing hospital admissions.
- There were no reports of gynaecology day cases being diverted due to a lack of beds.
- The maternity ward bed occupancy was 62.7% to 78.2%, which was worse than the national average of 55%-60%. Gynaecology bed occupancy was only just worse than the national average at 63%. The senior team were not aware they were higher than the national average. However there was on-going work in the trust to improve flow and a company had been asked to look at maternity services as part of the “Better for you” campaign.

Meeting people’s individual needs

- Specialist maternity clinics included medical maternal ‘one stop’ clinics for women with complex medical needs, healthy lifestyle clinic, fetal medicine clinic, and psychological support clinics.
- The trust had access to 24-hour interpreting services via a national database. Staff described the service as efficient and easy to use.
- People using the maternity services could access clinical midwife specialists. This included midwives with specific skills, knowledge and experience to care for women with diabetes, alcohol and substance misuse

issues, and women who may have undergone female genital mutilation, FGM). There was a midwife with special responsibility for safeguarding vulnerable women and a midwife who counselled women following a miscarriage or termination of pregnancy.
- The trust provided women and families with a wide range of supportive health education literature, including leaflets, posters and electronic information. The information leaflets had the facility to be in additional languages.
- The provision of scanning and assessment rooms within the early pregnancy unit provided a one stop service for women. On average, the staff could see 24 women a day and perform 10 ultrasound scans.
- Women were given a choice of place of birth in line with national guidance, which recommended both a choice in place of birth and lead carer. This included choice to have a home birth, birth in a local facility under the care of a midwife in a midwife led unit (MLU), or birth in a hospital supported by midwives, anaesthetists and consultant obstetricians.
- The use of an innovative new pregnancy phone application (pocket midwife) assisted in the information given to women. The phone 'app' consisted of general pregnancy information that was useful to all prospective parents and their families. It also contained information specific to the trust, such the trust's own maternity leaflets and useful contact telephone numbers.
- There were parent education classes run by the trust's midwives, these included information about labour, birth and the postnatal period. The trust also ran weekly 'Active vision, active birth' classes, to educate women on the use of relaxation, mobilisation and positions to adopt during labour and birth.
- Partners could not stay on the ward overnight unless it was exceptional circumstances. Staff explained that there were four side rooms available and each request was dealt with on an individual basis. We saw evidence of one partner staying during his partners hospital stay.
- The early pregnancy unit was designed to allow comfort privacy and dignity at all times. Two counselling rooms were available for breaking of bad news.

Learning from complaints and concerns

- Throughout the department there were boards containing patient feedback and suggestions from women, and the actions taken.
- Patient Advice and Liaison Service (PALS) information leaflets were displayed in some areas. The leaflets informed patients how to raise concerns or make a complaint. Women we spoke with felt confident to address concerns locally. Three of the 12 women knew that there was a hospital service for complaints.
- Complaints in maternity and gynaecology were addressed at the clinical governance meetings. Information was fed back to the staff at ward meetings and via the supervisor of midwives. Data we saw demonstrated that all complaints were dealt with in the recommended time frame.
- Staff described the value of dealing with people's concerns immediately before they developed into complaints that were more significant. The maternity wards completed a 'ward concern' form if women's complaints were dealt with face to face prior to discharge from hospital. This information was collated and sent to PALS in case further advice was required.

Are maternity and gynaecology services well-led?

Good

Overall, we found the leadership of maternity and gynaecology services was good.

Governance processes had been strengthened and were becoming embedded in the service although still in their infancy, national reports were benchmarked and actions identified were put in place.

The senior team had plans in place to address the backlog of incidents and had made good progress closing 335 in the last three months.

There were open pathways up to the trust board and to all of the staff working in the service. The senior team were aware of the improvements needed in the service and had robust plans to address them. However data for Queens Medical Centre was not always examined separately from City hospital maternity data. This meant it would not be possible to establish if one site was performing significantly better, or worse that the other.

National reports were used to assess the quality of the service and actions identified were put in place. The senior

team were aware of the improvements needed in the service and told us of robust plans to address them. The senior team told us they had good working relationships with the trust board.

The leadership and culture encouraged openness and transparency. Staff told us they were well supported by their managers and many, loved their job. Staff across all levels also told us that senior managers were approachable.

Women were able to share they experiences in a variety of ways. A number of innovative projects had been developed by staff to improve the service for the women accessing the service.

Staff were not aware of a maternity strategy and could not explain any goals from the annual plan.

Vision and strategy for this service

- The strategy for the maternity service was not defined into a simple format for staff to understand. The strategy was not displayed for staff to see and staff we spoke to did not know that there was a maternity strategy.
- The medical and midwifery leads of the service had an 'Obstetrics and Midwifery Annual Plan 2015/16' which identified the vision and clarity for the service's future. The senior team were aware of the improvements that were required and actively sought to make a difference to improve services. However, there were no vision and values aligned within the plan such as compassion, dignity and equality. What was difficult to identify was a strategy that was short and simple for staff to be aware of and remember.

Governance, risk management and quality measurement

- A cross site governance framework was in place for maternity and gynaecology services. Meetings were monthly and multidisciplinary, all grades of staff were welcome to attend. The meetings covered topics including serious incidents, safety thermometer, the risk register, staffing levels, and patient experience. Previous actions were reviewed and monitored, we reviewed minutes of three meetings which demonstrated this.
- The governance team had escalated problems with reviewing and clearing incidents to the executive team. They were supported to identify two members of staff to strengthen their governance team and investigate incidents. During our visit, the governance team told us that they had reviewed processes and agreed a new system to improve incident management. This was demonstrated by the improvement of a reduction from 616 to 303 open incidents in three months.
- Performance data was not always examined for Queens Medical Centre in isolation. This prevented the managers from planning services to meet the needs of local people.
- Ward staff had set up new shared governance teams to feedback information from the wider governance groups. They were also responsible for benchmarking care against 10 defined criteria, such as dignity and privacy, record keeping communication. The new teams were in their infancy but had strengthened the work of the existing governance structure.
- Risks identified within the service were scored and agreed at the risk management meeting and signed off at the directorate clinical governance meeting. We reviewed three risks on the register, all had action plans that were reviewed regularly.
- We saw that the maternity and gynaecology risk register was reviewed and updated regularly. Actions taken were visible and the process completed for removing risks from the register.
- The government had commissioned an independent investigation into maternity and neonatal services nationally (the Kirkup report), to examine concerns raised by the occurrence of serious incidents. The report of its findings was published in May 2015, and included recommendations directed nationally at the NHS, to minimise the chance that these events would be repeated elsewhere. The maternity, neonatal and paediatrics senior team had benchmarked the report to their services in June 2015. We saw a plan produced in response which had a number of actions allocated to staff for completion in set time frames.

Leadership of service

- Staff in maternity described the trust wide managers as visible and inclusive at both hospitals.
- Local leadership within all areas was strong and supportive. Staff described a good relationship with ward managers, and an assurance that complaints and concerns would be addressed.
- The senior team were quite a new team and demonstrated strength and determination to improve services and staffing to meet the needs of the service.

- Midwifery and medical leads were active in implementing the annual plan.

Culture within the service

- Staff were friendly and welcoming. They were enthusiastic and strived to provide quality care and were proud to work at the hospital.
- Throughout the hospital all grades of staff described a culture of good team work and supportive colleagues.

Public engagement

- The senior team explained that they actively sought women's views from the groups that they held such as the Partnership in Maternity group. For example, the women of the antenatal classes named the antenatal assessment unit ABC (Antenatal Baby Care unit).
- Women could communicate their experiences on the trust website. This was available for the public to view. We reviewed the website and saw it invited people to share their experiences.

Staff engagement

- Staff described good opportunities for development with seconded roles and champion roles such as safeguarding, infection prevention and control, incident investigation, and breastfeeding.
- Staff and management were proud of the shared governance team and the changes they had achieved.
- We saw 'Smile' compliment slips in the staff room where staff could highlight good caring attitudes amongst colleagues.
- Ward staff were encouraged to nominate staff as the 'Star of the month'. This was for all ward staff including contracted domestic staff and developed a teamwork approach.
- The trust had run a well-advertised nurse or midwife of the year award. This was in addition to NUH Honours awards nominations.

Innovation, improvement and sustainability

- The maternity governance team attended regional forums to share good practice.
- A member of staff designed a maternity app specifically for the women at NUH called the 'Pocket Midwife'. The free 'app' had information about each stage of pregnancy, including leaflets and information. The service could add news flash information to the app for women to see, for example flu vaccinations alerts. Maternity leaflets and trust guidelines were easily accessed via a guideline app.
- Staff in ward areas actively sought charitable funds to improve services for women through the trust's 'Just do it' funding.
- Maternity services identified successful processes within the hospital and engaged with the staff who were involved. For example the 'breaking the cycle team' had been successful in reducing emergency waiting times. This team were invited to work with maternity services to improve the efficiency of the discharge process.
- The managers were focusing on succession plans to sustain services. They looked for proactive staff members and actively developed them, for example support workers who wished to work complete national training and midwives with interests in safeguarding or governance. This enabled them to apply for a promotion when available.

Services for children and young people

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

Information about the service

Children's services at Nottingham University Hospitals NHS Trust are based at Queens Medical Centre (QMC) and City Hospitals. The children's service had 119 beds; over 75,000 episodes of care were delivered for children and young people in the past year from Nottinghamshire and beyond.

The majority of children's services are based at QMC where care was provided to children and young people between the ages of 0-19 years of age.

Children's services at QMC include outpatient services, an 18 cot surgical neonatal service and a range of children's specialities including regional children's intensive care and high dependency care services. A number of speciality outreach clinics to surrounding hospitals and clinics are also provided.

The neonatal service is the lead centre for the 'Trent Perinatal Network.' The service operates as a single service, despite being based on two sites and includes joint clinical governance arrangements, training, joint guidelines, audit and clinical research. The service provides a regional neonatal surgical service at QMC and a tertiary service for the north of the East Midlands Network. Care is provided for all the smallest and sickest babies and for babies with surgical problems. Babies with medical needs are treated and cared for at the City Hospital neonatal unit. Babies with cardiac problems are stabilised and transferred to other hospitals that specialise in this field.

The children's service included 15 clinical areas, including the neonatal unit. During our inspection of children's services at Queens Medical Centre, we visited the neonatal unit, the children's outpatients departments, the paediatric intensive care and high dependency unit and 11 inpatient children's wards.

We spoke with 21 medical staff, 65 nursing staff including managers, 13 members of the multi-disciplinary team, 38 parents and a group of young people.

Services for children and young people

Summary of findings

Overall, the children's and young people's service was rated as good.

We found services for children, young people and their families were effective, caring, responsive and well led. However, improvements were needed for the service to be safe.

Although, staffing shortfalls had been recognised some staff felt this had impacted negatively on staff morale, although the staff survey results for children's services were largely positive. Additional monies were identified for the recruitment of trained nursing staff within the children's and neonatal service. The 2015 workforce review document identified 25 vacancies in children's services, and 28 vacancies in the neonatal service. The trust met the Royal College of Paediatrics and Child Health (RCPCH) standards for paediatric consultant staffing levels.

Shortfalls in trained nurse provision on the neonatal unit and within children's services were managed through escalation pathways. The family health directorate recognised that staffing did not meet Royal College of Nursing (2013) and British Association of Perinatal Medicine Guidelines (2011) and had identified this on the trust risk register.

There was generally good access and flow within the children's service. Patients received evidenced based care and treatment and good multi-disciplinary working existed between the children's services, external providers and the child and adolescent mental health service (CAMHS). However, the admission of children who experienced mental health problems had increased and we were told their needs were not always met. This meant that children were cared for in an environment, which did not meet all of their needs.

Risks to patients were assessed but we did not see that all risks had been addressed. Ligature risks remained in place, despite ligature audits, which had been completed within the clinical areas we visited. Actions remained to remove these risks to reduce the risk to children and young people with mental health needs who may be at risk of self-harm.

There were difficulties when discharging children to tier four mental health beds which had delayed children's and young people's discharges. Tier four beds are specialist mental health beds.

Monitoring records of resuscitation equipment and neonatal transport systems showed that monitoring of this equipment had not taken place daily.

Whilst the trust identified they did not have one nurse per shift with either the 'Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training', there was a plan where the trust were aiming to have one nurse per ward (resuscitation link nurse). A training schedule was in place to monitor and plan the delivery of training. However, we were aware that the children's service were supported by children's critical care and retrieval services which meant that these staff may be available to support emergency resuscitation situations throughout the children's service.

The children's service had no planned out of hours radiology support and a full review of the paediatric forensic examinations service and environment was required. Both had been recognised as a risk by the trust.

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

The service was well led and a clear leadership structure was in place. Individual management of the different areas providing acute children's services were well led. Governance processes, clinical risks monitored, and feedback from staff, parents and children and young people had resulted in changes to aspects within the service.

Services for children and young people

Are services for children and young people safe?

Requires improvement

The safety of the service required improvement.

There were shortfalls in qualified nurses and nurses trained in speciality within both the children's and neonatal services and current staffing did not meet best practice guidance. The family health directorate had identified nurse staffing within the children's hospital and neonatal unit as risks on the trust risk register. Random staffing rotas from the children's wards showed that there was not a band 6 nurse in charge of each shift. The trust met RCN (2013) staffing guidance , that there was a competent, experienced band six nurse throughout the 24-hour period to provide the necessary support to the nursing team, by the use of a nominated band 6 nurse bleep holder. Additional funding for nursing staff was identified and recruitment of nursing staff had been on-going, however, challenges remained as there were difficulties recruiting children's nurses.

Neonatal staffing did not fully meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM) because they were unable to provide one nurse to one baby care in the intensive care unit for all intensive care (level three) babies.

The children's service confirmed that they were compliant against the Royal College of Paediatrics and Child Health (RCPCH) consultant staffing standards.

Specialist radiology cover was not available out of hours except Saturday mornings. The lack of radiology cover was identified on the risk register.

There were shortfalls within the clinical environment. The neonatal unit at Queens Medical Centre was compact with limited space around the cots and the clinical environment was very warm. There was no room provision for the end of life care of a ventilated baby.

The admission rates of children and young people (C&YP) with mental health issues to the children's service had increased. This meant that children were cared for in an environment, which may not meet all of their needs. Risks to patients were assessed but we did not see that all risks had been addressed. Ligature risks remained in place, despite ligature audits having been completed within the clinical areas we visited. Actions from the eight ligature audits identified either to monitor or investigate the proposed actions so we were not assured that the actions identified had reduced the risk to young people at risk of self-harm.

Staff identified some concerns about resuscitation trolleys remaining unsealed despite the trust resuscitation policy referring to sealed resuscitation trolleys . We observed different practices existed as neonatal resuscitation trolleys remained sealed. Despite daily checks of resuscitation equipment having been implemented since July 2015 we found gaps in these monitoring checks, as they had not taken place daily. These differences in practices and the failure to follow the trust resuscitation policy guidance were escalated to a senior manager and our inspection lead as an area of concern.

Whilst the trust identified they did not have one nurse per shift with either the 'Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training', there was a plan where the trust were aiming for one nurse per ward (resuscitation link nurse). A training schedule was in place to monitor and plan the delivery of training. However, we were aware that the children's service were supported by children's critical care and retrieval services, which meant that these staff may be available to support emergency resuscitation situations throughout the children's service.

We found shortfalls in medical staff attendance at level three children's safeguarding training and were told that currently there were shortfalls in nursing staff who had completed the advanced paediatric life support course.

Children's records were not always stored securely and we found information gaps in some children's records.

Incidents

- At the time of our visit the children's service incident log identified a total of 516 incidents from March until June 2015. Each incident was categorised, identified actions taken, actions taken following investigation and lessons learnt. Two examples of changes following lessons learnt included implementing additional staff learning and transitioning adult patients who had previously been cared for by the paediatric consultant staff to adult service consultants.

- At the time of our visit we saw that 154 incidents had taken place across the neonatal units from March until June 2015. Each incident was categorised and identified the actions taken.
- We saw an example of incident discussions taking place within the 'Directorate Report to Quality Governance Meeting' (17 July 2015). The minutes identified that since October 2014 five incidents were reported within the children's hospital and neonatal unit. Three incidents had been reassigned as low harm after investigation, whilst two incidents had initial Duty of Candour applied in that the parents were spoken to and given written information.
- Systems were in place to ensure that incidents were reported, investigated and lessons learnt. Incidents, complaints and significant events were discussed at ward meetings, clinical governance meetings, during the quarterly quality governance meeting and at monthly trust board level meetings.
- Medical and nursing staff confirmed they knew how to report incidents and had received feedback via email, weekly bulletins and associated learning. Staff told us they had to attend incident training before they could complete the electronic incident reporting forms and that they could request to receive feedback from incidents as part of the incident reporting process. Following the inspection the trust told us that all staff could complete electronic incident forms and no formal training was required.'
- We tracked one serious incident, which had taken place from June 2014 to January 2015 within the children's hospital. The investigation included a full root cause analysis report, internal and external investigation reports and an action plan. We saw evidence of learning following this incident. The outcome had resulted in changes to processes, for example, the children's ward attender policy within PEWS (paediatric early warning score) guideline, now identified that physiological observations, such as temperature, heart rate and respiratory rate should be recorded at the initial assessment, used as a baseline and as part of routine monitoring. This has also been applied to ward attenders (day patients).
- Staff told us that safety alerts were circulated via emails.
- Clinical performance data was captured monthly for each clinical area and was reported within the 'Children's & Young People's Services Nursing Dashboard.' Staff told us they could access this information on the trust intranet, therefore keeping them informed of performance indicator outcomes. We reviewed five clinical area audit results for the period from August 2014 to July 2015. The audits identified the areas monitored, for example, the proportion of patients with a paediatric early warning score (PEWS) completed, triggered and not escalated
- The children's hospital and neonatal unit had monthly mortality and morbidity review meetings, which reported to the directorate governance meetings. Minutes of the 'Directorate Report to Quality Governance Meeting' (4 June 2015) confirmed that the children's hospital was not an outlier in this area.
- Close links existed between the bereavement team, children's safeguarding board and child death overview panel. Meeting minutes from the 'Directorate Report to Quality Governance Meeting' (17 July 2015) identified that learning and concerns from mortality data were discussed.
- Four clinical staff demonstrated some knowledge about the 'Duty of Candour' regulation. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- We saw that the 'Duty of Candour' integrated into the incident reporting and complaints processes. A 'Duty of Candour' flowchart (v1) for incidents graded moderate harm or above was available for staff to access. The guidance within the flowchart reflected regulation 20. Staff told us there had been drop in sessions for them to attend to learn about the 'Duty of Candour. We saw guidance on the hospital intranet which identified what this regulation was and that it was a new regulation applicable to all providers.

Cleanliness, infection control and hygiene

- Each clinical area had an infection control 'link' staff member who had six hours protected per month to undertake infection prevention and control work. Staff told us that they could easily contact the infection control team, which meant appropriate professional advice was available.
- The areas we visited had cleaning schedules and infection prevention measures in place, such as infection prevention and control guidance and wall

mounted hand gels. One staff member told us that occasionally they had problems with hand gel dispensers being removed by visitors. This person did not identify what if any actions had been put in place to prevent removal of the hand gel by visitors.

- Generally good infection control practices were observed by staff, however, we observed on occasion that some medical staff did not always use hand gels on entering and leaving clinical areas. Staff used personal protective equipment such as gloves and aprons when undertaking tasks.
- We observed the necessary precautions in place for those children nursed in a cubicle. Guidance displayed outside the cubicle, stated what barrier precautions were necessary when entering the child's cubicle, for example, gloves and aprons.
- The 'Family Health Directorate' scorecard confirmed the findings of audits relating to infection prevention and control, for example, cleanliness and hand washing audits. The average baseline scores for compliance ranged from 85% to 100%. We saw that not all clinical areas had achieved these levels of compliance. For example in the children's clinics the score for nurse's hand washing compliance was 71% against a target of 95%, whilst in the paediatric intensive care unit 85% compliance had been achieved for hand washing by doctors. These figures showed that improvements were required to achieve compliance against identified targets. The Family Health Directorate did not provide any additional information to demonstrate how they would improve compliance in those clinical areas identified as falling below expected compliance targets.
- On ward D33 we were told that the infection control audit target was to achieve above 95%, the recent ward cleanliness audit had scored 93% so did not quite meet the target.
- Staff received infection prevention and control training as part of their induction and as part of the annual mandatory training DVD. Staff confirmed they had completed a hand washing assessment on the neonatal mandatory training day.
- All staff had received infection control training on induction and again as part of their annual mandatory training DVD.
- We saw an information leaflet which identified that the children's hospital had an 'Advertising Sepsis' week from the 7 September 2015 to raise awareness in the hospital. Staff in the children's intensive care unit received sepsis training as part of the critical care induction and had also completed a sepsis quiz recently to test their knowledge.
- Two staff told us that sepsis six had not been implemented and that it was currently under discussion within the children's service. Two additional staff from within the children's service confirmed they had attended the drop in sepsis awareness week. We saw posters about sepsis awareness displayed.
- The children's service training statistics confirmed that 133 staff which included nurses and doctors from the multi-disciplinary team had attended world sepsis training in 2015.
- The service had a 'Recognise severe sepsis / shock' flowchart in place which advised on the treatment routes to take which was supported by a 'Severe Sepsis' guideline (October 2015) which advised on sepsis management.

Environment and equipment

- Equipment suitable for babies, children and young people was seen in all clinical areas.
- We were told there had been complaints about the environmental temperature in the children's outpatient department as it was too hot. As an interim measure, temperatures were being monitored before any changes were made.
- We found the environment on the neonatal unit (NNU) was very warm and were told that parents had complained about the temperature. Staff told us that this concern was identified on the risk register. The theatre ventilation system linked with the neonatal unit (NNU) resulting in the high temperatures on the unit. A project lead had been identified and a business case was being written to present at trust board in November or December 2015.
- The NNU at Queens Medical Centre had limited space around the cots and there was no separate room available for the end of life care of a ventilated baby. Bay five in the unit was used as a multi-purpose room in which equipment was stored and babies from the post-natal wards seen for screening procedures.
- Staff told that a new system of daily monitoring of resuscitation equipment had been implemented (July 2015) which included leaving resuscitation trolleys unsealed. We reviewed six resuscitation trolleys throughout the service and found that different

practices existed. The resuscitation trolleys within the neonatal units remained sealed when not in use; those on the children's areas were unsealed. Some staff we spoke with identified concerns about the resuscitation trolleys being unsealed as any person could access the equipment and medication which meant that the equipment may not be available when needed.

- We reviewed the resuscitation policy and saw reference made to sealed resuscitation trolleys. We were shown an email which had been sent to a resuscitation link nurse which identified that resuscitation trolleys be left unsealed. We escalated these differences in practices and what the trust resuscitation policy guidance identified to the neonatal matron. We did not receive any information confirming whether any actions had resulted following this escalation.
- In the neonatal unit, we observed gaps in the monitoring of the resuscitation equipment and no retrospective monitoring records were kept for the neonatal resuscitation transport bags.
- We reviewed both neonatal transport systems and found that daily monitoring was in place; however, we observed that there were gaps in the monitoring records confirming that daily checks had not always been completed. We asked to see the previous monitoring records for the transport systems and were shown three partially completed monitoring books named 'Transport System Check' which did not identify which transport system they referred to, for example transport system one or two. From the information provided, we were unable to establish which book related to which transport system. We asked the nurse and they were unable to confirm which book belonged to which transport system.
- We observed that some equipment on resuscitation trolleys and in the resuscitation bags did not have identified expiry dates. This equipment included, needles; laryngoscope handles and blades which is equipment used to maintain an open airway. This was raised with the neonatal critical care lead who immediately replaced the needles. They also raised a query with the manufacturer about the equipment which had no expiry dates. The response was that the devices had been supplied non-sterile and packaged from an accepted specification used within the medical packaging industry.
- We reviewed the patient safety checklist (January 2015) in the Burns clinic. This checklist identified the daily and weekly checks required on the ward. For example, daily checks of buzzers, oxygen, suction, and the resuscitation trolley. The checklists for January, April, May, August and September 2015) showed that some of the daily checks had not taken place, which could potentially pose a risk should equipment be missing or become faulty.
- Appropriate measures were in place to maintain security within the children's hospital and neonatal units. Security cameras were located throughout the building and people either had to ring a bell to enter the clinical environment or use swipe card access.
- Babies in the neonatal unit had additional protection in the form of an electronic tag. The tag was attached to their person when other forms of clinical monitoring were not in place. We tested one of these tags by taking it to a door exiting the ward and observed that the alarm went off. We were told that this alarm automatically informed security who would come to the unit. In this instance, security were informed this was a test.
- One senior manager told us that since the previous Care Quality Commission inspection they estimated 90% of the clinical equipment had been tested. There had also been spot checks on clinical equipment. Following the inspection, we received the October 2015 equipment servicing compliance report. The report confirmed there were 2,491 items in the medical equipment service unit. Equipment was prioritised into three service priorities, high, medium and low. The equipment serviced to date within each priority category was high – 80%, medium – 45% and low 43%. These priorities were assessed by senior clinical engineering technologists taking into account both the intrinsic hazards related to the equipment and the likelihood that routine assurance testing or maintenance will reduce the associated risks. To support this decision, senior clinical engineering technologists complete an assessment using the assurance and preventative maintenance schedule template. The first page of the template guides the decision process on Servicing Priority, Assurance and/or Performance Testing and service frequency (based on manufacturer recommendations). The second page of the template allows documentation of any supporting information (which might have been relevant to the decisions on page 1) as well as allowing for explanations/justifications of any deviations.

- Staff identified concerns that ward D33 was not the right place for children with mental health care needs. We also saw that CAMHS children were also admitted to other clinical areas.
- We were told that some children's wards had collapsible hooks and curtains. These were designed to reduce the risk of a self-harming patient using the hook as a ligature point. A ligature point is any feature in an environment, which could be used to support a noose or other strangulation device that a patient might use to self-harm. On wards D33 and E17, we observed ligature risks throughout the clinical areas, which included fixed hooks. We asked one nurse in charge if a risk assessment had been undertaken. They advised it had not been carried out which meant that children had access to possible ligature points on the ward and could potentially harm themselves.
- Environmental audits had been completed across the children's hospital since January 2015 for potential ligature points, glass risks and falls from height. Since the inspection we have been informed that these audits take place yearly. The children's service has, since the inspection provided updated ligature audit assessments for nine clinical areas. We visited two wards D33 and E17 to confirm the progress made against these audits and found that the areas identified for action remained to be actioned. Therefore, despite the audits the risks remained.
- Information received from the hospital identified that wards, E17, E37, E38, D33 all had anti-ligature pull cords fitted and a ligature cutter on their resuscitation trolley. However, when we visited wards D33 and E17 on the unannounced part of the inspection we did not find evidence or were told by staff of the presence of these anti-ligature pull cords or the availability of the ligature cutter.
- Risks to patients were assessed but we did not see that all risks had been addressed. Ligature risks remained in place, despite ligature audits having been completed within the clinical areas we visited. Actions from the eight ligature audits identified either to monitor or investigate the proposed actions so we were not assured that the actions identified had reduced the risk to young people at risk of self-harm.
- Additional information received since the inspection identified that by January 2016 all remediable risks had been completed. This included anti-ligature pull cords and ligature cutters in the high risk wards where children and young people with mental health problems are admitted (including D33, E37, E38 and E17).
- On ward E17 in the patient carer room, a hot water urn supplied hot water for drinks. The patient carer room was unlocked and had not been risk assessed as a potential danger to the children and young people. This meant children and young people were at risk of scalding.

Medicines

- The trust policy for safe management of medicines was in line with National Institute for Health and Care Excellence (NICE) guidance.
- Medicines management was in line with trust policy, for example medicines were locked in cupboards; the nurse in charge carried the controlled drug keys which were separate from the ward keys. We reviewed seven drug charts and no gaps were seen against the majority of entries. However, we saw some gaps in one drug chart and brought this to the attention of the child's nurse. We were told that the mother had given the medication to their child, but had not signed that she had given it.
- To reduce medication errors we saw nursing staff wore red tabards or plastic aprons whilst on the medication rounds. This indicated to staff, visitors and parents that the nurse(s) must not be disturbed. Medical staff had an identified prescribing space or corner on the ward where they went when reviewing and prescribing medication.
- A medicines safety week had recently taken place at the trust where learning had taken place from medication incidents.
- Nursing and medical staff received medicines training at induction. Local medicine competency documents were in place for nursing staff to complete. We were told that neonatal nursing staff completed a yearly competency assessment and two yearly medication administration papers. The annual neonatal mandatory day had a safety session, which presented incident trending and medication management information.
- Paediatric pharmacists and pharmacy link nurses were attached to each clinical area. Staff we spoke with told us they attended quarterly multi-disciplinary team (MDT) meetings to discuss drug incidents and the meeting minutes from these meetings were cascaded to

staff. Staff also received a newsletter following the quarterly MDT pharmacy meetings. We saw the latest newsletter, which had information about a type of medication infusion.

Records

- The trust health records management policy 2010 (v2) identified that records should be stored securely 'from unauthorised or inadvertent alteration or erasure, that access and disclosure are properly controlled and audit trails will track all use and changes.' There were facilities for children's records to be stored securely, for example, lockable cabinets and trolleys. However, we saw that records were not always stored securely and we brought this to the attention of staff.
- We reviewed a mixture of 24 sets of medical and nursing notes. Information gaps existed within some nursing records. For example, the nursing documentation assessment tool; gaps were seen in one child's orientation to ward and ward facilities section, there was no confirmation that the swabs to test for methicillin-resistant staphylococcus aureus (MRSA), a bacteria which is responsible for difficult to treat infections, had been taken.
- Reviews of children's care had taken place and changes documented. However, we observed that on occasions, there had been longer time periods between nursing reviews, for example, one child's neurological and pain care plan had reviews of between one to 11 days.
- Children's care plans were pre-printed, standardised plans. Some had been individualised and were relevant to the child's care.
- The trust wide medical health records keeping audit April 2014 – October 2014 included 36 records from the children's service. The findings confirmed that the family health directorate compliance levels ranged from poor compliance (below 85%) to good practice (above 95%). The family health directorate did not provide a copy of their action plan or progress to-date, which meant we were unable to judge what any progress made.

Safeguarding

- Safeguarding reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide. The medical director was the trust executive lead for safeguarding children.
- A dedicated children's safeguarding team was in place, with close working relationships with the adult safeguarding team. The children's safeguarding team is led by the named nurse for children's safeguarding. This person worked closely with the named midwife. The safeguarding structure included, 3.6 whole time equivalent (wte) band seven nurses, and one domestic abuse lead that was based in the emergency department. One band six-specialist midwife also had close links with the team. There were 56 ward based safeguarding champions trust wide, 17 were based in the children's services.
- Staff told us they had effective working relationships with the local children's safeguarding teams and other healthcare professionals such as health visitors. The new e-observation system automatically alerted the safeguarding team of any concerns who then followed these alerts up.
- Staff demonstrated knowledge of the safeguarding guidance to follow. They knew what to do and who to contact should a concern be raised. For example, children with challenging behaviours and if children absconded. Staff confirmed that feedback was received and lessons learnt from individual safeguarding incidents.
- Families and children who do not attend their outpatient appointment, a 'did not arrive form' was completed and put in the child's file. The paediatrician reviewed this document and made a decision as to whether a safeguarding referral should be made.
- The National Institute for Health and Care Excellence (NICE) safeguarding guidance recommends that qualified staff groups are trained to a level three standard in safeguarding. Staff attended child safeguarding training, initially at trust induction and then during annual mandatory training. Safeguarding training at level three was provided by the safeguarding team. The trust-training target was 90%; in 2014-2015, 90% of nursing staff had completed this training. Following inspection we received some updated training information from the trust dated from the 1January 2015 to 31 December 2015 which confirmed that 78.18% of medical and dental staff, 100% of nursing and midwifery staff and 86.67% of administrative and clerical staff had completed level three safeguarding training in the children's hospital during this time period.

- Safeguarding supervision was provided on an as required basis to members of staff when safeguarding concerns were raised, and following a formal debrief after complex safeguarding incidents. Staff from the neonatal family care team confirmed that they received regular supervision sessions. The trust confirmed that they did not monitor safeguarding supervision attendance.
- A trust children's and young people's safeguarding annual report was presented at the trust board meeting in 2014.
- Staff told us systems were in place to enable them to follow-up social care referrals. These systems included multidisciplinary team involvement and meetings.
- Safeguarding teams had supported families whose infants were placed under a child at risk prior to birth. Following the baby's birth, the multi-disciplinary team had been involved in the discharge planning process to ensure that appropriate measures and support were put in place for the baby and family. We tracked an example of one referral including the discharge plan and saw that both the baby's and parents needs had been met by the measures put in place. For example, prior to discharge the parents had completed a teaching protocol for home oxygen.
- The safeguarding team liaised with the specialist midwifery team when a pregnant young woman was admitted to the antenatal maternity service. Systems were put in place to support the young woman.
- The children's safeguarding team became involved with children and young people with mental health needs (CAMHS) once notified of their admission. They attended medical handovers, made social care referrals and attended discharge meetings. The team had recently met with the children's service lead nurse to discuss how CAMHS inpatient care could be improved.
- Clinical areas received details of missing children alerts via the trust chief executive officer.
- The hospital had an internal register of children and young people who were known to the local authority. On admission to the hospital, this register was checked to see if the child was known to the local authority.

Mandatory training

- We spoke with members of staff of all grades, and confirmed they had received a range of mandatory training and training specific to their roles, for example, incident reporting, paediatric resuscitation, fire safety, manual handling, infection control, and safeguarding. Staff told us that they attended yearly mandatory training in their birth month.
- The mandatory training target was 90% and the senior management team told us there had been an improvement of staff attendance at mandatory training sessions.
- Training statistics for the 2014 - 2015 training year period confirmed that 72% of neonatal staff had attended mandatory training.
- We submitted an information request prior to the inspection, which requested the percentage of paediatric medical and nursing staff attendance at mandatory training for 2014/15 for the children's service. However, this information was not provided.
- The trust confirmed that all registered children's nurses undertook the paediatric intermediate life support (PILS) course three yearly and a paediatric recognition and acute illness management (PRAM) course in the intervening years.
- Training attendance figures from February 2014 to December 2014 confirmed that 175 candidates attended PILS training. This included 96 paediatric staff, 20 theatre recovery staff and 52 junior doctors. We saw that there had been a 48% paediatric staff attendance at this course.
- Training attendance figures from April 2014 to December 2014 confirmed that 180 candidates attended PRAM training. This included 140 paediatric staff and 35 theatre recovery staff. We saw that there had been 69% paediatric staff attendance at this course.
- Whilst the trust identified they did not have one nurse per shift with either the 'Advanced Paediatric Life Support (APLS) or European Paediatric Life Support (EPLS) training', there was a plan where the trust were aiming for one nurse per ward (resuscitation link nurse). A training schedule was in place to monitor and plan the delivery of training.
- The trust ensured emergency care provision was available for children by having staff who were advanced paediatric life support / European paediatric life support trained in the retrieval team, one nurse per shift on PCCU and a minimum of 17.5% of nurses in day case recovery areas. This meant that there were shortfalls in the nursing staff available with advanced

resuscitation skills to care for children should their condition deteriorate. Monitoring of the responsiveness of the team was completed an and reviewed. These showed staff were always available in an emergency.

- Training attendance information taken from the 'Provision of basic and advanced paediatric life support training at Nottingham Children's hospital (updated June 2015)' confirmed that 16 staff had achieved the APLS training across five clinical areas. The majority of staff (11 staff) who had completed this training were based in the paediatric critical care unit. A further 10 places were booked from June 2015 to November 2015.
- In addition, training figures for European paediatric life support training over the same time period confirmed that 17 staff had completed this training in four clinical areas. The majority of staff (13 staff) who had completed this training were based on the paediatric critical care unit. A further 10 EPLS training sessions were booked and were planned to take place in November 2015 and March 2016.
- The trust confirmed that all neonatal staff had completed their neonatal life support training.

Assessing and responding to patient risk

- The service had identified guidelines and protocols to assess and monitor patient risk in real time, and react to changes in risk level.
- The service had 14 paediatric critical care unit (PCCU) beds; from which a local retrieval service was delivered. The retrieval service brings children who require specialist care from other hospitals.
- Some areas within the children's service had implemented an e-observation system. This is where children's physiological observations such as heart rate are recorded electronically. If the child's observations fell outside of an acceptable range an alert was triggered and sent to the child's doctor's handheld device. This ensured that the doctor identified and actioned the next steps in the child's treatment plan. Staff we spoke with told us the alert system worked effectively to ensure that children's treatment pathways were appropriate for their needs.
- The paediatric early warning score (PEWS) and the neonatal early warning score (NEWS) are additional tools used to monitor children and babies who may be at risk of deterioration.
- The NEWS tool is used to assess babies who were cared for in the low dependency unit; it was completed once per shift and escalations were triggered according the score.
- The NEWS tool was not used for babies who were on continuous monitoring because vital signs, pain levels if any and potential risks were identified through this monitoring, therefore, negating the need for NEWS scoring.
- Risks to babies on the neonatal unit were identified during their initial assessment and identified within care plans. These risks were reviewed daily or as required. At the shift handover, safeguarding issues when identified were communicated.
- Each baby on the neonatal unit had its own personalised resuscitation box which stayed with them until discharge.
- From January 2014 until the end of December 2014, an audit was undertaken to review all paediatric 2222 calls and emergency events. The audit identified a number of issues and key learning points over the year. We saw that the learning points included changes to practice, for example, the asthma guideline and a guideline for infusions was being rewritten by the pharmacy department. This showed that there had been ongoing learning from this audit process.

Nursing staffing - Children's service

- Best practice staffing guidance within children's services which includes the neonatal service was not fully implemented. Staffing within the children's hospital, although currently considered as being safe by the senior management were recognised as not achieving Royal College of Nursing (RCN) (2013) guidance. British Association of Perinatal Medicine Guidelines (2011) (BAPM) staffing standards were also identified as not met. These staffing shortfalls were recognised as a risk and recorded on the hospital risk register.
- The 'Paediatric Intensive Care Society Standards' audited by the 'Paediatric Intensive Care Audit Network' (PICANet) (2015) identify that the unit's nursing establishment and nursing rosters should be appropriate to the anticipated number and dependency of patients. Staffing levels should be based on the ratios in Appendix 13. Appendix 13 - the minimum number of qualified nurses required to staff 1 critical care bed is, at least 7.01 (WTE). The workforce review completed by the trust identified non-compliance against the RCN 2013

staffing standards. The action identified from this workforce review document said that as the retrieval service was being reviewed and discussions were taking place with regards to the high dependency unit.

- Following the workforce review in late 2014 there was agreement to an uplift in establishment, by 16 nurses to open additional capacity. Monthly meetings had taken place with commissioners and another hospital trust to negotiate a shared and separately funded transport service. Recently, funding for the retrieval service was agreed with commissioners.
- Although, staffing shortfalls had been recognised, some staff felt this had impacted negatively on staff morale, although the staff survey results for children's services were largely positive. The Picker staff survey results were published in January 2016, these benchmark the trust against other trusts, The results showed that out of nine ratings, six were green (positive) ratings and three were amber (average) ratings.
- Some staff told us they did not think there was always enough staff to provide a safe service. In addition, staff told us they had missed meal breaks and communication problems had increased. Staff told us they had often left the clinical areas late from day shifts. When asked whether these situations were reported through the incident reporting system, we were told that many had not, as staff had been too busy to complete these incident forms.
- The children's eye clinic had a designated children's nurse, however, it was not known by children's services management whether this nurse was replaced by a children's trained nurse when they went on leave.
- The 'Safer Nursing Care Tool' (SNCT) asks staff about what staffing levels had been implemented within the children's service during the preceding week. The SNCT recorded actual staffing levels against planned staffing levels. Two senior staff we spoke with perceived that the tool did not take into account patient acuity. However, the trust regarded the tool as being important to inform staffing establishment which did consider acuity.
- Staff told us that when children who self-harmed were admitted additional agency nursing staff were employed. On occasions, the CAMHS team had supplied a mental health trained nurse within the first 24 hours of the child's admission. However, staff told us there had been occasions when children and or young people had not been provided with the one to one nursing support required. We did not find any other evidence to support this.
- The updated workforce review document dated 15 September 2015 identified 25 vacancies within children's services. The staffing review had resulted in recommendations, which were presented to the trust board in April 2015. Staff we spoke with were aware this review had taken place; however, some senior nursing staff said they had not been involved in the process, although the trust have informed us that all staff were consulted. Funding for nursing staff had increased by £550,000. Recruitment of nursing staff was on-going; however, challenges remained because it was difficult to recruit children's nurses. The updated workforce review document (dated 15 September 2015) identified which clinical areas currently met the RCN standards, six clinical areas. The workforce review had identified eight clinical areas as not meeting RCN guidance.
- We reviewed six, monthly nursing rotas from wards D33, D35 and E17. These showed that some shifts were managed by a band six nurse that band five nurses were in charge of some shifts. There were some vacancies for band six nurse, for example, figures for the funded staff establishment that we were shown for ward D33 identified 3.6 whole time equivalent nurses; currently, there were three nurses in post.
- The RCN (2013) staffing guidance, states there should be a competent, experienced band six nurse throughout each 24-hour period to provide the necessary support to the nursing team. The trust was managing this requirement through the supernumerary band six and band seven bleep holders.
- The children's service had an identified bleep holder per shift who was a senior children's nurse at band six or band seven. One band seven nurse carried the bleep as part of their full time job, this person provided specialist advice to wards each day with out of hours cover being provided by the band six bleep holder. A second home based on-call person could also be contacted when required. Staffing shortfalls were escalated to the lead children's nurse as necessary and through to the site on call system.
- Staffing shortfalls were escalated to senior managers, for example, on ward D35, the bed capacity had been reduced to 12 beds and specialist nurses had come to

the ward, offered assistance or had worked as an additional nurse on the ward. Staff told us that nursing shortfalls were covered either internally or through additional agency nursing staff.

Neonatal staffing

- Neonatal staffing did not fully meet the British Association of Perinatal Medicine Guidelines (2011) (BAPM) because they were unable to provide one nurse to one baby care in the intensive care unit for all babies.
- The neonatal matron told us the neonatal service met the qualified staff in speciality (QiS) 70:30 ratio, and the registered to non-registered nursing staff of 80:20. In addition, specialist nurses also worked within the team who were additional to the existing funded establishment.
- The May / June 2015 rota for the Queens Medical Centre neonatal unit confirmed nine shift coordinator roles and 13 nurses qualified in speciality at band five.
- The neonatal service has eight advanced neonatal nurse practitioner (ANNP) posts which contribute significantly to medical rotas and provide advanced nursing support and education across the service.
- A critical care and critical care transport team, which consists of ten experienced neonatal nurses, deliver expert nursing mainly within the neonatal intensive and critical care settings for transport in other hospitals.
- Escalation pathways were in place which worked effectively and nursing staff had worked across the units when gaps in staffing had been identified. Eight advanced nurse practitioners work across City Hospital and Queens Medical Centre.
- The trust escalation process for neonatal staffing was used to identify issues when they occurred during shifts. An incident report was completed for shifts, which were calculated to be below requirements, according to the neonatal risk rating. We tracked two staffing incidents with the unit and saw that appropriate escalation and measures were in place. Staffing incidents were discussed and actions planned with the Matron on a daily/weekly basis, at monthly ward sister review and shared at the monthly safer staffing meetings. These were now identified as 'red flag 'incidents. For the neonatal service as a whole there were 12 staffing incidents reported from February 2015 to August 2015.
- Additional funding of 7.5 whole time equivalent band five nursing staff were received from safer staffing monies, which had resulted in additional trained nurse recruitment within the neonatal unit. The neonatal unit had 10 band five, and four band six nursing vacancies. Recent recruitment had resulted in promotions of three existing staff to band six and five conditional band five offers. One of the band five candidates was qualified in speciality; the remaining four candidates were not and would require specialist training. The new band five nurses were due to start at the trust in September 2015.
- We reviewed one neonatal unit duty rota and saw that every shift had a band six nursing staff qualified in speciality on shift. The band seven nurses confirmed that they worked Monday to Friday from 8am to 4pm.
- A family, continuing care and outreach team within the neonatal service assists families during their baby's stay, discharge preparation and liaises with allied services in the community to ensure ongoing care and support is provided. We spoke with one staff member from the team who told us how she had enjoyed and had developed this service.

Medical staffing

- The children's service confirmed that they were compliant against the Royal College of Paediatrics and Child Health (RCPCH) consultant staffing standards.
- Information provided by the trust showed that across the Children's Hospital and Community they had filled the following substantive posts: 84 consultants, 28 specialist registrars, 38 trainee doctors and six junior doctors.
- The trust identified out of hours paediatric radiology support as a risk on their risk register. A national shortage of radiologists has made it difficult for the trust to fill their radiologist vacancies, which meant babies, were transferred to other hospitals for radiology care. Specialist radiology cover was not available out of hours except Saturday mornings.
- The trust had identified issues affecting junior medical staffing due to a third of doctors on the middle grade rota being on maternity leave or reduced hours.
- One medical trainee confirmed their rotas were compliant against the working hour's directive.
- We saw a range of paediatric surgical rotas which confirmed on-going consultant, middle grade doctor and junior doctors were available within the surgical specialities.
- Staff told us that there was a good medical presence throughout the service and that consultant staff

(paediatricians) were available until 10pm each evening. In addition, the out of hours support provided by consultant level staff was described by staff as supportive. Junior medical staff told us they had been able to access consultant or registrar level doctors when needed.

- Anaesthetic consultant and intensivists were available out of hours to provide anaesthetic advice and support for children's services.
- We observed one paediatric handover and one neonatal medical staff handover and saw they were thorough. The discussions included discussions about newly admitted children and those who were unwell or required some input.
- The neonatal service had 14 consultants' posts. Three newly appointed consultants contributed to resident out of hours cover and some of the medical cover for the transport service. In addition three 0.5 whole time equivalent (wte) academic consultants and two hybrid consultants were in post. A hybrid consultant's time was split between 33% traditional consultant role, 33% resident middle grade doctor (when performing this role this doctor is supported by a second consultant) and 33% of the time is spent on the transport rota.
- Nine registrars, three advanced neonatal nurse practitioners (ANNP) and seven senior house officers also worked within the neonatal service. All the medical staff and ANNP provide cross site support on both neonatal units.
- Neonatal consultants covered Queens Medical Centre and City Hospital neonatal units during the out of hour's period. This practice breached the 'British Association of Perinatal Medicine standards (3rd edition) – section 5.1.4' at QMC neonatal unit which stipulate that ''for all levels of unit it is not appropriate for a consultant to provide out of hours cover to two geographically separate sites simultaneously.'' Other medical staff identified told us that consultant staff could be accessed by phone for advice out of hours however; consultants rarely came into the unit out of hours.

Major incident awareness and training

- The trust had a business continuity plan, which ensured critical services were delivered in exceptional circumstances.
- A trust major incident policy (version 2.3 - 2010) was in place. This policy identified staff specific roles and the measures to be put into place should a major incident take place. The senior nurse for paediatrics will follow the action card 'QC8' when managing this situation. The senior nurse on duty for paediatrics will after assisting in the establishment of a functioning Control Room will move into the hospital and establish capacity and ensure that appropriate actions are being taken. All children requiring hospital admission for injuries sustained in the incident will be admitted to the designated receiving Wards on the Queen's Medical Centre Campus (E37 for Children) unless they require admission to a Specialist Unit or Theatres/Paediatric Critical Care Unit. The consultant paediatrician who is based on ward E37 is responsible for the re-triage and continuing care of admitted patients and will decide, in consultation with the consultant general surgeon and lead adult surgeon on call with regard to priorities for treatment.

Are services for children and young people effective?

Good

We judged the effectiveness of children's and young people's service as good.

We saw that services provided evidenced based care as identified within evidenced based clinical guidelines. Monitoring of clinical guidelines had resulted in reviews by consultant staff, however, we saw that 19 neonatal guidelines had passed their review dates so could not be assured of the robustness of this monitoring process. We observed that a number of clinical guidelines were allocated to consultant staff to review.

Auditing systems had informed practice, introduced changes and lessons learnt to improve outcomes for children and young people. The neonatal service had achieved a stage three UNICEF Baby Friendly accreditation. Improvements in children's and babies outcomes were observed in the areas we reviewed.

Multi-disciplinary team working within and outside of the children's service resulted in positive outcomes for children.

Trust appraisal statistics (2014) confirmed an improvement in staff yearly appraisal uptake in the last twelve months.

However, we observed that shortfalls in staff appraisal rates remained despite these improved appraisal rates. Staff told us their training needs were supported and they had received development appropriate to their needs.

There were some shortfalls in nurses trained in some specialities. The RCN (2013) staffing guidance states that 70% of nurse's should be trained in specialities. We observed that this target had not been achieved in all specialities.

The children's service identified they had some transition arrangements in place for young people entering adult services. These included areas such as diabetes, oncology, diabetes / endocrinology and renal services. Effective working relationships between CAMHS professionals and paediatricians existed.

Evidence-based care and treatment

- Guidance from authorities such as the Royal College of Paediatricians and Child Health and the National Institute for Health and Care Excellence (NICE) were used to inform care. We reviewed a selection of evidenced based guidelines and saw a sample of 17 children's and nine nursing guidelines were within their review by dates and were evidenced based.
- The neonatal dietitian had developed approximately 10 guidelines for use on the neonatal units and across the neonatal network. These guidelines included guidelines relating to parental nutrition manufactured on site.
- We saw a list identifying 86 neonatal guidelines of which 47 were under review. The guidelines under review had an allocated person and estimated review date. However, we observed that 19 of the estimated review dates had passed. These review dates ranged from January 2015 until August 2015. No further information was available to confirm whether these guidelines were now updated.
- Monitoring systems were in place to ensure that clinical guideline reviews had taken place, however, we were not assured of the robustness of this monitoring as 19 of the neonatal guidelines had passed their review by dates. We saw that discussions about clinical guidelines had taken place at the 'Directorate Report to Quality Governance Meeting' (4 June 2015).
- We reviewed three children's treatment histories and saw that the treatment prescribed followed the correct guidance for that condition. For example, a child with suspected meningococcal disease treatment followed NICE guidance on meningococcal sepsis diagnosis and management.
- The neonatal unit followed evidenced based practice through the implementation of an electronic ear' which was placed in the high dependency area. The function of the ear was to monitor noise levels to alert staff to high noise levels which could distress the babies. Where noise levels were too high the ear's colour would change. We saw this in action during the time we spent on the neonatal unit.
- The children's service practice development group remit included, coordinating the link nurse groups within the service, leading on training and initiatives such as pressure ulcers and eating matters.
- Senior managers and staff we spoke with confirmed that guidance was in place for nursing staff on how to care for children who self-harmed.

Pain relief

- The children's pain management team was led by a designated anaesthetist and nurse. They were supported by two nurse specialists and ward link nurses who had had additional training and time allocated to enable them to provide this care. Members of the pain team also attended oncology multi-disciplinary team meetings.
- Both nurse specialists completed ward rounds Monday to Friday to identify children and young people who required pain management and specialist team review.
- Children and young people with chronic pain who attended as outpatients could access a clinic. The pain clinic was on an 18-week pathway. The current waiting time for patients was 4 - 6 weeks. The clinic was funded by commissioners as part of the specialist commissioning group.
- The children's pain team had a service review undertaken in 2015, the outcome confirmed compliance with the 'General Paediatric Surgery Peer Support & Service Assessment Review 2014 Standards'. Overall feedback and results of the review were very positive.
- We tracked two children's pathways who were admitted for surgery; part of the pathway related to pain management. We observed pain management

discussions with one child's parents prior to surgery. For the second child the nursing staff had assessed the child for pain post-operatively to determine whether the child required any further pain relief.

- Babies, children and young people had access to a range of pain relief. If babies were unsettled or appeared to be in pain, this observation was discussed with the doctor to determine whether pain relief was required.
- We reviewed a sample of children's pain charts and saw that children's pain scores were escalated as per trust guidance.
- Children's pain scores were reported monthly through the 'Children's & Young People's Services Nursing Dashboard.' This is a clinical performance tool used to report on clinical performance data.
- The nurse specialist responded to staff referrals to the pain team and monitored the electronically recorded pain scores.
- Out-of-hours an anaesthetist was on call and structured pain relief was in place for each child. Surgical and oncology medical trainees had received training to enable them to prescribe patient controlled analgesia.

Nutrition and hydration

- A specialist dietetic service for children and neonates is provided across both hospitals sites.
- A variety of food choices was available to children and young people. Special diets, for example renal and allergy diets were available. Children who had multiple allergies and / or metabolic disorders had their meals prepared and cooked by a designated chef.
- All mothers on the neonatal unit had lunch provided.
- Each clinical area had a link nurse whose role was to champion the role of nutrition for all children within the children's hospital.
- Seven children's records were reviewed to assess the type of nutritional assessments, which had taken place. We saw nutritional assessments completed in three children's records for those who had required them. Nutritional care plans were in place, dietetic referrals made and feed charts implemented where there was a need.
- Paediatric dietitians were involved in developing care plans for children and providing advice and guidance. We saw the care plan of one child who was under the care of CAMHS had a very detailed care plan, which included all aspects of nutrition and hydration including how food and drinks were to be administered.
- Infant feeding sisters support the promotion of breast feeding and enhancing feeding initiatives across the neonatal service.
- The 'Baby Friendly Initiative' is a worldwide programme. The Organiszation and UNICEF established in 1992 to encourage maternity hospitals to implement the 'Ten steps to successful breastfeeding.' The neonatal unit achieved the 'World Health Stage Three Baby Friendly Accreditation' in 2014. Stage three of the programme involved parents' experiences.

Patient outcomes

- Shortfalls identified within the national neonatal audit programme (NNAP) 2013 said that the hospital had not achieved on all five items. For example, there were outliers for screening of 'Retinopathy of Prematurity' by NNAP on 2013 data. However, the trust identified that the shortfalls in compliance had been a result of data recording failures not of failing to comply with standards and no risks or safety issues were identified due to this.
- In 2013 – 2014, the ROP screening result for babies who were inpatients was 83.5% (132 of 158 eligible babies). The remaining babies were screened for ROP as outpatients. A recent audit at the City campus confirmed 100% compliance with ROP screening in April 2015.
- The document 'NICU Data Summary for CQC – September 2015' identified that NNAP outcomes had been audited separately on several occasions during the last three years and had shown the outcomes relating to the NNAP audit questions were better than presented in the NNAP dataset. There was recognition that outcomes could be improved further by better data collection. Yearly reviews of the NNAP report and data had taken place and improvements made.
- Outcomes had improved in some areas for Nottingham babies when we looked at comparisons against some of the NNAP data for six neonatal units including Nottingham. These NNAP audit results dated from 2011 until 2013. For example, 98% of babies, less than 28 weeks gestation had their temperature taken within the first hour of birth and antenatal steroid use was 90% in 2013.
- We reviewed the 2014 NNAP unit level data which was launched on the 5 November 2015 and observed some slight shortfalls against the previous NNAP data. The data showed that 90% (47 eligible babies) were ROP

screened, 97% (28 out of 29 babies) of babies had a temperature taken within one hour of birth and 76% (99) mothers had received antenatal steroids. We observed shortfalls remained in babies feeding with their mother's milk. The audit identified that 19 babies fed with their mother's milk at discharge.

- The proportion of infants who received some breast milk on discharge in 2013 – 2014 was above the standard of 58%, falling mainly in the 60-70% range. The breast feeding item was identified as a CQUIN for the service in 2014 – 2015 and the target was met which was a 10% improvement on the previous year.
- Audits to monitor consultation with a senior clinician within 24 hours of admission to the neonatal unit had taken place. In the 2012 audits, 118 cases (95%) of parents were documented as having been seen by a senior clinician within 24 hours. Because shortfalls in documentation were identified in the medical notes through the neonatal survey in 2013, this information had also been added to the nurses' admission to discharge paperwork.
- The clinical audit plan for 2014 – 2016 identified which audits the service was participating in and the lead for each audit. Discussions with the medical service lead identified that the children's service had taken part in a number of national audits, for example, the diabetes and epilepsy 12 audits.
- The paediatric epilepsy 12 audit identified problems with two-week access and documentation. To ensure that children and young people could access appropriate medical support some local paediatricians were identified to attend training in this area and would support children and young people until a neurology consultant has been appointed.
- The national peer review programme (July 2015) briefing on paediatric diabetes identified two serious concerns in the 2013 / 2014 peer review cycle. These concerns related to a robust system not being in place to ensure retinopathy screening for children over 12 years of age and results being seen by the multi-disciplinary team (MDT). The second area identified that the MDT were not formally reviewing children and young person diabetes admissions quarterly for trends or to identify factors for individuals or the service. The trust response was all NUH patients were now being screened and quarterly meetings had been introduced.
- During the visit in February 2014 the national peer review programme (paediatric diabetes) identified areas of good practice which included, the transition service, recruitment to clinical trials and identified this to be a highly effective program to target and reduce the numbers of children with a high HbA1c(above 80mmol/mol). The MDT had lowered their HbA1c pathway target from 86mmol/mol to 80mmol/mol. From 1 April 2013 to 30 September 2013, 9% of patients had an HbA1c above 80mmols, compared to 22% in 2010.
- Surgical safety Checklist (previously referred to as WHO audits) audits had taken place. The audit was completed to show compliance with the World Health Organisation(WHO) surgical safety checklist documentation.
- The five steps to safer surgery training had been rolled out to over 800 staff of all levels across the Nottingham University Hospital theatres. 290 randomly selected patients WHO surgical checklist documentation was audited across both hospital campuses . Twelve specialities were audited at Queens Medical Centre. Speciality compliance was identified for each speciality. For the paediatric speciality on the Queens Medical Centre campus compliance against the five quarters ranged from 76.9% to 100%. Recommendations and action plans had resulted from this audit. We saw that the full audit report and results had been taken to theatre and anaesthesia safety and governance meetings on the 10 September 2015. We also saw that shared learning had been identified with the patient safety champion and at staff meetings during September and November 2015. The action plan identified that a repeat audit had commenced in December 2015.

Competent staff

- Staff from some clinical areas and trust training figures (2015) confirmed attendance at 'Management of Actual or Potential Aggression (MAPA)' training (82 staff) and 'Self Harm and Awareness Resource Project (SHARP)' training (39 staff).
- Information provided by the children's hospital said that staff could also access introduction to self-harm and suicide and eating disorders conferences. We were not provided with the training statistics for these training sessions despite requesting training compliance levels at our initial information request for staff attendance at any mental health type training sessions.

Services for children and young people

- The RCN (2013) staffing guidance states that 70% of nurse's should be trained in speciality. We requested information from the children's service confirming what percentage of the nursing staff were trained in speciality.
- Information provided by the children's service confirmed 52% of nursing staff had the oncology qualification on the oncology ward (E39). Seven of the eight (87.5%) band six nursing staff had the oncology qualification.
- Following inspection, we received additional training information, which confirmed that some staff working on the oncology clinical areas (E39, E39 day care unit and E40) had completed external specialist oncology training. The oncology speciality qualifications obtained by staff in these clinical areas were 45%,(E39) 10% (E39 day care unit) and 82%(E40) respectively. Between 50 to 100% of nursing staff had completed a full internal training, for example, were able to administer chemotherapy, whilst all staff had attended foundation training within the oncology areas.
- In the paediatric critical care unit (PCCU), 43% of staff had completed the PCCU degree course, whilst newly qualified staff completed a 12-month critical care foundation programme. New starters followed a six-month foundation programme, which included five study days and six to eight weeks of supernumerary practice.
- The renal team comprise of 14 people, 11 (78%) had completed a specialist course or module. On the ward six (33%) of the 18 nurses have completed a specialist course or module. Some nurses also had the ENB 136 adult renal course. In-house training includes a foundation in renal and urology competency, support from the clinical practice educator, competency assessments and annual study days. We did not see examples of any of the training sessions, which had taken place in 2015 – 2016.
- Neurology – Information provided confirmed that 14% of nursing staff had completed an external accredited neuro course. In-house training includes, a new starter package for neuro, medical device competencies and clinical skills training for enhanced roles.
- Cleft training – Six out of seven (86%) of clinical nurse specialists had completed an external accredited cleft course and one person is currently completing this course.
- Burns training – The clinical nurse specialist had completed an accredited burn's course, 12% of staff have completed the emergency management of severe burns course, which enabled staff cover Monday to Friday 8am – 4pm as a minimum.
- Formal processes were in place to ensure medical and nursing staff received mandatory, role specific training and an annual appraisal. Nursing staff told us they received yearly appraisals and training specific to their needs. Information provided by the trust confirmed that 79% (266 of 336) of nursing staff and 85% (67 of 79) of medical staff had an appraisal in the last 12 months.
- We saw dates for the QMC teaching programme 2014, which included teaching in areas such as constipation, trauma and paediatric urology. Two of the medical staff we spoke with confirmed they had completed child protection and life support training and confirmed that three teaching sessions had taken place weekly for trainee doctors.
- Neonatal medical staff told us junior doctors received regular teaching sessions following the 8:30am medical handover sessions including training days every two months. Consultants were described as keen on teaching, however, some staff described a culture where minimal feedback was given, and when given was often negative. This information was obtained from the GMC trainee survey. To discuss these concerns a trainee forum had been established which we were told had resulted in some improvements in this area. Clinical supervision for junior medical staff was described as good.
- Twelve of the hospital play staff had completed the health play specialist qualification. Appraisals for the youth team were completed by the youth team manager and ward sisters completed appraisals for play staff. Supervision sessions took place every six weeks for the play and youth team.
- Medical and nursing staff confirmed attendance and satisfaction with their corporate and local inductions. We saw that comprehensive local inductions were in place for new staff throughout the service, for example, the neonatal service staff inductions included a six-month induction for band five nursing staff. The induction included monthly study days, completion of competency-based assessments, supervised and independent practice and working alongside the

practice development team to enhance their skills. We saw a new nurse's induction folder, which confirmed the types of training and assessments completed during their induction.
- Staff undertook six-month rotations to develop their skills via an 18-month rotation programme within the children's hospital.
- Neonatal nursing staff rotated across both neonatal units to enhance surgical and medical skills.
- Local transitional training was not available for staff in a structured format; however, the clinical nurse specialist had identified learning from conferences. The service did not identify what learning had been shared and how it had improved young people's transition experiences.

Multidisciplinary working

- Staff identified there were effective working relationships between children and adolescent mental health service (CAMHS) professionals and paediatricians. Guidelines were agreed by the trust and CAMHS personnel, which identified CAMHS pathways.
- Discharge planning for the child or young person involved all those members of the multidisciplinary team involved in their care, for example, nurses, community teams, continuing care team, GP, social care professionals and therapists.
- Staff described examples of partnership working and we saw examples documented in children's records. For example, one nurse told us how they had made referrals to the specialist diabetes nurse, psychologist and to the safeguarding team for a child whose chronic condition had not been kept under control.
- When a looked after child was admitted to hospital or had received outpatient treatment or support, the school nurse and health visitor was part of the team to ensure that the child's needs were met.
- The neonatal service had joint senior nurse meetings with another trust in Leicestershire and quarterly governance meetings have taken place with the 'Trent Perinatal Network.'
- Consultant teams at QMC and City Hospitals met together after each Wednesday grand round. These meetings had not been formalised which meant that no meeting minutes were taken to confirm discussions held between the consultant teams.
- Dietetic multi-disciplinary working occurred across the renal and diabetic specialities and at ward rounds where children's care and treatment plans were discussed.
- Joint monthly perinatal death review meetings took place with obstetrics and genetics.
- Weekly meetings had taken place with foetal medicine to discuss upcoming deliveries.
- Joint weekly meetings had taken place with the neonatal consultants and surgeons to discuss surgical babies.
- Joint weekly meetings with Leicester oncology and regular nephron-urology meetings had taken place.
- A clinical psychologist was available to support the nursing teams.
- The neonatal unit had two Bliss Champions who were previously parents on the unit. Their role was to support and talk with new parents. Bliss is a UK charity working to provide the best possible care and support for all premature and sick babies and their families.
- Eighteen play specialists worked within the service. Out of hours on call arrangements consisted of one play specialist per floor of the children's hospital were in place.
- Clinical nurse specialists, clinical psychology support, and advanced neonatal nurse practitioners were available for children, young people, parents, carers, and staff to access for support and explanations where needed.

Seven-day services

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

Access to information

- Weekly multi-disciplinary handover meetings took place to discuss babies currently receiving support.

Services for children and young people

- All safeguarding referrals of children and young people were discussed and attended by members of the multi-disciplinary team.
- The monthly neonatal grand round alternated across hospital sites on Wednesday afternoons.
- We saw agendas, which confirmed network meetings had taken place. For example, the general paediatric surgery network project group and paediatric oncology meetings. Minutes from the East Midlands General Paediatric Surgery Network Project Group' (22 May 2015) confirmed that representatives from across Derbyshire, Nottinghamshire and Leicestershire had attended these meetings. We saw that discussions had included areas such as an annual training event and an update on progress made following the peer support and service reviews region wide.
- Quarterly meetings had taken place with CAMHS team to discuss pathways of care. CAMHS had also been involved in monthly service development meetings with the trust.
- The service used the 'Ready, Steady, Go' transition documentation identified for young people. In the following specialities, diabetes, oncology, diabetes / endocrinology and renal services transition processes for young people were in place, which meant that all the information required for their care was shared in a timely way.

Consent

- Staff demonstrated through discussion that they were informed of and understood the consent process.
- Some of the staff we spoke with said they had attended Mental Capacity Act (2005) and best interests training sessions.
- Staff explained the consent process was completed by surgeons for children requiring surgery and that written consent was obtained prior to this.
- Gillick competence refers to the assessment that doctors could make in regards to whether a child under 16 years has the capacity to consent to treatment without parental or guardian consent. We saw three examples of completed consent forms in babies and children's notes; for example, consents for photography and the insertion of a venous access line.
- We saw information available on consent displayed for parents and young people. Information on consent specifically written for young people with learning disabilities was also available.

Are services for children and young people caring?

Good

We judged caring as good as the service provided caring services to the local population.

Children, young people and their parents received compassionate care with good emotional support. The majority of parents and young people were fully informed and involved in decisions relating to their treatment and care. However, some parents who were visiting the outpatients department told us that they had not received feedback following investigations for their child.

Generally facilities for both parents and children were satisfactory and support had been provided by the multi-disciplinary team during the child's admission, stay and in preparation for their discharge home.

Compassionate care

- Throughout our inspection, we observed that members of medical and nursing staff provided compassionate and sensitive care that met the needs of babies, children, young people and their parents and carers.
- Staff had a positive and friendly approach and explained what they were doing, for example when completing their clinical observations.
- We spoke with 38 parents of children using the service who told us they had generally been happy with the care and support they and their children had received. However, one parent told us that it had been difficult getting the nursing and medical staff to listen to them.
- Satisfaction surveys were carried out from January 2014 to March 2015 within the acute children's service. Staff told us that parents, adolescents and children had completed satisfaction surveys.
- Feedback cards and comment boxes for parents to use were available throughout the service.
- Information was captured from children, young people and their parents through 'FABIO the frog' and the 'Friends and Family Test.'

Services for children and young people

Understanding and involvement of patients and those close to them

- We spoke with 38 parents and seven young people about their experiences. Parents told us that they had been involved in and were happy with the care and treatment their children had received. However, some parents in the outpatients department told us that they had not received feedback following investigations for their child.
- The parents we spoke with told us they were given sufficient information and training to care for their child's needs. We saw this in action when we were on the paediatric high dependency unit as two parents were being taught how to perform basic life support for their child. We also saw some completed parent's competency records for tracheostomy care (this is an entry into the child's windpipe to allow them to breathe).
- Information was displayed throughout the service for young people and their parents. This information was in English; however, staff confirmed that this information could be provided in different languages and formats on request.
- Parents from the neonatal unit could access coffee mornings every Thursday and parents support groups. We saw evidence of these groups displayed in poster format within the neonatal unit.

Emotional support

- Parents were offered counselling sessions following the death of their child.
- An annual family bereavement day organised by the children's hospital bereavement team took place, other professionals, for example, play staff, supported this.
- Play staff provided one to one and facilitated group play activities formally or informally to support children and young people dealing with grief and bereavement issues.
- The needs of new mothers were re-evaluated regularly, demonstrating that appropriate emotional support was available for both mother and baby.
- Parents and families could access spiritual support through the multi-faith service provided by the chaplaincy within the hospital. Chapel and multi-faith facilities were available for families to access.

Are services for children and young people responsive?

Good

We judged responsive as good as the service provided responsive services to the local population.

The children's, young people and families' service were responsive and generally met children's needs. The service had good support from tertiary centres such as Sheffield Children's Hospital.

There was generally good access and flow to services, which met most children's and young people's needs. The 18-week referral to treatment performance data confirmed that the target was met for the majority of specialities. Monthly compliance totals ranged from 91% to 100%.

Parents and staff told us that care had been delivered in a variety of settings including outpatient clinics at times that had generally met their needs. We were told that when children and / or young people (C&YP) had been treated outside of the children's service support and advice had been given by paediatric staff from the children's service to ensure that C&YP needs had been met.

Difficulties were experienced when discharging children to tier four mental health beds which had delayed children's and young people's discharges. We are aware that this falls outside of the control of the trust, as this is a commissioning issue. Tier four beds are specialist mental health beds.

A full review of the paediatric forensic examinations service and environment was required and had been recognised as a risk and identified on the risk register.

Service planning and delivery to meet the needs of local people

- A full review of the paediatric forensic examinations service was identified on the service risk register in October 2014. A full service review and new service specification was required. In the interim the development of a regional rota where the clinician travels to the child or young person rather than a

centralised service had been suggested. We are not aware that this has been implemented as yet. Plans to discuss this at the regional commissioners meeting were identified.
- Children and young people who required eye surgery at the eye centre were admitted under one of the four consultant ophthalmologists dedicated to treating children. The emergency department and paediatricians when required provided additional input to the child's care.
- A dedicated afternoon children's emergency theatre list was in place.
- Parents could access discounted parking and after a month received free parking. Additional support provided in the form of meal vouchers, snack boxes and access to information and associated social care support provided to families whose child or baby received long-term health care.
- Parents had access to parent's accommodation throughout the service, for example, parents who had babies on the neonatal unit could access accommodation on ward B26. Accommodation consisted of bedrooms with ensuite bathrooms. There were two parent's rooms on the neonatal unit for those parents of seriously ill babies or babies who were receiving end of life care.
- We reviewed eight patient conditions information leaflets dated from 1999 to 2015. We were told that a project to update patient information leaflets was under way.

Access and flow

- Staff confirmed children were seen by their consultant within four hours of admission.
- The children's hospital is a tertiary referral centre who works closely with other trusts and acute providers. Joint clinics take place in a number of trusts within secondary care in the region. All children's letters are copied to their consultants in their local hospital.
- We reviewed the children's hospital 18 week referral to treatment performance data (January to December 2015) for admitted and non-admitted performance against each speciality. During the 12 month period the monthly range for admitted performance was between 91.7% (August) to 100%. Non-admitted performance monthly totals confirmed 99 to 100% compliance against 18-week targets.
- The children's hospital policy is to see all children and young people in designated children's clinics as far as are possible. Young people aged 16 – 18 years were offered a choice dependent on clinic availability. Since the inspection we have been informed that children under 16 years of age were seen in adult areas the guidance found in the trust access policy was followed.
- Trust figures provided for children on adult wards / areas from November 2014 to July 2015 identified that 1,729 children and young people had received treatment either in adults clinics or adult clinical areas. The main age group this affected was young people aged between 16 – 19 years of age.
- When young people were admitted to adult wards, for example, the trauma ward, guidance was in place for staff to follow which included a list of conditions for young people aged between 16 – 18 years. In the last year, staff said that there had been two occasions where young people were admitted to the adult trauma ward.
- Statistics for young people aged 9 to 18 years who presented with mental health disorders, self-harming and eating disorders from April 2015 to December 2015 identified that 215 young people received treatment through the children's hospital. Monthly admissions ranged from 17 to 34 young people.
- Difficulties and delays had occurred when discharging children to tier four beds (these are specialist mental health beds), this was due to a lack of tier four bed availability.
- The safeguarding children information management team (SCIMT) could be accessed 24/7 for data and information sharing. When children who are considered at risk they are assessed in a designated cubicle. This cubicle can be booked through a referral system.
- Neonatal and children's services provided good access to its services. Children with long-term conditions had open access to the service.
- Transitional care within the neonatal service was led by unit staff. Prior to discharge some parents with their babies were encouraged to stay in a transitional care room supported by staff. In addition, the transitional care team provided support to parents with babies less than 34 weeks of age on the post-natal ward.
- A regional retrieval service from birth to 18 years of age was provided by the children's hospital, which covered surrounding areas and other regions.

- Parents had varied experiences of waiting times between appointments. Some parents identified long waits whilst others told us there were no delays or cancellations in relation to their child's treatment in the outpatient department.
- Staff from the children's fracture clinic told us delays had occurred as the clinic was very busy and this had resulted in some complaints. We spoke with one young person who had attended the clinic for many years. This young person described only positive experiences and their parents identified no complaints.

Meeting people's individual needs

- A designated paediatrician was responsible for ensuring that children and young people with mental health needs care needs were met. Staff said CAMHS admissions had increased within the children's service. The timeliness of CAMHS reviews had improved and there had been no difficulties accessing CAMHS support out of hours, as an on-call psychiatrist was available for children who self-harmed or were at risk of suicide. A psychotherapist also worked in the children's hospital Monday to Friday.
- The specialities used the 'Ready, Steady, Go' booklet to prepare young people for the transition to adult services.
- An adult learning disability team offers advice as required to staff, parents, children and young people. Support for children and young people with learning disabilities is provided from the education service and social care. In addition, a specialist nurse is in post to advise and support children with attention deficit disorder type conditions.
- Primary and secondary school teacher support was available for young people.
- The children and parents we spoke with confirmed involvement when planning and agreeing their care. Care plans were up to date and appropriate to meet the child's assessed needs.
- Some staff had received training sessions in equality and diversity training to inform their clinical practice and decision-making. We had requested the level of attendance of staff within the children's service at equality and diversity training, however, this information was not provided.
- The youth service provided daily drop in sessions, support and social groups. Young people told us how they had benefited from this service and what they had been able to access in terms of support, for example, curriculum vitae writing workshops, advice through Facebook when the youth office was closed and participation in the 'Youth Achievement Awards' at bronze, silver and gold level. These awards are similar to the 'Duke of Edinburgh' awards. One young person showed us their bronze award folder that they had been compiling towards their submission. The folder contained details of activities the young person had been involved in.
- Links were in place with a sexual health clinic through a 'C' card scheme, which aimed to decrease teenage pregnancies and sexual disease. Young people could obtain a 'C' card, which they register, and this enables them to obtain preventative measures such as free condoms.
- Access to interpreters or a language line service was available.
- Parent information boards were located in the corridor and parents room of the neonatal unit. The types of information seen related to faith, car-parking charges, what is comfort holding and breastfeeding support in Nottingham and immunisations up to 13 months of age.
- A lead nurse, designated doctor, bereavement nurse specialist and two palliative care nurses were available to support parents and staff when there was a child or baby death. The child death review nurse had attended neonatal unit meetings.

Learning from complaints and concerns

- Parents and visitors could raise concerns and complaints locally, through the Patient Advice and Liaison Service (PALS) or the trust complaints department. We received a mixture of responses from parents about how or who to approach should they have a complaint. Some parents were unaware of the complaints guidance whilst others confirmed they knew how to access this service.
- Staff told us that they had been encouraged to be transparent in their communications and that complaints were referred to the ward sister or PALS. They said they had received feedback from managers following complaints investigations and that this feedback had either been given via email or at an individual level if they had been subject to a complaint.

Services for children and young people

- PALS basic training had been attended by staff on induction. All the ward managers had attended complaints training.

Are services for children and young people well-led?

Good

Overall, we rated the leadership of children and young people's service to be good.

Clinical strategies and priorities were in place against which were action plans and progress updates. A clear leadership structure was in place within the service. Individual management of the different areas providing acute children's services were well led.

Governance, risk and quality measurement processes were in place.

Public and staff engagement processes captured feedback from both groups. There was evidence of on-going innovation and improvement that had taken place within the service which meant that service provision had been focused towards the needs of the child's and the surrounding community's needs.

Vision and strategy for this service

- Children's and neonatal services had an 'Annual Plan 2015 / 2016' and a speciality plan to support trust objectives. The timescale finish dates against the children's hospital action plan ranged from August 2015 to April 2016. We saw that some of the speciality objectives related to the findings and objectives from the 2014 survey results.
- A separate 'Children's Hospital Strategy 2015/16' was also in place, which identified three strategic goals to improve acute, and community children's services.
- The trust vision and values were displayed on noticeboards throughout the services we visited. Staff were aware of the trust's value statement and were creative in how it had been implemented and what to look for. For example, on ward D33 we saw a project displayed about the trust vision and values and the areas considered important to achieve this vison, for example, staff should be approachable, supportive, professional, work as a team.
- Staff from the burns unit told us they had been involved in the development of their unit vision. This unit vision was displayed in the unit.
- A play and development service strategy (undated) was agreed and implemented in 2014, following trust board approval.

Governance, risk management and quality measurement

- A divisional quality governance structure was identified within the family health division. The organisational diagram for governance showed a comprehensive governance system in place which identified the lead persons for each area.
- The service had a practice development matron responsible for quality, risk and safety within the children's hospital. We were told there were some differences in the reporting of governance and risk within the children's and neonatal specialities. Children's services had joint governance and risk meetings whilst, the neonatal service had separate monthly risk management meetings to their governance meetings.
- The service had a performance dashboard and local risk registers, which were monitored monthly.
- Risk ratings and actions for each incident were approved through the governance group. Risk ratings of 15 and above were discussed at trust board subcommittee level; whilst those incidents with risk ratings of 10 and above were discussed and reviewed monthly within each speciality.
- We did not see evidence in the clinical areas we visited that the actions from all the anti-ligature audits from the clinical areas had been actioned. However, since the inspection additional information provided by the trust identified that by January 2016 all remediable risks had been completed. This included anti-ligature pull cords and ligature cutters in the high risk wards where children and young people with mental health problems are admitted (including D33, E37, E38 and E17).
- Monthly service improvement meetings took place to review action plans for risks, reported.
- Staff received alerts from the chief executive team regarding missing children.
- The trust policy was that incidents were closed within three months and that where incidents had been left

open staff were contacted to complete the process. We saw the details of 25 incidents, which were open, and the associated message histories, emails and letters sent to staff asking them to complete this process.
- Monthly discussions of risk and quality had taken place at a number of forums. For example, trust board, governance, quality, risk and safety committee meetings. Escalation to trust board had been through the hospital leadership team. Quality, risk and governance information updates were discussed through team meetings, newsletters, senior nurse meetings and morbidity and mortality meetings. Some of the staff we spoke with confirmed they had received feedback and emails following incidents and governance issues.
- Meeting minutes from the Directorate Report to Quality Governance Meeting dated 17 July 2015 included items such as, trust risk register, root cause analysis action plan update environmental concerns, Neonatal planned peer reviews, reducing distress for CAMHS patients , progress against compliance against NICE guidance, clinical audit, clinical guidelines, outcomes, risks, incidents and complaints.

Leadership of service

- A management structure identified clear lines of accountability across the service.
- One staff member told us good communication existed between band seven managers and the trust executive team, however, we were told of perceived communication gaps between the band seven and eight nursing staff and the staff on lower grades. For example, changes were not always communicated to the remaining staff by band seven or eight staff.
- The service had designated professionals who led in identified areas, for example, safeguarding, governance and risk.
- Staff had been provided with opportunities for leadership development in 2014. We saw evidence of this through previous study day agendas and by discussions with staff. Staff told us that there had been ward manager development days, the last one had taken place approximately two weeks ago. The trust told us development days were held quarterly.

Culture within the service

- A positive culture was demonstrated among all the teams and staff we met. Staff spoke positively about their service however, they identified concerns in relation to safe practice, staffing and daily support. For example, we were told that newly qualified nursing staff had not always received the level of support they required because senior staff had been so busy. This lack of support related to junior staff being left to manage the clinical area whilst the senior nurse carried the bleep.
- Staff described positive working relationships including those between the multidisciplinary teams and other agencies involved in the delivery of children's health services.
- One staff member told us that should they need to raise a concern they felt confident and supported to do so.

Public engagement

- One 18 year old had been invited by the trust board to talk about their experiences as a patient in the service.
- A young person's representative group managed through the youth service reported through to the patient participation and involvement function. The youth group had reviewed the trust complaints leaflet and made some amendments to make it more child and young person friendly.
- The youth service had drop in sessions from 2-5pm weekdays and Saturday mornings for young people who received treatment in hospital. Other groups, which young people could attend, included a young person's well-being group and the Clic Sargent young people's group.
- Young people were involved in the youth service recruitment processes and the monthly youth forum.
- Young people we spoke with said they had been involved in their care and hospital processes, for example two young people we spoke with told us how they had been involved in producing the new complaints leaflet 'Not Happy?' Information within this leaflet was written to inform children, young people and their parents.
- The NHS England 'Neonatal Survey 2014' survey results for Queens Medical Centre compared to national average results showed that most of the trusts ratings were either within the top 20% of trusts or the intermediate 60% of trusts. The 2014 survey of parents' experiences of neonatal care involved 87 hospital neonatal units in England.

- The NHS England Nottingham Children's Hospital 2014' survey action plan for Queens Medical Centre identified the areas for improvement, actions, measures, timescales and responsibilities. The timescales ranged from June to December 2015. Some of the areas for improvement included staff communication, ensuring that families were given the opportunity to ask questions and ensuring that staff do all they can to help ease a child or young person's pain. The survey outcomes and a request to approve a specified course of action was discussed at the Directors Group on the 9 June 2015 by the clinical lead.

Staff engagement

- Staff engagement had taken place through a number of forums, for example, ward meetings, via email correspondence, development and training days and at formalised meetings aimed at various staff groups such as senior nurse meetings.
- Staff told us that the play and youth teams attended monthly team meetings.
- There were mixed views from staff about the visibility of the executive team, with some staff feeling they were not as visible as others.

Innovation, improvement and sustainability

- Implementation of the e-observations system had taken place within targeted areas of children's services. This system records and monitors physiological observations, for example, respiratory and heart rates. If the recording was outside of set parameters the system alerted staff to this so that appropriate actions can be taken.
- The children's service referral to treatment targets had been met.
- The national peer review programme had visited cancer services, paediatric diabetes and trauma services at Nottingham University Hospital in 2014. Where concerns had been raised we saw that the trust response had been proactive in resolving them, for example, 'No robust mechanism in place to ensure retinopathy screening is taking place for all children over 12 years of age and that results are seen by the MDT. The trust confirmed that all Nottingham University Hospital (NUH) patients were now being screened by the NUH service, where ever they live.
- Peer assessments and service assessment reviews had taken place for general children's surgery services in 2014 and 2015. These assessments had been completed by the 'East Midlands Strategic Clinic Networks Maternity and Children.' We were unable to comment on the outcomes of the 2015 children's surgery review because the trust had not submitted the action plan following this review. An action plan which related to the previous surgical review visit date of the 16 September 2014 was submitted as evidence; however, we were not given an update as to the progress made to-date against this action plan.
- Health Education East Midlands gave positive feedback following their visit in 2014 to NUH following their assessment for healthcare, education and training. Feedback about their visit to the acute care skills training course in the DREEAM suite was (Department of Research and Education in Emergency & Acute Medicine and Trauma) 'observed a true inter-professional learning environment offering simulated training and clinical skills training in a supportive and developmental way.' The programme was a seven day course for newly qualified adult and children's nurses and nurses with no recent acute care experience.
- The Trent Perinatal Network peer review of the neonatal service at Nottingham University Hospitals took place on the 3 November 2014. The action plan confirmed eight areas to action. We saw that progress had been made against some of these areas in that the actions had been completed. For example, the 'Nursing Service investment proposal to be re- submitted to Deputy Director of Nursing as part of safer staffing agenda' and the development of hybrid consultant posts that provide out of hours cover had been implemented to increase the consultant cover for the two neonatal intensive care unit sites.

End of life care

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

Information about the service

Queen's Medical Centre is one of two locations providing end of life care throughout the trust.

Patients with palliative or end of life care needs are nursed on general wards in the hospital. When specialist palliative care is required, for example to obtain effective pain control or psychological support for a patient, there is an option for patients to be referred to Hayward House in the grounds of City Hospital. The total number of in-hospital deaths between January and December 2014 was 3,344 across the trust.

End of life and palliative care services are supported by the chaplaincy team, bereavement services and the mortuary. The trust does not provide a designated consultant post for end of life care, although a specialist palliative care consultant working 0.5 whole time equivalent is the designated lead for end of life care in the hospital. They are supported by 7.8 WTE specialist nurses, who work across both Queen's Medical Centre and City hospitals, dependent upon their workloads.. They work from Monday to Friday 8.00am to 4.00pm, excluding bank holidays. Outside of those hours, support can be obtained via a telephone call to specialist nurses and doctors at Hayward House on the City campus. We visited 10 wards, some of whom had been identified as caring for end of life patients, the bereavement office, the mortuary and places of worship available to patients and staff of different religions.

Prior to our inspection, we reviewed performance information from, and about, the hospital. During our inspection we spoke with three patients, four relatives and 14 staff, including nursing staff, medical staff, the specialist palliative care team, porters, a member of the chaplaincy team, mortuary staff, the mortuary manager and the bereavement officer. We observed interactions between patients, their relatives and staff and considered the environment. We looked at 17 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and seven medical and nursing care records.

End of life care

Summary of findings

Overall, we judged that end of life care for patients required improvement.

The trust did not have an overall strategy for end of life care and we were concerned that end of life care in the hospital was not seen as important as services for patients receiving palliative care, where there was strong leadership. Staff understood and fulfilled their responsibilities to raise concerns and report incidents with investigations into incidents completed. Learning was not always shared with staff teams. There were systems in place to handle and investigate complaints and arrangements were in place to minimise risks to patients, although assessments were not always completed in full. We saw elements of good practice in infection prevention and control. End of life care training was not mandatory, although specialist nurses spent time with new staff to ensure they knew about the services that were available. Dedicated end of life champions were in place although they had no protected time for teaching others.

Patients' needs for pastoral care was not assessed or identified within their care plan and audits to determine the effectiveness of managing pain were not undertaken by the trust. Patients were unable to access a seven day face-to-face service from specialist staff and Do Not Attempt Cardio-Respiratory Resuscitation decisions (DNACPR), were not always completed in line with the trust's policy.

Patients were involved in their care as much as possible and were supported and treated with dignity and respect with facilities provided for families to be close at hand. Staff were sensitive to the needs of patients and their loved ones. There was a 'fast track' discharge policy in place but it did not specify how soon patients should be discharged to their preferred place of care at the end of life. Specialist dementia care and learning disability nurses were available to provide advice. However, there was no individualised care-planning for patients with specific needs such as hearing impairment or a dementia.

Are end of life care services safe?

Good

Overall, we found the safety of the end of life service was good although there were elements within the domain that required improvement.

Arrangements were in place to minimise risks to patients with measures to prevent falls, malnutrition and pressure ulcers. However we identified two out of seven records where these assessments were not completed in full. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and where incidents had occurred, investigation had taken place. There were some occasions where learning was not shared with entire staff teams.

Dedicated end of life champions were in place on all but three wards throughout the hospital although specialist end of life medical and nursing staff were not available to visit patients 24/7. Specialist medical support could be obtained via the telephone at any time. End of life care training was not mandatory; however specialist nurses spent time with new staff to ensure they knew about the services that were available and how to access specialist support. Specific medical devices were available to deliver pain relief and we saw elements of good practice in infection prevention and control.

Incidents

- Incidents at Queen's Medical Centre were reported by staff using the trust's electronic reporting system. All staff we spoke with knew the process for reporting incidents, accidents and near misses using the system. Nursing staff told us there had been very few reported incidents relating to end of life care. On one ward a member of staff informed us of an incident that had occurred earlier in 2015 resulting in relatives not being present at the end of a patient's life when it had been their wish to do so. Relatives had raised a complaint about the incident and although this was discussed with the staff involved, it had not been taken forward to a team meeting for wider learning.
- In the mortuary four incidents had occurred since May 2015 that had needed reporting to the Human Tissue Authority (HTA). The HTA regulates organisations that

remove, use and store human tissue. One of those incidents involved human tissue being removed that had not been sent promptly for specialist analysis; the issue had been resolved quickly and the family kept informed. A root cause analysis had been instigated for all four incidents. Mortuary staff had identified learning from the incidents which had been shared amongst the staff team and procedures changed as a result.

- Staff we spoke with were aware of the trust's duty of candour responsibilities under regulation 20 of the Health and Social Care Act. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology. We were not made aware of any incidents under the duty of candour relating to end of life care at the hospital.

Cleanliness, infection control and hygiene

- Staff knew the procedures for managing, storing and disposing of clinical waste, environmental cleanliness and prevention of healthcare acquired infection within the mortuary. We observed staff using personal protective equipment (PPE) appropriately. This included the use of gloves and aprons.
- The trust had a policy in place for managing the body of a patient who had been suffering from or was suspected of suffering from an infectious disease. Correct procedures were followed by nurses and porters to ensure their protection when in contact with the deceased patient. This included the use of PPE by staff when managing the body and the use of a body bag for the movement and storage of the deceased patient.
- From information the trust sent to us stringent procedures were in place in the mortuary for any high risk post mortem examinations, for example infectious patients.
- The mortuary was clean when we visited and we saw cleaning and mortuary staff ensured that appropriate cleaning protocols were adhered to.

Medicines

- We reviewed seven prescription records of patients identified as being in the last hours or days of life in the hospital. We saw where anticipatory medicines were prescribed appropriately and in a timely way. Anticipatory medicines are those prescribed for symptom control, for example pain relief, breathlessness, sickness and excessive secretions in the chest. The medicines were prescribed before they were needed on a 'when necessary' basis so could be administered quickly when they were required.
- Specialist palliative care nurses informed us they had chosen not to undertake training to prescribe medicines for patients. A specialist nurse told us they preferred to advise junior medical staff how to undertake this important role as it would benefit both staff and patients by ensuring doctors knew how and what medicines to prescribe.
- Palliative Care Formularies (PCF5) were available on most of the wards we visited. The formularies give comprehensive guidance to healthcare professionals on specialist drugs and their dosages which may be helpful for patients at the end of their lives.
- Some patients at end of life required a continuous infusion of drugs to control their pain, for example morphine, through the use of a syringe driver. A syringe driver is a small, battery-operated pump that is used to give medication continuously under the skin for a period of time, such as 24 hours. Staff we spoke with told us they always had access to such equipment when it was required through their equipment library. The syringe drivers used were tamperproof because of lockable cases and were equipped with alarm features to alert staff of any malfunction.

Records

- Storage of medical and nursing notes for end of life patients was secure. Notes were accurate, legible and up to date.
- We viewed seven patient records. Risk assessments for two patients were not completed appropriately or reviewed at the required frequency to minimise risk. One patient's record evidenced that their manual handling assessment was dated but not signed by the assessor and the patient's weight and body mass index had not been recorded as part of their nutritional assessment. In addition, the visual infusion phlebitis score (VIP) had not been completed fully over three days. The VIP is a tool for patients receiving intravenous therapy (into the vein treatment) in order to identify if they have any swelling or redness of the area surrounding the cannula. The assessment tool stated

they should be checked twice daily; day and night. We found that it had not been checked for 50% of the time over the three days. The remaining five records were completed accurately.
- We reviewed one patient's notes that consisted of two separate files. One set comprised information from previous admissions plus a large quantity of loose pieces of information including previous medicine prescription charts, nursing records and doctors letters. The cover of the file was falling apart. This meant records were not always being maintained appropriately which may have led to pieces of information becoming lost or misplaced and could breach patient confidentiality.

Safeguarding

- The trust had provided all staff with information relating to safeguarding adults. The information could be kept in their ID badges and was therefore readily available to them. It explained the types of abuse that could occur and contact numbers for key personnel in the trust to seek advice if needed both in and out of normal working hours.
- None of the staff we spoke with during our inspection could recall a recent safeguarding incident regarding a patient receiving end of life care.
- The trust had a safeguarding lead in place. Staff told us they knew the lead's contact details and could approach them if they needed advice or support.
- Staff we spoke with were able to identify the different types of abuse and knew how to respond to safeguarding concerns and allegations of abuse.
- Staff told us the safeguarding team were accessible and responsive to concerns and issues. The safeguarding team offered training on safeguarding, mental capacity legislation and deprivation of liberty safeguards as part of the trust's mandatory training programme. We saw evidence that supported this.

Mandatory training

- At the time of our inspection end of life training was not included in the trust's mandatory training programme. However, specialist nurses raised awareness of end of life care to all new staff appointed in the trust and discussed how to contact the specialist nurses team when required.

Assessing and responding to patient risk

- We reviewed the nursing notes of seven patients who had been identified as requiring end of life care. New paperwork had been introduced two weeks prior to our inspection for assessing patients and highlighting those who were at risk, for example from falls and pressure ulcers. Staff told us they had received a short training session on using the documentation and were getting used to it, although not all we spoke to were confident about this. The risk of developing pressure damage was assessed using the Braden Scale, a scoring system that assessed a patient's risk of developing a pressure ulcer by examining six criteria, including skin moisture, mobility and nutrition. Staff we spoke with found the falls risk assessment was particularly confusing because they had received little training on the use of the mini mental state tests.
- The end of life care bundle stipulated when risk assessments may not be required, for example when a patient's nutritional needs may change.
- The trust used an early warning system (National Early Warning System or NEWS) to record regular physiological observations such as temperature, blood pressure and heart rate. This was used at Queen's Medical Centre. We saw the NEWS score was used to monitor patients and when outside acceptable parameters stated staff called a doctor when required. However, for patients identified as being at the end of their lives and on the appropriate care bundle, this system was rarely used as no active treatment would be initiated.

Nursing staffing

- Queen's Medical Centre (QMC) had no dedicated 'end of life' beds. Patients requiring end of life care were nursed on general medical and surgical wards unless they required specialist care or treatment when they would be transferred to the City campus to be cared for on an oncology ward or in Hayward House, a specialist palliative care unit.
- Information from the trust showed that 33 wards out of 36 had a dedicated end of life 'champion' in the form of a qualified nurse or healthcare support worker. Only three wards did not have an end of life champion. Champions were initially nominated by each ward to help with the implementation of the new end of life care 'bundle' following the removal of the Liverpool Care Pathway in June 2014.

End of life care

- End of life champions were appointed after an expression of interest for the role was made. We spoke with one champion who showed enthusiasm and dedication to their role. They told us staff tried to spend as much time as possible with people at the end of their lives if they had no relatives or friends with them. They did not receive any additional staff to specifically undertake that role.
- Nursing staff were able to independently refer a patient to the specialist palliative care nurses if they considered a patient was in need of specialist care. They did not have to request this from any members of the medical team.

Medical staffing

- The trust did not provide a designated consultant post for end of life care, although a specialist palliative care consultant working 0.5 whole time equivalent was the designated lead for end of life care in the hospital. A consultant was available during normal office hours from Monday to Friday. Outside of those hours, medical advice was obtained from Hayward House, a specialist palliative care unit situated on the City Hospital campus, where doctors could always be contacted 24/7 by telephone.
- Medical interventions for patients at end of life was delivered by the on-call doctors in the medical team at the hospital whenever this was required.
- We were informed the trust had reviewed a seven day service for end of life care but there had been insufficient resources to put it in place.
- The Commissioning Guidance for Specialist Palliative Care recommends one whole time equivalent (WTE) consultant for every 250 beds. There were 1,793 general and acute beds in total at Queen's Medical Centre and City Hospital and therefore the trust provision did not meet recommended guidance.

Major incident awareness and training

- The trust had a major incident plan in place. As a minimum, a live exercise took place every three years, a table top exercise was undertaken every year and a test of the communications cascade every six months. Clear actions were in place for mortuary staff. Although the plan did not identify any actions to increase the holding areas for deceased patients, staff informed us they were aware of the procedures to use which duplicated those in place when it was necessary during the winter season.
- The provision of chaplaincy services was identified in the trust's major incident plan.

Are end of life care services effective?

Requires improvement

Effectiveness for end of life care services at Queen's Medical Centre required improvement.

Newly appointed trust staff received end of life training although this was not part of the trust's mandatory training programme. Patients' need for pastoral care was not assessed or identified within their care plan and audits to determine the effectiveness of managing pain were not undertaken by the trust.

Patients did not have access to a seven day face-to-face service from specialist staff in accordance with National Institute for Health and Care Excellence guidance. Do Not Attempt Cardio-Respiratory Resuscitation decisions (DNACPR), were not always completed in line with the trust's policy

The trust had participated in the National Care of the Dying Audit 2013/14. The results had shown the trust was above (better than) the England average in nine out of ten clinical indicators including clinical protocols for the prescription of medications for the five key symptoms at the end of life and protocols for promoting privacy, dignity and respect.

Evidence-based care and treatment

- The trust had participated in the National Care of the Dying Audit 2013/14. The results had shown the trust was above (better than) the England average for nine clinical indicators including clinical protocols for the prescription of medications for the five key symptoms at the end of life and protocols for promoting privacy, dignity and respect. The trust had not achieved five out of the seven organisational indicators including continued education, training and audit, trust board representation and planning for care of the dying. Actions had been put in place and the trust reported they were compliant with four of the five indicators.

End of life care

- A review of four records showed symptom control for end of life patients in the hospital had been managed in accordance with the relevant NICE Quality Standard. The Quality Standards outline best practice for safe and effective prescribing of strong pain medication in end of life care of adults.
- End of life care in the hospital. mostly followed the National Institute for Health and Care Excellence (NICE) Quality Standards relating to best practice in end of life care for adults. However, the hospital did not comply with Statement 10 of those standards: 'People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.' Further explanation of this standard indicates face-to-face consultation is required. The trust was aware of this but we did not see evidence that plans were in place to comply with the standard.
- The specialist nursing team attempted to see all referred patients regardless of diagnosis within 24 hours but owing to the lack of seven day cover this was not always possible.
- The staff we spoke with stated most patients they referred to the specialist team were seen in a timely manner although at weekends it proved problematic. One staff member told us of a patient who was seen within four hours when a referral had been made.
- The total number of Queen's Medical Centre (QMC) deaths between January and December 2014 was 2411.
- Between April 2014 and March 2015, 725 patients had been referred to the specialist palliative care team from QMC : Of those, 61% had a cancer diagnosis, and 35% a non-cancer diagnosis. 23 had not been documented. From our discussions with staff it appeared good relationships were in place between ward staff and specialist nurses although patients with a diagnosis other than cancer had not always been identified as requiring specialist input at the end of life.
- In response to the review and withdrawal of the Liverpool Care Pathway (LCP) in 2013 the trust had introduced a specific end of life care 'bundle' in July 2014 to be used within the last few days or hours of a patient's life by nurses. The bundle was used to aid communication with the patient, family and significant others and was only used when medical staff determined it should be put in place. A member of nursing staff told us doctors were sometimes hesitant in implementing the care bundle. The document included a range of guidelines, for example; pain management, nausea, vomiting and agitation. It also included a care plan and assessment form.
- We saw the care bundle in use. It was person centred and included physical and nutritional needs of the patient as well as a discussion concerning the patient's preferred place of death. Care assessments were designed to be undertaken every four hours or more often if required. It did not prompt staff to ask patients if they required pastoral care from their own religious leader or the trust's chaplaincy team. The Chaplains informed us they would see any patient or their relative whether or not they had a belief.
- We observed end of life resource folders for staff guidance relating to end of life care on some of the wards we visited. In one folder we found paperwork including symptom guidelines from 2006 referring to the Liverpool Care Pathway (LCP) and other paperwork referring to the LCP as best practice: this was not up to date or reflective of best practice. On another ward when we asked to see the folder, staff did not know where it was and told us they did not think it had up to date information in it.
- In July 2013, the Department of Health released a statement which stated the use of the LCP should be 'phased out over the next 6-12 months and replaced with an individual approach to end of life care for each patient'

Pain relief

- Audits to determine the effectiveness of managing pain were not undertaken by the trust. However, results for the trust from the National Care of the Dying Audit 2013/14 demonstrated the trust had achieved above the England average for medication prescribed for the five key symptoms that may develop at the end of life, including pain.
- The trust had no formal feedback process from bereaved family and friends about how they felt with regard to pain relief given to their loved one.

End of life care

- Three patients we spoke with told us they were comfortable and not in pain. All patients receiving end of life care we observed during our inspection appeared comfortable and not in distress.

Nutrition and hydration

- The trust had participated in the National Care of the Dying Audit (2013/2014). The results showed that the trust performed better than the England average for reviewing of the patient's nutritional and hydration requirements; 54% and 60% respectively compared to the England average of 41% and 50%.
- We reviewed seven nursing records for patients in the last days of life and found patients were screened using the Malnutrition Universal Screening Tool (MUST). This is a five-step screening tool to identify who are malnourished, at risk of malnutrition and those who were nutritionally at risk and identified accordingly.
- Where interventions were required we saw these documented on the patient's daily record.
- Staff told us patient's families were encouraged to assist their relatives at mealtimes when this was appropriate.
- Patients had access to drinks when this was appropriate and safe.
- Most of the wards we visited had a nutrition link nurse who provided support for end of life care patients, such as advising on menu options and assisting at mealtimes.
- We looked at the menu on each ward we visited. The menu had a main section and one for cultural meals which included kosher, Afro-Caribbean, halal, vegetarian and vegan options. Staff told us patients could also order from the children's menu.
- We spoke with two patients about the food provided. They raised some concerns over the temperature at which food was served. One patient told us food was "Good, there is a wide choice and it is well presented, but not very warm at times." Another patient told us "There is a good choice, but it is not always hot when you get it".

Patient outcomes

- We reviewed the trust's paper from March 2015 which identified a review of end of life care benchmarking. Benchmarking is a standard by which something can be measured or judged.
- Benchmarking for end of life was undertaken across all in-patient areas in December 2014. The trust had taken part in the National Care of the Dying Audit 2013/2014. The Trust performed better than the England average for nine out of ten clinical indicators but did not achieve the key performance indicator (KPI) for five of the seven organisational indicators. The Trust scored particularly well for the clinical provision/protocols promoting patient privacy, dignity and respect, up to and after the death of a patient (nine as opposed to seven for the England average and multidisciplinary recognition that the patient is dying (81% as opposed to 61% for the England average.
- During our inspection we found the trust was contributing data about palliative care to the National Minimum Data Set (MDS). The MDS for Specialist Palliative Care Services is collected by the National Council for Palliative Care on a yearly basis, with the aim of providing an accurate picture of specialist palliative care service activity. It is the only annual data collection to cover patient activity in specialist services in the voluntary sector and the NHS in England, Wales and Northern Ireland. The collection of the MDS is important and allows trusts to benchmark against a national agreed data set. By examining the data trusts can identify unmet needs and develop services to support good quality palliative and end of life care. The data for April 2014 until March 2015 stated the specialist nursing team had provided care to 1186 new patients. There was no breakdown of figures between the trust's two main sites.
- Feedback from relatives we spoke with was divided with one relative informing us the assessment process of their loved one was lacking. Another relative was happy with the assessment of their loved one. However, the trust had scored 92% in the National Care of the Dying Audit 2013/2014 for the number of assessments (five +) undertaken in the last 24 hours of a patient's life as opposed to 82% for the England average.

Competent staff

End of life care

- Most nursing staff we spoke with told us they had received training to enable them to safely administer medications via a syringe driver. On one ward we saw 11 of the 19 trained members of staff had received the training and the remaining eight were all booked on a course. Training records received from the trust showed 92% of staff had been trained on the use of syringe drivers which was above the trust's target of 75%.
- The specialist nurses provided education to individual ward based staff on a routine basis, during visits to see the patients referred to them. Training was also provided on a when necessary basis. Information from the trust showed specialist nurses had undertaken 116 teaching sessions from the year January to December 2015 which had included sessions to student nurses and health care assistants as well as medical staff.
- End of life training was not included in staff's mandatory training, although we saw newly qualified nursing staff received a two hour session relating to end of life care during their introduction as part of the trust's seven day acute care skills foundation programme. The programme also included an introduction to pain management. A total of 177 nurses had completed the training since the course commenced in October 2013; of these 66 had undertaken the course from January to July 2015.
- A senior member of staff informed us end of life champions did not receive any dedicated time for training other members of their ward's team. This was unlike the role of link nurses, for example tissue viability link nurses who received six dedicated hours a month to receive and deliver training. This information was corroborated by an end of life champion.
- Portering services were delivered by an external provider. Training requirements on respect and dignity for the deceased patient were provided by the trust mortuary staff.
- Some nursing staff in clinical areas told us they had received end of life care training from the specialist nurses when they had needed it. They had found this extremely useful.
- One of the specialist care nurses considered that whilst they felt end of life care was generally good in the hospital, staff on the surgical wards needed more support and training than those on medical wards as they were less used to caring for patients at end of life.
- We reviewed the outcome of an audit of post mortem examination procedures undertaken in March 2015. This was undertaken to assess the performance of the observed post mortem procedures in place in the hospital's mortuary against the trust's documented procedure. Two health and safety issues were identified in the report with eight actions to be taken to resolve the issues raised. We had no further information with regard to the monitoring of the actions.

Multidisciplinary working

- Any patient could be referred to the specialist end of life care nurses when it was deemed appropriate for symptom control and those with complex needs. Those patients known to the specialist team were visited as often as was required; this varied between every two or three days to those requiring input on a daily basis.
- The specialist team of nurses visited four specific areas of the hospital, Monday to Friday to ensure they could provide input when required. These included general medical wards and two admissions units.
- Although medical staff could refer patients to the specialist team if required we were informed it was mostly nursing staff who made the referral.
- Patients were transferred to an oncology ward at City Hospital if they had been identified as requiring specific interventions, for example radiotherapy.
- For patients with more complex needs who required daily specialist input, a transfer to Hayward House was requested. Hayward House was a specialist palliative care unit in the grounds of the City Hospital campus. However, there was sometimes a waiting list for admission which meant those patients continued to be nursed on general wards.

Seven-day services

- The specialist end of life nursing team provided advice to staff and face to face visits with patients and their

relatives from Monday to Friday, 8.30am to 4.30pm. Outside of these hours a telephone advice line was available from specialist nurses and doctors at Hayward House.

- One member of staff informed us they got frustrated when a patient may be admitted on a Friday at the end of their life but could not be physically seen by the specialist team of nurses prior to their death on a Saturday or Sunday.
- The trust had no dedicated end of life beds at Queens Medical Centre. Although a twenty-four hour seven day service from specialist nurses to support patients and their families had been considered previously, we were told this had not happened and there were no plans to implement this in the near future. Therefore the trust was not meeting NICE (National Institute for Health and Care Excellence) Quality Standard number 10 published in 2011 for end of life care for adults which states:- "Visit and assess people approaching the end of life face-to-face in any setting between 09.00 hrs and 17.00 hrs, seven days a week."
- Bereavement services were open Monday to Fridays from 10:00 hrs until 16:00 hrs except Bank Holidays.
- The mortuary was staffed from 8.30am to 4.30pm Monday to Friday, excluding bank holidays. An out of hours service was available for cases under investigation by the Police or for receiving the deceased from the community.
- During the first twenty-four hours after a death, relatives could view their loved one at any time by arrangement through the Bereavement Services.
- After the first twenty-four hours, viewing was restricted to the hours of 8:30 to 4:30pm, Monday to Friday unless there were exceptional circumstances, for example relatives travelling long distances. The decision to allow a visit outside of these hours was dependent upon the on-call bereavement staff.
- The mortuary provided a twenty-four hour service to both the hospital and coroners.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients and relatives told us staff did not provide any care without first asking their permission.
- On checking patient records, where patients had the capacity to consent, we found copies of appropriately signed consent forms.
- Nursing staff we spoke with had a basic awareness and understanding of the Mental Capacity Act 2015 legislation and Deprivation of Liberty Safeguards. The 2005 is legislation applying to England and Wales. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the to make particular decisions for themselves. The Safeguards () are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.
- We did not see any patients receiving end of life care and being deprived of their liberty during the inspection. Staff told us doctors normally completed the mental capacity assessments for patients when appropriate which was recorded in the patient's medical notes.
- We saw evidence of appropriately completed mental capacity assessments being undertaken within patient's notes.
- The trust's policy on DNACPR, approved and implemented on 30 July 2015, gave clear directions for staff on the completion of DNACPR directives including the use of a mental capacity assessment and full documentation of the discussion held with patients and their relatives.
- We looked at 17 do not attempt cardiopulmonary resuscitation (DNACPR) forms in medical records across seven wards. The purpose of a decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. Out of the 17 DNACPRs reviewed across seven wards, four were completed correctly. All of the 17 DNACPR's were signed by a senior clinician, six of them being a registrar grade, the remaining by a consultant.
- DNACPR's were not completed accurately for a number of reasons. These included lack of mental capacity assessments for those deemed to lack capacity, lack of information regarding the discussions held with patients and/or their families and absence of a senior clinician's

signature supporting the DNACPR decision. This meant the trust's DNACPR policy was not being adhered to, and the legal process of the Mental Capacity Act 2005 was not always followed.

- A trust wide audit of 121 DNACPR'S was completed between January and March 2015 to assess if the DNACPR process was fully documented. The data showed 73% of forms had a documented summary of communication with the patient and 88% of relatives or friends had been involved in the DNACPR decision. There were no recommendations or actions from the findings stated in the report.
- Most of the DNACPR forms were easy to read, but some of the entries we found to be illegible.
- DNACPR forms were filed at the front of the notes, allowing easy access in an emergency.

Are end of life care services caring?

Good

End of life services at Queen's Medical Centre were caring.

Patients were involved in their care as much as possible and both patients and their relatives were supported and treated with dignity and respect.

Staff were sensitive to the needs of patients and their loved ones. Patients and their families were involved in decisions relating to their care and treatment.

The services provided by bereavement and mortuary staff took into account patient's religious and cultural beliefs and were families were regarded in a sensitive manner.

Compassionate care

- We spoke with three patients and three relatives during our inspection and the feedback received was very positive. Relatives generally thought staff were very compassionate in their attitude although one stated staff could be a bit 'short' on occasions although not rude. Another told us their relative was being well looked after and they could not fault the care being delivered.
- During our inspection we observed patients being treated with respect, dignity and compassion.
- Staff we spoke with showed an awareness of the importance of treating patients and their families in a sensitive manner. One end of life 'champion' told us how they encouraged relatives to bring small pieces of memorabilia, for example photographs, into the ward for the patient in order they could have these around them to give them some comfort.
- Services provided in the mortuary demonstrated respect and understanding of a patient's cultural or religious needs. However, the mortuary was not able to provide the opportunity for families to wash the deceased when there was a religious or cultural reason for this.
- We spoke with a family in the emergency department about their loved one who was nearing end of life. Staff had been very sensitive in their discussions about possible organ donation.
- The bereavement service provided specialist support to relatives when a patient died. The bereavement service was involved in the period immediately following death and provided help and information to relatives. When required, the service offered support to obtain consent for a hospital post mortem examination.

Understanding and involvement of patients and those close to them

- The trust had participated in the National Care of the Dying Audit 2014. The results showed the trust was identified as being better than the England average in relation to health professional's discussions with both the patients and their relatives/friends regarding their recognition that the patient was dying. The survey also identified the trust as being slightly better than the England average for communication regarding the patient's care plan during the dying phase. The trust scored 76% as opposed to the England average of 75%. The trust scored significantly higher than the England average in relation to the assessment of spiritual needs of the patient and their nominated relatives or friends. The trust scored 77% as opposed to the England average of 37%.
- In the same survey, the trust had not achieved the indicator for formal feedback processes regarding relatives and friends' view of the care delivery for their loved one.

End of life care

- One of the patients we spoke with told us staff regularly spoke to them and their family and kept them well informed of their treatment. They said staff spoke to them using language they could understand.
- We spoke with three patients during our inspection. Patients were appreciative of the care and treatment they had received. One patient told us staff had been wonderful and had always tried to support them when they felt depressed about things. They felt staff had explained their care and treatment to them in a way they could understand.

Emotional support

- The National Care Of The Dying Audit (2013/14) showed the trust's assessment of patients' and their relatives and friends spiritual needs was above the national average; 77% as opposed to 37% for the England average.
- Ward, nursing and medical teams offered emotional support to patients in addition to the specialist nurses for end of life care. The trust had a large chaplaincy service which could cater for a number of different faiths. Dedicated places of worship were available for six different faiths next to the chaplaincy offices in the hospital. This included facilities for Sikhs, Jews, Muslims and Buddhists as well as Christians and Hindus. Support for carers, family and friends were provided by the chaplaincy and bereavement services. The chaplaincy staff also supported staff when required.
- We spoke with three relatives and three patients during our inspection. All the people we spoke with told us they felt emotionally supported by all the staff involved in their care.
- The chaplaincy worked closely with the palliative care team and would attend, as necessary, with the team to see patients when there was a need to break bad news.
- Although not licensed to conduct weddings for end of life care patients, the chaplaincy team were able to facilitate weddings with a community registrar within four hours of a referral for an end of life care patient and their partner.
- Volunteers were used to escort patients to religious services in the hospital or sit with end of life care patients as required.
- The chaplaincy worked with local faith leaders to ensure deceased patients were cared for following their cultural and religious requirements.
- The viewing of deceased patients was carried out in a dedicated area in the mortuary divided into a waiting room and two separate viewing rooms.
- Arrangements for viewing could be made directly with the mortuary staff by the ward or department staff concerned and by relatives when appropriate. This ensured that a time could be agreed for the viewing to take place and was normally between 8.30 am and 4.30 pm Monday to Friday. Mortuary staff told us every effort was made to ensure the viewing room was arranged sensitively. The viewing room was non-denominational with no religious articles although these were available if required depending on the individual's religious beliefs.
- A dedicated telephone line was available in office hours for relatives to ring if this was requiredto arrange a viewing. Mortuary staff were available to escort families and provide sensitive support when viewing their loved ones.
- The trust had received a £20,000 donation from a charity to redecorate the mortuary waiting room and viewing areas. This had yet to be undertaken.

Are end of life care services responsive?

Good

Overall, we judged the responsiveness of end of life services to be good.

Patients were asked about their preferred place of death. There was a fast track' discharge policy in place but it did not specify how soon patients should be discharged to their preferred place of care at the end of life.

Specialist dementia care and learning disability nurses were available to provide advice. There were interpretation services available where English was not a patients first language.

There were facilities for families and loved ones to be close at hand when patients were gravely ill. Open visiting arrangements were in place to allow patients to be with those close to them at the end of their life.

End of life care

There were systems in place to handle and investigate complaints.

Service planning and delivery to meet the needs of local people

- A remote telephone support service was available from experienced clinicians in Hayward House, a specialist palliative care unit in the grounds of City Hospital.
- Nursing staff we spoke with all told us that where possible and if appropriate patients receiving end of life care were nursed in side wards to afford them and their relatives more privacy and dignity. On the coronary care unit side wards were not available although we saw where one patient at end of life had arrangements in place to enable them to move to a side room on a different ward.
- The hospital had hotel facilities in the grounds of City Hospital where relatives could stay when necessary. Some of the 52 rooms offered family accommodation.
- Wards were able to offer the use of a relatives' room or the use of a folding bed in the patient's room if there was room for it. The folding beds could be requested from the equipment library when required. This ensured relatives could be with their family member as much as they wished.
- Staff told us there were no visiting time restrictions for family and friends visiting a patient receiving end of life care. This allowed them un-limited time with the patient.
- A number of printed leaflets for relatives and friends of patients was available for supporting their loved one prior to and after death. They gave factual information about what to expect in a clear and simple way and included information about what to do after a death, collection of property and registering a death. A trust leaflet was also available informing families about who the palliative care team were, what service they provided and how they could be contacted.
- Although we did not see leaflets other than in English, we were informed other languages were available.

Meeting people's individual needs

- Bereavement packs included written information for bereaved family and friends and were available through the bereavement service. Staff informed us this information could be translated for people whose first language was not English.
- Patients were discussed at the weekly multidisciplinary team meetings where clinical staff from differing specialties reviewed their treatment and care needs. The trust had participated in the National Care of the Dying Audit 2014. The results showed the trust was identified as being better than the England average in relation to multi-disciplinary recognition that the patient is dying. The trust scored 81% as opposed to the England average of 61%.
- There was a dedicated team of learning disability nurses who had a system to identify when a patient with a learning disability was admitted. This team provides support and advice to ward staff.
- All patients were placed on the end of life care bundle which did not necessarily reflect the specific needs of those types of patients although it is acknowledged the care bundles could be personalised for each patient. There was access to specialist dementia care and learning disability nurses where staff could seek advice and guidance.
- Translation services were available and because of the multi-cultural staff group within the hospital staff informed us it was comparatively easy to obtain a translator quickly when required.
- Free parking facilities were available for relatives of patients at end of life and also when viewing their loved one.
- The bereavement office was situated in the same corridor as the chaplaincy team. A family room was available for relatives waiting to see the bereavement officer.
- In order to preserve the dignity of deceased bariatric patients, a small number of specialist trolleys were used to transport those patients to the mortuary. If they were all in use then transfers would be made on their bed: the deceased was covered by another sheet draped over the bed after preparation by the nursing staff.
- Interpreters were available when required for patients whose first language was not English. We saw documentation from the trust which stated all interpreters were trained in social, health and mental care for vocabulary and terminology purposes with some interpreters having had specific training in breaking bad news and others had undertaken training to work with people who had terminal cancer.

End of life care

- Reclining chairs were available for relatives who wished to stay by their relative's bed side as there was sometimes insufficient room for a fold out bed.
- The hospital used a document called 'All about me' for patients with a dementia. The document was filled in by those close to the patient and knew them well. It was used to tell health-care providers about the patient: –their needs, likes, dislikes and interests. It helped staff to build relationships and support personal care needs of the patient.

Discharge and Flow

- For patients with a rapidly deteriorating condition which was irreversible and likely to be entering the last stage of their illness, the trust had a 'fast track' discharge policy if they wished to be discharged. There was an area in the care bundle directing staff to use the 'fast track' discharge guide and pathway if this had been requested. This enabled a rapid discharge where possible, for patients to their preferred place of death. We saw information relating to this for relatives including the people who would be involved, transport and medicines.
- The 'fast track' discharge document did not specify how soon patients should be discharged to their preferred place of care or death but did highlight an agreed discharge date. Nursing staff told us 'fast track' discharges usually took up to 48 hours to arrange but in some cases could take longer. We saw the option of a fast track discharge was given to a patient who had been assessed for such a discharge by a member of the continuing healthcare team. Information about the discharge was left with relatives to discuss.
- The trust had introduced a team of six advanced nurse practitioners to support the care of the elderly wards in the hospital. The team supported nurses and doctors and were available when required. One of the practitioners told us they helped with complex discharges when necessary.

Learning from complaints and concerns

- Information about how to complain was available for patients and their relatives in all areas and staff knew about the complaints process and how to direct patients and their staff to use it.
- Staff told us there had been very few complaints relating to end of life care services and almost all relatives had been complimentary of the care their loved ones had received. On one ward we saw two cards from grateful relatives relating to end of life care.
- Information received from the trust showed there were five complaints relating to end of life care at QMC from 1 July 2014 until 30 June 2015; one of those related to care principally outside the county. We did not have information relating to any actions that may have been taken as a result of the outcome of the investigations**.**

Are end of life care services well-led?

Requires improvement

We found the leadership of end of life services required improvement.

The trust did not have an overall strategy for end of life care although there was one in place for those receiving palliative care. We were concerned that end of life care in the hospital was not seen as important as services for patients receiving palliative care where there was strong leadership.

Whilst staff we spoke with were unaware of a vision for end of life services within the hospital, they were able to demonstrate their commitment to endeavouring to ensure patients and their relatives received the care and treatment they required.

The quality, risks and performance issues within end of life care were monitored through the clinical effectiveness committee. Some areas of performance were not being monitored, this included the monitoring of fast track discharges and if patients preferred place of death was respected. There was a dedicated executive lead in place for end of life care within the trust although most staff were unaware of who this was.

Vision and strategy for this service

- The trust did not have an overall strategy for end of life care at Queen's Medical Centre (QMC) although there was one in place for those receiving palliative care.
- We interviewed the consultant for end of life care. They informed us their vision for end of life care in the

hospital followed the trust's strategy for palliative care and the National Institute for Health and Care Excellence (NICE) guidance, although a seven day service had yet to be implemented.

- The trust had produced a specialist palliative care plan dated January 2015 to cover the period 2015 to 2016. Ten actions had been identified including increasing the number of patients accessing the specialist palliative care nurses at QMC, improving the delivery of compassionate care, increasing the number of trust staff trained in end of life care and communication. The first action had been recorded as being completed in April 2015. The other two elements had been recorded as 'on-going'.
- Whilst staff we spoke with were unaware of a vision for end of life services within the trust or the hospital, they were able to demonstrate their commitment to endeavouring to ensure patients and their relatives received the care and treatment they required.

Governance, risk management and quality measurement

- The quality, risks and performance issues within end of life care were monitored through the clinical effectiveness committee.
- We identified two risks on the trust risk register relating to end of life care, although these did not relate directly to Queen's Medical Centre (QMC). The risk identified that the destination of syringe drivers for the continuous delivery of pain relieving medicine should be monitored. This was because some of the syringe drivers were sent home with patients and were not always returned to the hospital. The end date for the reduction of the risk was June 2015 and we were informed on one ward the monitoring of this was still in place.
- We saw evidence the trust had audited 'fast track' discharge in 2013-14 but we did not see the outcome of the audit and were therefore unable to identify whether the trust had addressed potential delays.
- The trust had not undertaken audits of the number of patients wanting to die at home over the previous twelve months and how many of those requests had been facilitated effectively. Staff told us they tried to meet patients' wishes but we could not evidence how often this was achieved due to the lack of monitoring. The end of life care bundle did document patients preferred place of death.

Leadership of service

- The trust did not have a clinical lead for end of life care although a clinical director and lead were in place for palliative care under the speciality cancer and associated specialties. Spiritual and pastoral care was led by the director for diagnostics and clinical support.
- Although there was leadership and vision for the service, a seven day service had yet to be put in place. There was no evidence the quality of care for patients at the end of their lives was being monitored or any actions put in place to improve the care delivered.
- There was strong leadership for specialist palliative care services at the trust. However, although the same professionals were identified as the leads for end of life care, this was less well known. Staff throughout the trust knew exactly who the specialist palliative care team was, however when asked who the leads for end of life care were, staff were unable to tell us. This meant there was more focus on specialist palliative care services with a risk that wider end of life care services were not being monitored or fully developed.
- The staff we spoke with were all aware of the specialist palliative care nursing team available to them as well as a knowledge of the out-of-hours help they could access when required. Staff could also give examples of various support mechanisms available to deliver good end of life care and spoke of the chaplaincy team and the bereavement office.
- Staff were able to tell us of regular visits to their wards from members of the executive team.

Culture within the service

- The staff we spoke with informed us they enjoyed working at the hospital but on occasions wished they had more staff to deliver good quality care to patients at the end of their lives. This was because they were busy delivering care to other patients. They felt there were training opportunities and could progress in their career if they wished to. One member of staff said: "I love working here".

End of life care

- Staff felt their concerns and ideas were listened to by their immediate line managers and consistently told us of their commitment to provide good quality care. One nurse told us, “We have only one opportunity (to deliver end of life care) and we always need to do it well. That’s what I try to do.”
- We saw good morale and camaraderie amongst staff.

Public and staff engagement

- The trust did not distribute bereavement surveys although relatives and friends of patients had opportunities to provide feedback in ward areas through using comment cards.
- Most wards had a designated end of life ’champion’ in place with responsibility for promoting the use of the end of life care bundle when this was appropriate. Unlike colleagues with ‘link’ roles, for example tissue viability and nutrition, they did not have protected time to study or teach their ward colleagues about giving good quality end of life care.
- The trust introduced shared governance in 2012 to give staff opportunities to create councils for each ward or department. Any grade of staff could join the council which was aimed at empowering staff to change practice and improve care at the point of delivery. This was then discussed at senior management meetings.

Innovation, improvement and sustainability

- We did not identify any innovation, improvement or sustainability in end of life services at Queen’s Medical Centre.

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

Information about the service

Queen's Medical Centre provides 63 outpatient clinics. Services include ears, eyes, nose and throat (EENT), general medical, orthopaedic and cardiology. There are also ad hoc emergency and drop in clinics to help meet demand. Most Outpatient clinics are consultant led, with full time dedicated clinicians; others are nurse and technician led clinics with dedicated teams. In addition, there are diagnostic, clinical support and allied health practitioner clinics, including physiotherapy and occupational therapy.

The radiology department is a large multi-disciplinary department, providing plain film computed radiography (CR) and direct radiography (DR), computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, interventional radiology, fluoroscopy, and theatre imaging. Nuclear medicine is provided by the Medical Physics and Clinical Engineering department.

In 2014/15 more than 500,000 people attended outpatients appointments at Queen's Medical Centre, comprising 60% of the trust's outpatient attendances.

We visited a range of outpatient clinics and services: radiology departments, fracture, spinal, cardiology, ophthalmology, audiology, physiotherapy, medical and pathology. We observed care and interactions between patients and staff; we spoke with 28 patients before and after their appointments and a range of staff including nurses, doctors, health care assistants, allied health professionals, technicians, clerical staff, porters, and managers. We reviewed performance information from and about the trust.

Summary of findings

Overall, we judged the outpatients and diagnostic imaging services to be good.

There were reliable processes to protect patients from avoidable harm. Departments were mostly clean and hygienic, and risks to patients attending appointments were monitored and well managed. Staffing levels were appropriate to the needs of each outpatient clinic but there were unfilled vacancies in radiology which had an impact on the service. Patient records were not always well managed; paper files were overdue for collection and secure storage, and patient letters were sometimes miss-filed.

Patients' care and treatment were planned and delivered in line with current evidence based practice and recognised national guidance. Staff had good opportunities for personal and professional development. There was effective multidisciplinary working in many departments. There were few seven day services. Staff supported patients in a caring, kind and compassionate way. They respected patients' privacy and dignity and made sure that people's individual needs were met.

Services were largely planned to meet people's needs. While the trust was able to provide timely assessments for people with non-urgent conditions, the trust did not meet national standards for urgent referrals. There were higher than average rates of cancelled appointments, both by hospital staff and patients. The hospital had put

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in place some innovative methods aimed at reducing cancellation and unattended appointments. There were largely effective governance structures but not all risks were recorded and addressed. There was work in progress to re-design the outpatient pathway and improve the trust-wide outpatient service. Staff were committed to their roles and in most departments there was a positive supportive working culture. There was good staff and public engagement and a focus on continued improvement.

Are outpatient and diagnostic imaging services safe?

Good

Overall, we judged outpatient and diagnostic services were rated as good.

There were reliable processes to protect patients from avoidable harm and abuse. Patient safety incidents were reported and learning was shared amongst staff. Outpatient departments were mostly clean and hygienic but infection control audits were not available. Risks to patients attending appointments were monitored and well managed, including when patients' health deteriorated or there were medical emergencies. Staffing levels were appropriate to the needs of each outpatient clinic and there was a good mix of staff with different skills. Patient records were not always well managed; paper files were overdue for collection and secure storage and patient letters were sometimes miss-filed.

In radiology there were systems in place to record, investigate and learn from incidents. However there was concern regarding the management of radiation incidents from departments outside of radiology. Equipment was regularly tested and checked. There were radiology vacancies which had an impact on the capacity of the department. The Medical Physics and Clinical Engineering service had carried out an excellent 'mapping' exercise of radiation protection and regulatory requirements meaning that policies and procedures were in place to deal with risks to patients and keep them safe. Some radiation equipment needed replacing and despite a rolling replacement programme under way there were concerns about the amount of time this was taking.

Incidents

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

to ensure surgery is safe) and the Interventional Radiology checklist was reviewed and revised. This enabled staff to strengthen the procedure to ensure it was a more proactive process at both City Hospital and Queens Medical Centre.

- Between 1 March and 30 June 2015 there were 28 reportable patient safety incidents in outpatients. Most were categorised as causing no harm, with three categorised as causing low harm to the patient involved. The most frequent were related to transport delays (21%) and missing or incorrect patient records (21%). Records showed that these were managed and followed up appropriately.
- We saw that all radiology incidents were recorded internally on the trust's incident reporting system and there was prompt notification of reportable incidents to the radiation regulator and Health and Safety Executive (HSE) as appropriate. The 'IR(ME)R' regulations protect patients from excessive or incorrect exposures to radiation,
- Staff were aware of how to report incidents and were encouraged to do so. Medical physics experts were an integral part of radiology incident management. Technical leads and senior radiographers were aware of reportable dose thresholds.
- Clinical and support staff we spoke with described the incident reporting system and felt comfortable using it. They gave us examples of reported incidents and changes to practice that had happened as a result. Following an incident when a patient fell and fractured their arm, a red alert system was adopted by plain film radiology for older patients with a history of falls. This made sure they received additional support while in the department.
- Staff received feedback on learning from incidents in monthly team meetings. Other staff had weekly meetings at which incidents and learning were shared; many staff also told us they read the weekly trust bulletins and ad hoc alerts on the trust's staff website.
- Information on incidents was presented on posters in some clinics, and information about Duty of Candour was clearly displayed in staff rooms and on the trust intranet page. The duty of candour is a regulatory duty that requires providers of health and social care services to disclose details to patients (or other relevant persons) of 'notifiable safety incidents' as defined in the regulation. This includes giving them details of the enquiries made, as well as offering an apology.
- In nuclear medicine there was a good review of IR(ME)R and IRR policies. These are the regulations that protect patients from excessive or incorrect exposures to radiation, such as through X-ray or a scan. Staff carried out regular audits of compliance with the procedures, and the department was compliant with statutory requirements across all regulations. Each treatment type had an appointed radiation protection supervisor (RPS) whose role was to ensure compliance with regulations.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and tidy, with uncluttered clinic and utility rooms, corridors and doorways. We saw completed cleaning rotas for different areas, which confirmed that the required cleaning had taken place.
- Clinical staff had access to personal protective equipment as needed, such as disposable gloves and aprons, and they wore these when appropriate. We observed clinical staff were bare below the elbow, in keeping with trust policy to help prevent the spread of infection. Staff followed the trust's infection prevention and control policy, although we found an unlabelled urine sample in a clinic room. We saw staff washing their hands correctly. There were numerous hand gel dispensers throughout the radiology department.
- Patients could not always access cleansing hand gel on entering and leaving outpatient clinics. In a few waiting areas there was no hand gel available. Where it was available, signs advising patients to use the gel were not always well positioned; for example one was above a doorway and was not easy to see. In many clinics there were small bottles of hand gel on reception counters. These were not fixed in place and could easily be removed. We asked the trust for a risk assessment in relation to using these rather than fixed dispensing units but they did not provide one.
- There were regular infection prevention and control audits, for example in relation to dress code and hand

hygiene. Most waiting areas displayed results of recent audits and patient feedback on hygiene, which showed very good compliance with the required standards and positive patient feedback.

- Before the inspection we asked the trust for infection control audits and related action plans. They sent us a 'Safety Inspection / Risk Assessment' dated 30 March 2015 for three clinics. This included a few items relevant to infection control such as availability of protective clothing and up to date information. The inspection noted in two clinics that single use items (i.e. clinical instruments that should be disposed of after use) were reused. However, there was no record of any actions taken in response to this identified cross infection risk.

Environment and equipment

- The trust was well supported by its Medical Physics and Clinical Engineering service and had appointed radiation protection advisors (RPA), radioactive waste advisors (RWA) and the support of medical physics experts. The Medical Physics and Clinical Engineering service had carried out an excellent 'mapping' exercise of radiation protection and regulatory requirements. This made sure the department was continually updated on the compliance requirements for all relevant regulations. Protocols for each piece of equipment were available for staff in paper and electronic formats.
- Some radiology equipment was in need of replacement and although a rolling replacement scheme was in place there. All new equipment was purchased through a procurement programme, taking advice from Medical Physics and Clinical Engineering. However this had proved difficult at times due to lack of forward planning.
- The Safety Inspection / Risk Assessment dated 30 March 2015 for three clinics identified several areas of water leaks causing hazards. At the time of our visit one of the clinics was closed due to flooding making the area unusable.
- The physiotherapy department had excellent gym facilities but had problems with the flooring in the department. There was insufficient storage space and staff used a tiny office the size of a cupboard for computer work. Several outpatient areas had vinyl flooring that was bubbling and uneven, causing a trip hazard. There were no incidents of patients tripping or falling in physiotherapy as a result of the flooring. In fracture clinic the treatment rooms were small and there was little room for storage.
- Emergency resuscitation equipment was available in outpatient clinics and we saw records showing this was checked daily to ensure the equipment was well maintained and safe to use. In one clinic the trolley drawers did not have a safety tag and it was possible to open them and remove items such as needles and syringes. In another, some of the drawers were not completely secured by the appropriate tag and items could be removed. These were both rectified at the time by staff.
- We saw a few pieces of electrical equipment that were overdue regular servicing. These were done within 48 hours. Generally equipment was identified with a green sticker when serviced. Staff told us repairs were carried out on request but could take several weeks. Department leads carried out regular health and safety checks of the environment and equipment.
- There was a full quality assurance programme for testing the equipment and this was monitored by the head of service at the monthly governance meeting.

Medicines

- The majority of medicines were stored securely in locked cupboards in locked rooms with access limited to clinical staff. Staff carried out weekly medicines checks. We saw examples of accurate and up to date medicines checks and monitoring the temperature when medicines need to be stored at certain temperatures to maintain their effectiveness. Controlled drugs were stored appropriately in accordance with legal requirements. We saw a small number of medicines left unattended in an unlocked side room in ophthalmology.
- Nursing staff explained any medications to patients and gave them advice about how to take them and any likely side effects. They gave patients information leaflets to support this.

Records

- Patient records were not always managed securely, and this was not identified by the trust as a risk. Radiology patients' records were held securely on the radiology

information system (RIS) and picture archiving and communication system (PACS). They were protected through password access. Outpatient clinics used paper patient records. They were managed differently across the clinics. In some clinics they were stored in locked cabinets to make sure patients' details were kept safe. In others they were placed in temporary boxes outside clinic rooms, with no means of security or monitoring.

- In ENT outpatients, following appointments patient records were placed in a room behind the main reception desk and collected by porters once a week. We found an excessive number of patient record files, waiting for collection. They were heaped in crates and in stacks on tables, trolleys and on the floor. They were placed in colour coded boxes to aid retrieval but there were so many it would be difficult to find any file needed. Reception staff rang the porters department four times that day and eventually most of the files were collected in the afternoon of the following day. Porters were not able to collect all the files as they did not have enough containers. Reception staff told us if there was a backlog they would call the porters who would generally respond promptly. However, storage was insufficient for a week's worth of patient records. A receptionist told us some staff would refuse to attempt to find a patient's file amongst the mass and make a temporary set of records, which increased the risk of clinics not having access to a full patient record at the next appointment.
- In cardiology we found piles of patient records left in an unlocked clinic room in cardiology. These should have been collected following a clinic earlier that day, but were left unsecured. The manager assured us these would be properly filed by the end of that day. However, this did not impact on patient care because records were to be collected after patients attended for clinics.
- Between March and June 2015 there were two reported incidents when letters relating to another patient were found in another patient's file. In ENT we looked at five sets of patient records selected at random and found one contained a letter relating to a different patient (with the same surname).
- Clinic supervisors carried out random audits of clinics each month, checking patient labels, front sheets and continuation sheets. We looked at a selection of patient records in different clinics. Most were up to date and completed appropriately and clearly. Occasional details were missing such as time of appointment and physiotherapists did not include their professional registration numbers with their signature.

Safeguarding

- Clinical, support and administrative staff attended safeguarding training. Updates on safeguarding children and adults were part of a mandatory training DVD that staff watched annually. All managers we spoke with said their staff were up to date with this and this was confirmed by staff we spoke with. Data from the trust showed that 91% of staff at the hospital had received safeguarding training. The trust had recorded the dates of when staff had received the training.
- Appropriate information was displayed in clinical and waiting areas, including the processes to follow and contact details for relevant agencies. Clerical and reception staff referred to a guidance document on which issues to raise and with whom.
- Nursing and clinical support staff we spoke with demonstrated good understanding of safeguarding procedures; they were able to identify their local safeguarding link staff with whom they would discuss concerns before making a referral to the appropriate agency. Nursing staff were confident in escalating concerns as needed.

Mandatory training

- Data from the trust showed the majority of outpatient services had met the trust target of 90% of staff having completed their mandatory training. Ninety three percent of nursing staff and 90% of non-nursing staff had completed their mandatory training between July 2014 and June 2015.All of the managers and staff we spoke with confirmed they were up to date with annual mandatory training. Mandatory training included watching a two and a half hour DVD on infection control, the Mental Capacity Act 2005, health and safety, safeguarding and information governance. There were no checks or assessments following this, which meant that managers needed to monitor staff understanding of and compliance with essential procedures. Conflict resolution, resuscitation, paediatric safeguarding to level 2 and fire training were separate practical sessions. Staff told us fire safety training was sometimes difficult to access as there was limited availability.

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Assessing and responding to patient risk

- Clinical staff observed patients and recorded physiological observations such as blood pressure and heart rate. Staff were aware of the side effects of tests and kept patients under close observation. Staff used early warning scores for both adults and children to ensure patients at risk were managed appropriately. Staff told us of incidents when patients were transferred to wards when their health deteriorated
- There were resuscitation trolleys in all departments for cardiac emergencies. Staff had received training in emergency life support as part of their mandatory training. Out of eight outpatient and radiology teams, 5 achieved the trust's 90% target; two were over 85% and one was 72%. All staff we spoke with confirmed they were up to date with resuscitation training There were protocols in place for contacting the appropriate emergency team.
- Cardiology services were delivered across the two main hospital sites and at community health clinics. The service manager and their deputy reviewed and prioritised all referrals, and allocated to a site according to diagnostic and personal need, i.e. closer to home in the community or at one of the main centres.
- Each radiology treatment area had a radiation protection supervisor. There was an IR(ME)R practitioner, who with a radiologist developed a dedicated webpage on the trust staff internet. This was where all policies and procedures for radiation protection were held and were easily accessible to all staff. There was in-depth information relating to referrers and scopes of practice especially for non-medical referrers. The system was of a high standard and gave good assurance of radiation protection.
- Radiology staff used the interventional radiology (IR) safety checklist. The World health Organisation (WHO) safety checklist and the IR checklist had been revised in light of a serious incident at another location in the trust .

Nursing and allied health staffing

- In most clinics we visited there were at least three qualified nurses, a senior nursing sister and four health care assistants. Senior staff told us they were fully staffed and adjusted staffing levels to meet the demands of the clinics. There had been nurse staff capacity problems in ophthalmology earlier in the year, but these had improved.
- There were suitable numbers of support staff, and allied health professionals were allocated to clinics to provide continuity of service. Physiotherapy had a small number of vacancies but workload could be managed within the team, and by training physiotherapy assistants to NVQ level 4. Technical services made occasional use of locums.
- In some clinics, reception and/or clinical staff were working alone at times. This was an identified risk in two areas, and strategies were in place to help reduce the risks, including alarm systems and coded locks. In physiotherapy the main treatment room door off a corridor was left unlocked, and without reception staff, unauthorised patients entered on occasions.
- There were shortages of band eight clinical scientists and radiographers. The radiation protection supervisor said this was in part due to a national shortage of these professionals. This was assessed as a future risk to services in relation to undertaking dose audit work but not an immediate concern. Additional medical physics support was required in interventional radiology and nuclear medicine. The radiology service managers carried out an extensive workforce review and identified the skill mix needs of the department. Currently all band five radiographers rotated across both City and Queens Medical Centre with future plans to rotate all team leads and assistant practitioners. This meant a flexible staffing system was in place to ensure safe staffing levels.
- Overseas personnel had been recruited to sustain staffing levels in radiology, and there was a high use of agency and locum staff across all radiology staff groups. We looked at the training records of agency staff and saw that they attended training in line with permanent staff.

Medical staffing

- There were shortages of radiologists, in paediatric, neurological, interventional and chest specialities, comprising six vacancies. Recruitment for these specialities had been unsuccessful, but the department managed to be flexible to meet demand.Morning handovers between radiologists were effective.

Outpatients and diagnostic imaging

- Medical consultants and registrars worked in outpatient clinics on a rota. At the time of our inspection there were sufficient consultants to cover the clinics although some were very busy with long waiting times. There were no consultants in rhinology (nose and sinus disease) which meant they were unable to take routine rhinology patients. A rhinologist had been recruited but was yet to take up post.

Major incident awareness and training

- The trust had a major emergencies protocol and procedure for the department of diagnostic imaging. This had been reviewed in August 2015 and was effective from 9 September 2015.Clinic managers were aware of local business continuity plans in the case of inadequate staffing, power failure, bomb threat, IT failure, fire and flood. They were fully informed of procedures to follow. Radiology teams were aware of the role they played in the trust's major incident plan.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The effectiveness of outpatients and diagnostic imaging services were not rated.

In both outpatient and diagnostic imaging patients' care and treatment was planned and delivered in line with current evidence based practice and recognised national guidance. Some departments were active in research. Staff had the right skills to carry out their roles, and were well supported by their managers. There were good opportunities for personal and professional development. There was effective multidisciplinary working in many departments.

There were few seven day services, with most departments providing Monday to Friday clinics during 'working hours' only. Radiology provided a seven day, 24 hour service for all emergencies, including X-ray, MRI, ultrasound, interventional radiography, CT and fluoroscopy. Usually staff could access the patient information they needed in order to carry out assessments and treatments. Patients gave informed consent to their treatment and staff acted in line with legal requirements when patients did not have capacity to make decisions about their care and treatment.

Evidence-based care and treatment

- Outpatient clinics had local procedures in place based on relevant professional guidance, national service frameworks and evidence based practice.Staff accessed guidance on the trust's staff internet, and clinics had their own resource rooms where they kept up to date protocols and journal articles. Information about relevant medical conditions and national treatment guidance was displayed in some clinic waiting areas for patients and their families.
- In the radiology department there were appropriate 'local rules' and IR(ME)R procedures. These are required by law and summarise the key working instructions intended to restrict exposure in areas. There was a dedicated IR(ME)R practitioner who worked with medical physics, radiology management and clinical staff to write procedures, implement them, train staff in radiation protection and ensure compliance with regulations. All grades of radiology staff were well informed about doses and expected dose levels for routine examinations. The radiology department had adopted national diagnostic reference levels (NDRLS). These are doses of radiation that should Patient dose was consistently recorded for all examinations.
- Staff followed guidance set out in National Institute for Health and Clinical Excellence (NICE) guidelines, for example when assessing if a patient's sight impairment met the criteria for further treatment. Senior staff delivered education sessions for local GPs on changes to best practice, e.g. ear syringing. Staff were able to access latest guidance from the intranet and NICE guidance.
- The eye centre provided evidence based treatments to preserve vision in age related macular degeneration, including laser and light therapy and injections. Some nursing staff had completed counselling courses so that they could support patients more effectively. The centre was active in research in the field. The Medical Physics and Clinical Engineering department had a prominent role in trust-wide research studies. Dedicated clinical scientists carried out the assessments for these studies.

Patient outcomes

- Clinic managers told us they monitored procedures and patient outcomes. All patients have an outcome form which they take to reception at the end of their

appointment and these were inputted by administration staff. Clinics carried out their own audits; for example, the way the cataract clinic was run was changed following audit.

- Patients attending the macular treatment centre were re-scanned after three visits to check any improvements and attended monthly review appointments. Physiotherapy staff measured and monitored outcomes. Patient discharge was determined by a combination of objective and subjective measures. For example, they used a standardised self-assessment tool to measure health outcomes, so that changes over a course of treatment could be evaluated.
- Audits against IR(ME)R procedures were carried out regularly and compliance varied. There were concerns relating to recording pregnancy checks. Recording information on the radiology information system required improvement and all necessary supporting information should be scanned onto the patient record according to departmental procedures. These actions were highlighted in July 2015 and were being addressed currently
- There was a newly appointed full time radiology governance lead, who had established clinical governance information boards and electronic information for staff. We saw continual performance monitoring was made available to the clinical director and the trust board.

Competent staff

- Almost all staff we spoke with told us they were well supported by their managers and received a performance appraisal each year. Most told us the appraisal meeting was effective and helped them set goals for personal and professional development. Appraisals were monitored by the human resources department. Information from the trust showed that only 64% of radiology staff were up to date with an annual performance appraisal. Most staff said they had regular one to one meetings with their manager.
- We selected two nursing staff folders at random and saw the staff members had received an appraisal in July 2015, and one contained evidence of continued development for professional membership revalidation. This is a new process for nursing staff to renew their registration and demonstrate they practise safely and effectively. The clinic manager had attended a revalidation training session with the practice development matron.
- Physiotherapy staff told us they were well supported, managers were approachable, and there were good opportunities for professional and personal development. Staff could access training on mentoring, and some had gained Masters level qualifications. There were some specialist members of staff who delivered training courses at the hospital and ran professional development courses.The physiotherapy team carried out peer review each week, which helped staff to improve, and there were regular training sessions delivered by higher grade staff.
- In one clinic the manager planned staffing rotas to incorporate weekly or monthly training, and we saw these recorded on the rotas for July, August and September 2015. In another there were monthly staff meetings in which staff were informed about changes to the service and access to training, such as for the new digital health records.
- Clinical staff had training appropriate to the speciality clinic, such as medical suction, and oral and nasal care. Clinical educators attended the departments to check competencies and these were recorded in staff appraisal records. In the spinal clinic there were advanced physiotherapy practitioners who were able to assess patients, list them for surgical procedures and book MRI scans. Physiotherapy assistants were trained to deliver exercise classes and administer stretching and mobilisation treatments, under physiotherapy supervision. They received training from physiotherapists to meet defined competencies which were assessed and reviewed.
- We saw equipment training records for operators of all staff groups entitled to operate medical devices for the delivery of medical exposures. These were comprehensive and regularly reviewed to ensure staff competencies were up to date
- Continuous professional development was encouraged throughout the radiology department and staff were able to develop their roles such as advanced practice radiographers who are able to report on X-rays. There were seven reporting radiographers with one on

maternity leave at present. Their work was regularly peer reviewed and self-audited.Sonographers had been trained to undertake fine needle aspirations of the neck. The department employed six radiographic assistant practitioners, some of whom were being supported to complete radiography degrees.

Multidisciplinary working

- Many clinics were multidisciplinary and patients might see several professionals within one visit; this was sometimes called a 'one stop' clinic. For example, in the orthoptic clinic, patients with visual defects were assessed and treated by orthoptists, ophthalmologists, nurses and medical doctors. In ENT there was a voice clinic staffed by a team of consultant, singing teacher, nurse and speech and language therapist. The macular eye clinic was staffed by a multidisciplinary team of ophthalmologists, optometrists, nurses, ophthalmic photographers, patient assistants and the macular coordinator and administrative staff.
- Physiotherapy staff worked in the physiotherapy outpatient clinic, Accident and Emergency, spinal clinic and fracture clinic. They worked alongside the doctors in the different departments. Consultants in fracture clinic referred patients to the pain clinic if they needed specialist advice.
- Many staff, such as in audiology and cardiology, worked across two or three hospital sites. This helped integrate services and staff shared learning and good practice from different departments.
- In one clinic, the clinical and administrative leads shared an office. They said this helped ensure the department ran smoothly and there was a positive attitude to team working across the staff groups. Allied health professionals told us the multidisciplinary working was very good and helped improve outcomes for patients.
- Volunteers and charity employees attended or worked in a number of clinics to help provide support for staff and patients and their families. Hospital staff treated the external staff as part of the team. Many staff talked about good communication with local GPs, and some services, for example cardiology, provided outreach clinics in GP surgeries and health clinics.
- The interventional radiology teams were multi-disciplinary with good skill mix and a cohesive approach to work.

Seven-day services

- Almost all of the outpatient services were provided Monday to Friday during 'working hours'. Fracture clinic was open in the evenings five days a week. None of the outpatient services were provided seven days a week other than plaster clinic for fractures, which was open 8am to 8pm every day. Some services provided occasional clinics on Saturdays to help meet demand. Many departments had plans to add evening and weekend clinics to help reduce the number of non-attendances.
- Radiology provided a seven day, 24 hour service for all emergencies, including X-ray, MRI, ultrasound, interventional radiography, CT and fluoroscopy. The MRI department offered a seven day service with an on call service for cord compression and neurological patient emergencies. Currently Saturdays were assigned for inpatients and some radiographers worked Sundays on an ad hoc basis, but this was not part of their regular hours.

Access to information

- System facilitators were responsible for setting up and preparing clinics. Reception staff monitored the availability of patients' notes. If patient notes did not arrive the supervisor would search for them and if they could not find them they would make up a temporary set for that clinic; they printed off online letters and test results to include in the temporary file.
- Between April and December 2015 1% of patients were seen in outpatients without their full medical record being available. Between March and June 2015 there were four reported incidents at the Queen's Medical Centre of patient records not being available for clinic. In some cases this affected a number of patients; sometimes they were newly referred patients which meant they were seen by a consultant without any information from the doctor who had referred them. Staff were unable to locate missing notes in all four reported incidents, including patients with urgent clinical conditions needing an appointment within two weeks of referral.

- Clinic supervisors prepared a monthly report on attendances and notes availability. These reports went to the outpatient governance meeting which reported to the directorate governance meeting. We looked at minutes from the meetings held in June, July and September 2015, but could not see any record of these issues being reported or discussed. The trust said the reports would only be discussed if services were performing poorly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Clinical staff asked patients for their consent as part of their initial assessment at the clinic. Patients we spoke with told us staff asked for their consent and kept them fully informed about any procedures and treatments. Consent was recorded in patients' notes.
- A practice development matron told us staff training on the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards had been delivered to staff throughout outpatients. MCA documentation was available for staff to use if required in the assessment pack. Nursing staff we spoke with in ENT had a good understanding of the MCA. Administrative and booking staff followed procedures relating to people without the capacity to make decisions about their healthcare. These made sure that confidential patient information about appointments was only shared with relevant people.

Are outpatient and diagnostic imaging services caring?

Good

Overall, we judged that patients received good care in outpatients and diagnostic imaging services.

Staff supported patients in a caring, kind and compassionate way. They respected patients' privacy and dignity and made sure that people's individual needs were met.

Patients were kept well informed about their condition and their treatment options; they felt staff answered any questions they had. Patients and their relatives were helped to cope emotionally with their diagnosis and treatment.

Compassionate care

- Most of the patients we spoke with were positive about the caring attitude of staff. Patients told us they felt at ease and that staff treated them with respect. They said staff were polite, kind and reassuring.
- We saw reception staff talking with patients in a welcoming and supportive manner. One moved from behind the desk to speak face to face with a patient to better support them. In some clinics there were signs asking patients to respect others' privacy at the desk. In the macular treatment centre, phone calls were handled in a room separate to reception so that people waiting could not overhear. Some clinics also provided a quiet area for patients to speak in private if necessary.
- Health care assistants (HCAs) helped patients move to the different waiting areas within clinics, and they spoke with patients clearly, making good eye contact. Patients were supported at their own pace. We saw a nurse help support a patient by taking their arm to walk with them to a waiting area; another found a patient some biscuits as they had been waiting a long time and had left home early. Another nurse rang for a porter to help a patient who had a heavy bag. The porter was helpful and respectful.
- Patients told us they could request a chaperone if they wished. They also said that all staff maintained their dignity when they needed to remove clothing. Gowns were readily available and changing rooms were private. Where possible male and female patients were seated separately when changed.
- Friends and family test outcomes were displayed in all patient areas, and these were generally positive scores of over 80%. Trust-wide information showed that in June 2015 three quarters of patients reported a positive experience, and in August 2015 this had increased slightly to 81%. However, response rates were low at around 9%.

Understanding and involvement of patients and those close to them

Outpatients and diagnostic imaging

- Patients told us they had received good information before and after their appointment, so they knew what to expect and who to contact if they had concerns. Patients were kept well informed about their examinations, what would happen next and when their results would be available. They said staff were very helpful and flexible with booking appointments. Staff were able to answer their questions; they felt well informed and involved in decisions about their treatment options. In the macular treatment centre, nursing staff took patients into a quiet room to explain what would happen during the appointment, rather than in the busy waiting room. In some clinics there were notice boards of staff photos with each person's name and role.
- There were three Eye Clinic Liaison Officers, who were available to speak with patients and their families or carers. They were employed by a charity, but were permanently based at the hospital. They offered advice and support, and provided information to patients and carers on local and national visual impairment organisations. They also had direct links with local authorities and could arrange home visits from the visual impairment team.

Emotional support

- We observed staff comforting patients in an appropriate way, and involving relatives and carers. Patients told us staff were very understanding and did not rush them.
- There were clinical nurse specialists who supported patients with managing long term conditions. Volunteers from local support organisations such as Parkinson's UK were available at some clinics to speak with newly diagnosed patients and provide emotional peer support.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

Overall, we judged the responsiveness of outpatients and diagnostic imaging services required improvement.

Services were largely planned to meet people's needs. While the trust was able to provide timely assessments for people with non-urgent conditions, the trust did not meet national standards for urgent referrals. Few clinics monitored waiting times once patients had arrived for an appointment, even though this was a main source of patient complaint. There were higher than average rates of cancelled appointments, both by hospital staff and patients. The hospital had put in place some innovative methods aimed at reducing cancellation and unattended appointments. Learning from complaints was shared by staff and changes to clinics were made as a result to improve the patient experience.

The radiology department was flexible according to demand. Radiographers and radiologists would extend the working day when necessary to reduce cancellations and waiting times.There were online referrals for X-rays, but these were not used by all practitioners and sometimes duplications occurred. Patients were offered radiology appointments according to where spaces were available and not just on geographical location. . Diagnostic reporting was outsourced to other providers to help meet the demands on the service.

Service planning and delivery to meet the needs of local people

- Queen's Medical Centre provided a range of outpatient clinics to meet people's needs. Routine and specialist services were provided for people living locally and from across the East Midlands. The Macular Treatment Centre was one of the largest in the Midlands, seeing more than 1000 new and 7000 follow up patients each year.
- Some clinics, such as the Macular Treatment Centre, had been reviewed and staff increased as a result to be able to meet current demand. The ear, nose and throat department (ENT) had put on extra clinics, and held clinics on occasional Saturdays to help meet demand. The fracture clinic saw a diverse population including regulars who had problems with their cast, including frail elderly patients from care homes. The clinic had altered their staffing to meet patients' needs, and appointed plaster technicians to provide an improved service.
- Outpatient clinics did not monitor the demographics of people attending or failing to attend.
- New patients were sent a letter with their appointment and an information leaflet. The information included directions and maps. People told us the hospital was easy to get to by bus, although complaints about

parking difficulties were quite common. There was a free hospital bus service linking the two main sites and two park and ride locations. A tram stop had recently opened at the site. Several staff raised concerns about patient transport delays.Staff stayed late to remain with patients still waiting to be collected. In one clinic we saw the staff rotas included cover for staff waiting with stranded patients. This was a further problem in radiology departments caused by delays in porters bringing patients to and from the department. This caused disruption to the running of the clinics and meant that patients and staff were waiting sometimes for hours.

- Outpatient departments were situated throughout the large Queen's Medical Centre site and patients did not find the directional signs very clear. At the entrance to the eyes, ears, nose and throat (EENT)centre there was a small helpdesk staffed by a volunteer but they were not there the whole day. At the main hospital entrance there was a reception desk staffed by one person. Wheelchairs were available for patient use at the hospital entrance.
- The environment in the Macular Treatment Centre had good colour contrasts along the edges of the floor and walls that were clear for people with visual impairment. There was also good lighting and signage. The main eye clinic outpatient waiting area did not have the same clear colour contrast, and the carpet was an indistinct pattern that might be difficult for people with visual impairment to navigate. There was a variegated blue carpet on the stairs in the eye centre which a specialist told us was a hazard for people with visual impairment.
- In one of the cardiology departments the paintwork and furniture in the clinic rooms were worn.There was a large clinic room used for teaching and occasional scans. The décor in this room had marks on the walls and peeling paint.
- Some clinics had a 'self-check-in kiosk' where patients could check in electronically using a bar code on their appointment letter. We did not see anyone using the self-check-in facilities. In eight months between September 2014 and May 2015, 16% of patients attending the fracture clinic used the self-check in kiosk. Most waiting areas provided magazines, plenty of information leaflets and drinks. There were televisions in some areas. Most clinics had dedicated children's waiting areas.
- There were sufficient spaces in waiting areas for people using wheelchairs, although the high reception counter in the eye clinic was not suitable. There was a low area, but this had a large notice "Ambulance Transport Patient Waiting Area" which did not encourage people using wheelchairs to approach the counter.
- Seating in outpatient waiting areas was not always suitable for the patients using the service. For example in the ENT outpatients main waiting area, other than one wider than average chair, there were no seats with arms to help elderly people or those with visual or mobility problems sit down more easily. Macular degeneration is a condition that usually affects older adults. In the macular treatment clinic all the seats in the waiting area were normal height with low backs and only a few had arms.

Access and flow

- Patients were referred to outpatient services by their GPs, hospital consultants, other practitioners such as opticians, and in some cases themselves. Some patients received copies of letters sent to their GP following their appointment, and patients told us overall there was good communication between the hospital and their GP.
- The national standard for NHS trusts is that 95% of non-admitted patients and 92% of patients waiting to start treatment (at the end of each month) should start consultant-led treatment within 18 weeks of referral. The trust had consistently achieved better than these standards and better than the England average for each for the last two years.
- The national cancer waiting time standard is that at least 93% of patients urgently referred by their GP with a suspicion of cancer should wait no longer than two weeks to be seen in hospital. From April to June 2015, the trust had not met the target, with 90.4% of patients referred with suspected cancer attending within two weeks. There was a slight decrease to 90% in July 2015. There had been no improvement since the period January to March 2015. This meant that one in 10 patients were not attending hospital within two weeks of referral.
- In addition, 93% of patients referred with any breast symptoms should have their first hospital appointment within two weekseven if cancer is not suspected. In the

period April to June 2015, the trust met the target for patients with breast symptoms. This was an improvement on the previous quarter, but this was not sustained in July 2015 when 86.4% attended within two weeks.

- All patients who are newly diagnosed with a cancer should wait no longer than 31 days from the date of decision to treat to receiving their first treatment. In the period April to June 2015, 96.4% of relevant patients started treatment in this time frame, which was worse than the England average, but met the trust target of 96%. All patients who are urgently referred by their GP with a suspicion of cancer who are subsequently diagnosed with cancer should wait no longer than 62 days to start treatment. In the period April to June 2015, only 80% of these patients started treatment in this time frame, worse than both the trust target of 85% and the England average.
- Work was ongoing to improve the cancer waiting times performance. An action plan had the approval of the commissioners and had clinical oversight. This included finding extra clinic slots, weekend clinics, and business case to improve staffing, and daily monitoring of the two week wait waiting list.
- There were online referrals for X-rays, but these were not used by all practitioners and sometimes duplications occurred. Patients were offered radiology appointments according to where spaces were available and not just on geographical location. This made sure that if patients were able to travel, waiting times were reduced In light of National Institute for Health and Care Excellence (NICE) guidance on referral for suspected lung cancer, the radiology service offered GPs direct referral for CT chest scans. There were comprehensive referral criteria and all patients referred were assessed by a practitioner to ensure they met the requirements before scanning.
- The radiology department was flexible according to demand. Radiographers and radiologists would extend the working day when necessary to reduce cancellations and waiting times. MRI musculoskeletal scans plain film chest x-rays reviews were outsourced to another provider due to capacity issues.Despite a 15% rise in demands for services the trust was meeting the six week waiting targets but in January and February 2015 there were 100 MRI breaches. However, the breaches were managed well by staff working extended hours and outsourcing to another provider.
- The outpatient services team booked 80% of new appointments across the trust. Some clinic areas managed their own bookings but they were moving towards a centralised booking service. The central team had managed the two week wait bookings since January 2015, as part of a trust programme to improve the wait times.Follow up appointments were managed by the specific clinic administration team. In some clinics these were booked on leaving the department but not in all clinics, which had led to patient complaints.
- Once referred to the macular treatment centre, patients were brought in according to local protocol within two weeks, but usually quicker. If there were no available appointmentsfor an urgent patient, nurses would run a "virtual clinic" during which they carried out tests and scans and then a doctor reviewed the results later that day and contacted the patient within 48 hours.
- Cardiology services were delivered across the two main hospital sites and at community health clinics. GPs had direct access to heart scanning services.Managers reviewed and prioritised all referrals, and allocated patients to a site according to diagnostic and personal need. The service level agreement was to see and report on a patient within six weeks. This agreement was being met. Echocardiograms (an ultrasound check of the heart structure) were carried out at community sites, and most were reported on within 24 hours. Patients were currently waiting at most seven days for an appointment following referral, but the service manager told us this would most likely increase during the winter months. GPs could refer directly for some CT and MRI scans according to locally agreed guidelines.
- There were local targets for the time taken to report on a patient's X-ray or scan. There were varied rates of compliance with the targets and managers identified the need to improve job planning, as a means of addressing this. Inpatient reporting was meeting the target only 30% of the time while outpatients and GP patient services were meeting the targets at least 75% of the time, against a trust target of 90% There was clinical

oversight of reporting requirements and assignment of outstanding reports either to internal radiologists or to external providers; this was broken down by procedure and patient category.

- There were currently large backlogs of reporting across the NHS and there are no current guidelines from the Royal College of Radiologists. The trust was responsive and despite the financial implications, outsourced work to other providers so as to meet local targets. The way work was outsourced was well managed and work was prioritised according to need and/or risk.
- The physiotherapy department could see urgent referrals within two to three weeks, although staff could be flexible to see patients directly from clinics if necessary. Non-urgent waiting time for physiotherapy was six to eight weeks; in other areas, staff told us it was around four weeks.
- The number of follow up appointments compared with first appointments influences how many newly referred patients can be seen and meet the waiting times standards. A lower ratio improves patient flow. In 2014, the ratio of follow up appointments to new appointments at Queen's Medical Centre was better than the England average and significantly better than at the City Campus.
- In 2014, 6% of booked patients failed to attend their appointment at Queen's Medical Centre. This was slightly better than the England average of 7%. A newly designed outpatient dashboard for July 2015 showed that, trust-wide, failure to attend rates were increasing across the trust with 9.4% of patients not attending follow up appointments.
- To help reduce failed attendances, the trust developed an interactive texting service that reminded patients of their appointments and allowed them to rebook using text messages. Patients could also access an online booking system to change appointments. If there were no appointments available through this 'choose and book' system, there was an electronic system that flagged appointment issues and set up ad hoc clinics to provide the required appointments. On the day of our visit there were 20 patients, mainly with lower limb orthopaedic conditions, waiting for appointments to open up. This was now being closely monitored by the out-patient service improvement lead. In some areas there were plans to start evening and weekend clinics in order to make it easier for people to attend appointments.
- Trust information showed there were nearly 2000 ad hoc or emergency clinics across the trust in the six months since April 2015.
- Patients who failed to attend diagnostic and review appointments were not discharged if their medical condition indicated it was important they attended. Usually clinic administration staff 'phoned the patient and re-booked their appointment and then sent a confirmation letter. Often they contacted the GP or referring doctor to inform them.
- Few clinics monitored waiting times once patients had arrived at their appointment, although clinic coordinators told us they kept a check on how long patients were waiting. Trust-wide information showed that 13% of patients waited longer than 30 minutes after their appointment time to be seen. Signs in waiting areas advised patients to alert staff if they were waiting longer than 30 minutes. Several patients complained to us about waiting times on arrival and then to see different practitioners; we found patients waiting longer than 50 minutes to be seen in one clinic and over an hour in another. A health care assistant kept patients informed about delays. Many clinics we visited were running to time; patients told us they were often seen quite quickly and sometimes even before their appointment time.
- Most of the clinics used white boards or verbal announcements rather than electronic boards to inform patients of delays in clinics. These were not always clear especially for people with visual impairment attending an eye clinic. In one area the board was partially obscured by a curtain. We heard a staff member making a complex announcement to a crowded waiting room in audiology, close to people speaking at the reception desk. It was difficult even for people with average hearing to hear the information.
- The clinical director told us about work on improving the quality of the radiology patient pathway from referral including the right patient and the right test requested. There was a negative impact on capacity of the service due to inappropriate requesting from health

care professionals. Audits were regularly undertaken on inappropriate requests, which demonstrated the services ability to identify and respond to demands of the service.

Meeting people's individual needs

- Outpatient clinics contained displays of up to date information leaflets for patients on relevant conditions. There were very few leaflets in formats other than written English. For example in the eye clinic entrance there were racks full of information leaflets. Out of 42 different leaflets, only one (about rail travel) was in Braille, and two were in languages other than English. There were none on display in easy read or large print formats and we saw a sign in English stating that materials could be translated to other languages. However, those patients whose first language was not English would have found this difficult to read.
- The signs around departments were only in English. This meant that patients whose first language was not English would have difficulty finding their way to the right departments around the hospital.
- The appointment letter explained that people could change the time and date of their appointment if needed. The accompanying leaflet stated it was available in other languages, and staff told us they would contact the communications team for this. No one we spoke with had ever requested a leaflet in a language other than English. All staff we spoke with told us they could access interpreters. A patient with hearing impairment told us when they attended for eye tests staff did not arrange an interpreter and they felt embarrassed as a relative was used instead. More than one patient told us when the clinics ran late the interpreter was not always there at the time of the appointment. Other patients with hearing impairment told us the interpreters used by the trust were not up to British Sign Language standard.
- Information from the trust showed that since September 2014 approximately 980 patients attending outpatients were provided with a Polish-language interpreter. The trust did not collect specific data on usage of other languages or that showed the hospital sites or departments.
- Each clinic had link nurses or practitioners for dementia and learning disability who supported staff when caring for people with additional needs. Some but not all clinical staff had attended dementia awareness training and the reception staff we asked had not. Some reception staff told us they recognised patients with particular needs from their notes and referral letters, but others said this was not always the case.
- Several reception and clinical staff told us how they supported patients who were living with dementia or with a learning disability. We observed a patient with a learning disability attending an outpatient appointment. A specialist learning disability nurse had emailed the department a week previously with advice on how to reduce their distress during the appointment. This advice was followed and the appointment was successful. A nurse came to speak with the patient as they waited in the queue for reception. Then they were called straight through to clinic without having to wait. All staff communicated well with the patient making direct eye contact, remaining patient and using simple language. The eye test was adjusted to suit the patient's needs.
- A clinic manager gave an example of a patient with challenging behaviour. They were able to assess the risks and provide appropriate support throughout his appointment. Staff rang the patient's home later to check they had returned safely. In the macular treatment centre reception staff told us of one regular patient who had dementia; staff rang them the day before their appointment to make sure it was on their calendar and they were able to travel in.
- We saw staff members paying attention to people with particular needs, such as offering a drink of water to a pregnant patient, assisting a person with mobility problems or providing people with packed lunches when they had been at the hospital a long time. There were also notices advising patients they could request a chaperone if they wished, and patients told us they had done this. There were separate waiting areas for children, which were equipped with suitable toys and seating.
- A member of the local Parkinson's UK branch sat in the waiting area of a Parkinson's disease clinic and was available to chat with patients, hand out refreshments

and provide information about local support groups. This was particularly useful when patients had just been diagnosed. The MS Society also delivered sessions for patients with multiple sclerosis.

- Lockers were available in diagnostic clinics for patients' belongings. Staff gave patients bags to store their clothes in.
- In clinic two there were hatches between patient toilets and a clinical room, to pass urine samples through. There were no locks on the hatches so they could be opened at any time when someone was using the toilet.

Learning from complaints and concerns

- Clinics displayed information for patients on how to feedback and make a complaint. Contact details were also provided on the information letter sent out with appointments. Out of 160 complaints received by the trust during January to March 2015, 10 (6%) were about waiting to receive an appointment and waiting in the department after arrival. In April to June 2015, the proportion of these complaints had risen slightly to 7.5%, although the number remained the same.
- In ENT, patient feedback about waiting times had led to improved management of patients in the department to prevent over-booked clinics. In the macular treatment centre staff told us the main themes of complaints were waiting times, not being kept informed of what was going on, and not being able to see the same doctor. We saw a letter to patients dated April 2015, which acknowledged the concerns and explained why the service was under pressure and made a commitment about booking appointments. Reception staff told us it was a small but persistent minority of patients who raised complaints.
- As a result of patient complaints, waiting times in fracture clinic were audited about a year ago and the clinic booking process was re-designed. The sister told us this had a dramatic effect on reducing complaints. They told us that medical staff were more involved in responding to complaints and that had led to a better understanding of providing a good patient experience.
- The governance facilitator produced a monthly complaints report and every three months issues and themes were discussed at the sisters meeting. Clinical staff told us their heard about complaints and concerns from senior staff at regular meetings, although they rarely heard about those in other departments that they might learn from.
- Patient surveys and friends and family tests were carried out regularly in the radiology department and there were few patient complaints.

Are outpatient and diagnostic imaging services well-led?

Good

Overall, we judged the leadership of outpatients and diagnostic imaging services was good.

There was work in progress to re-design the outpatient pathway and improve the trust-wide outpatient service. The governance structures were largely effective but did not manage all identified risks. Staff were committed to their roles and in most departments there was a positive supportive working culture. Some administration staff were not happy with the way changes to their roles were being managed. There was good staff and public engagement and a focus on continued improvement.

There was a clear vision and leadership in radiology services. We found the service was responsive to key issues and risks, with clear plans in place to improve quality systems. Managers were aware of the key issues affecting their service, however not all of the risks we identified were included on risk registers. Risks included the environment and access to fire safety training. A backlog of radiology incident investigations by departments outside of radiology was not timely, which meant learning from incidents may be delayed.

The Medical Physics and Clinical Engineering service was considered innovative in its practice and continued to have high standards in quality and safety. Staff enjoyed working in radiology and were motivated. Radiology services continually strived for improvement and value for money.

Vision and strategy for this service

Outpatients and diagnostic imaging

- The trust had developed a five year strategy based on a vision of "working together to be the best for patients." None of the staff we spoke with told us about the strategy although most spoke about the values of the trust and the importance of attitudes and behaviours.
- Outpatient services sat within a number of different clinical directorates. Staff in outpatient clinics identified strongly with their own area of work but did not articulate a wider department identity or strategic direction.
- Most managers we spoke with described an aim to provide more extensive services. The trust had a digital health records, outpatients and administration re-design steering group. This was running the programmes to introduce electronic patient records and re-design the outpatient appointments system.
- At senior management level there was positive inter-directorate work on formulating strategies. For example, the leads on the trust strategy would attend the radiology strategy meetings to ensure connectivity between services and the trust as a whole.Other directorates would also attend these meetings because of the impact that radiology had on services across the hospital.This meant that there was connectivity across the trust as well as up and down.
- The radiology department had a good strategic vision; it was forward thinking and directional. The Clinical Director was well regarded. The Medical Physics and Clinical Engineering service had identified that making sure radiation doses were kept as low as possible (called optimisation of medical exposures) would improve public health and there was currently a large focus on improving this.

Governance, risk management and quality measurement

- The chief operating officer reported integrated performance, including benchmarking against similar trusts, at each board meeting. This report included outpatients targets such as referral to treatment times, and provided a narrative on causes of any reported underperformance and actions in place to improve performance. A new outpatient 'dashboard' on the trust staff internet, showing measures of performance, had been developed by an external company.
- Clinical directorates reported quarterly to the corporate governance team to demonstrate that they were monitoring all aspects of quality. Outpatient governance meetings reported to the relevant directorate governance meetings, and senior staff fed back to staff at department meetings.
- Outpatient clinics displayed performance information. In some clinics the information did not identify what type of performance the displayed score was for. Usually the performance was the friends and family test (FFT), which shows the percentage of patients who would recommend the service to others, and / or cleanliness audits. Clinics usually displayed waiting times and any delays.
- In February 2015 the "15 step challenge" tool was used in 16 clinics to evaluate the welcoming nature of the clinic, organisation and information. The team consisted of patients, nurse staff and board member. Patient representatives were sent a dummy appointment letter to test out finding the clinic. This produced qualitative themes such as "staff observed to be caring with patients" and "clinic areas badly in need of redecoration." We received no information about actions taken as a result of this exercise and whether it was repeated or part of regular quality assurance.
- In May 2015, the outpatient pathway lead and outpatient service improvement lead attended the Quality Assurance Committee to update the committee. They presented the work on improving wait times, ophthalmology follow-up appointment wait times and patient transport processes, and developing management oversight of out-patients.The issues had been tackled through the development of a performance management system and through service re-design. The presentation detailed the actions in place to address each of the issues. The minutes of this meeting went to the trust board.
- During our inspection we found concerns with records management, the environment and access to fire safety training but these were not identified on the outpatient risks sent to us by the trust and we could not see them on directorate risk registers.
- The radiology department had a weekly dashboard to report waiting times and diagnostic reporting issues. However, the data used appeared to be flawed and

included patients who were too unwell to attend the department or delays due to their clinical management. The Medical Physics and Clinical Engineering (Nuclear Medicine section) did not have a quality management system for documentation of procedures. There were plans to adopt a quality management system and to work towards meeting ISO standards. Medical Physics and Clinical Engineering were working towards ISO accreditation and the Radiology department working towards the royal college of radiologists' imaging services accreditation (ISAS).

- In 2011, the lead CQC IR(ME)R inspector wrote to the trust concerning delayed reports on actions following incidents; this was followed up by the trust's Radiation Protection Advisor (RPA) in 2013. The RPA considered additional investigations and actions following incidents that took place in departments outside of radiology were poor; directorates did not actively close off incidents despite escalation by the radiology governance lead and the trust radiation protection adviser (RPA). Open incidents required frequent "chasing" and some incidents were closed off by directorates too early. At the time of inspection there were still 68 open radiation incidents, five were open from 2014. Despite ongoing dialogue between the trust and the CQCIR(ME)R inspectorate, this remained in need of immediate attentionThis highlighted a key issue in relation to radiation incident management by other departments.
- Managers were aware of ongoing issues relating to open radiation incidents, and there were plans to adopt a more systematic approach. Managers were aware of the advice and expectations from the radiation protection service and had given assurances that their plans would meet recommendations.
- The Radiation Physics Service (within Medical Physics and Clinical Engineering) appointed Quality Assurance Coordinators to work directly with radiation departments to support quality assurance of equipment activities. Risk assessments for new equipment and procedures were carried out by modality leads within the service, and all risks were rated and placed on the Trust risk register where required.
- The radiation safety committee (RSC) met regularly. There were good governance arrangements within radiology with regular meetings and a dedicated radiology governance lead radiographer and radiologist. We saw regular radiation reports from the head of medical physics, clinical engineering and radiation protection services to the trust board.
- In response to increasing incidents within radiology the Medical Physics and Clinical Engineering department identified the requirement to train and appoint additional radiation protection supervisors, which had been done.
- Demands on radiologists had been identified as a stress point and improved ways of working were being established. Seventy five per cent of radiologists now had a job plan.
- Medical Physics and Clinical Engineering identified that the majority of trust radiation protection leads were clinicians and that governance meetings were not well attended by this group. At the time of the inspection there were plans to review the terms of reference of the RSC to ensure meetings were not postponed or cancelled due to poor attendance
- Medical Physics and Clinical Engineering set key performance indicators for dose monitoring and a quarterly report was generated. At times it was felt that management did not take this forward as would be required especially in light of personnel who are identified as non-wearers or non-returners of occupational monitoring.

Leadership of service

- Outpatient services were managed by different senior staff according to speciality and location. There was no single outpatient manager for the hospital or the trust.
- Virtually all staff we spoke with felt well supported by their managers but some administration and reception staff told us the job was too busy and stressful, and the department was not well managed. Staff were leaving and not being replaced, which meant a loss of experience. Others told us they felt the re-design of administration services was not well communicated to staff on the front line and they did not feel well supported by senior staff. Many staff were concerned about the impact of re-structuring on their jobs.

Sickness and absence were causing problems with maintaining staffing levels in some areas but a manager told us they were able to cope by adopting staff from other teams.

- Most staff we spoke with knew who the chief executive was and told us senior staff were visible around the hospital. Staff received a weekly trust briefing and senior staff attended training updates once a year, attended by the chief executive officer.
- The Medical Physics and Clinical Engineering department was extremely well led and innovative in its practice. Through its on-going work the Trust radiation protection culture was improving and standards were high. The radiology service management post was job shared and the two post holders worked well together with a cohesive approach to running the department. Radiology staff told us managers were sensitive to their concerns especially in light of the changes to the structure of the department, the workforce issues and financial constraints. Management at executive level was perceived at times as not being in touch with the demands on radiology, but the clinical director and lead radiologist were actively working towards raising local issues to board level.

Culture within the service

- The radiology department had gone through numerous restructuring and workforce challenges over the previous two years, yet staff remain motivated, patient focused and supportive of one another.
- Most of the staff we spoke with told us they really enjoyed working at Queen's Medical Centre; many had worked at the trust for many years and had no intention of moving on. Some departments had team building social events. Most staff were proud to work for the trust; they felt respected and valued. They liked the focus on involving patients and making sure services were designed around patients
- Staff felt senior members of the organisation listened to their views. They told us if they had good ideas there was the possibility of funding and implementation.
- Despite current staffing issues the trust managed to retain a high number of their own student radiographers post qualification. The trust was seen as a good place to work and staff were supported and supportive of colleagues. In radiology a preceptorship lead was identified to help new permanent and agency staff. The programme was excellent with sound orientation, policies and procedures well laid out and a holistic and supportive approach to new team members especially newly qualified radiographers.
- Radiology staff told us there was a culture of openness and honesty and they were encouraged to report incidents and to present new ideas and suggestions to the radiology service managers. A number of consultant radiologists discussed the excellent relationships that existed between colleagues within radiology and consultants in other specialities but that there was still a perceived lack of leadership at consultant level within the department. Registrars were concerned that consultants worked in silos according to their speciality and at times it was difficult to gain access to advice. Some trainees thought communication could be improved, and junior clinicians reported inappropriate behaviours by consultants. The consultants told us they were aware of the issues disclosed and were taking steps to address the ongoing concerns.

Public and staff engagement

- Staff gathered patient feedback through feedback cards. Friends and family test scores were taken from the analysis of these cards and other feedback was used to develop the service. Most waiting areas displayed "you said…we did." posters. There were displays in waiting areas about fundraising activities and events, for example for a sensory garden for the ENT department. These were also shared on social media.
- During 2014/15 the trust held over 400 patient and public involvement events with 8,500 participants. There were also a number of public, staff and stakeholder engagement events called ‘Events in Tents.’ These helped the trust to refresh its vision and values, and identify the quality priorities.
- Staff told us they felt well informed and involved with regular briefings, and had completed staff satisfaction surveys.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

- In recognition of the challenge to outpatient services, in July2014 the trust came together with five other NHS trusts from across the country to share good practice and highlight themes for development. This was reported in the Health Services Journal.
- Local Healthwatch, which represents the views of the public, praised improvements in ophthalmology outpatient appointments. A Healthwatch volunteer was invited to join the trust's head and neck patient partnership involvement committee and has been involved in monitoring the trust's action plan.
- Check-in kiosks were installed last year to reduce patient waiting times. Patients could check-in without standing in line at the front desk using new self-service kiosks. The trust sent us data for one clinic, which showed that less than one fifth of patients used the kiosk to check in. We did not see any patients using these kiosks during our inspection.
- Patients received a text reminder before their appointment. This also gave them the option to change the appointment if needed and choose from three different appointment slots, by text or by going onto the online 'choose and book' system.
- A main challenge to outpatients was the introduction of digital health records and administration redesign. Digital health records would mean that only a thin patient record folder would accompany the patient in a clinic. This was being introduced gradually in different specialities over the next six months, due to be completed by February 2016.
- Mindful of the financial constraints on the department, radiology staff were looking at ways to offer value for money for the service they provided. Demand and capacity were monitored and the growing needs of the service were discussed with the clinical director and other stakeholders. The plan was to set up a dedicated interventional radiology specialist interest group.

Outstanding practice and areas for improvement

Outstanding practice

Urgent and emergency care services

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

Medical care (including older people's care)

- An occupational therapist on ward F20 had undertaken a six month pilot project called 'Playlist for life'. The project involved asking patients about songs that were personal to them that they would like to listen to. Where patients were unable to list songs that were personal to them, their family or carers were encouraged to create a playlist on the patients behalf. The playlists were then created using hand held devices and provided to patients free of charge. Evaluation of the project was underway.
- With the support of nursing staff, a consultant on ward F20 had started an ice cream project in order to support patients who were nutritionally at risk. Patients who were nutritionally at risk had an ice cream sign placed on the board above their bed, this prompted staff to ensure these patients were supported to eat ice cream. The project had come to an end and the consultant was working on applying for more funding to continue the ice cream project.
- Patients wore a coloured wrist band to highlight the oxygen rate they were prescribed. This ensured staff could easily identify the patient's required rate to ensure they were receiving safe care.

Surgery

- Theatre staff had successfully standardised practices and processes at QMC and Nottingham City Hospital to ensure safe ways of working and reduce cultural differences. The theatres safety improvement programme implemented a variety of safety projects. It ensured that all theatre staff were trained on team etiquette. This emphasised safety, mutual respect, effective communication, accountability and situational awareness. As a result, theatres ran more safely and efficiently.

Outstanding practice and areas for improvement

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

Critical care

- Innovative approaches were used to gather feedback from people who used the service through inviting patients and carers to opening of a new bed area and getting their views regarding patient privacy.
- The 'just do it' project to avoid cancelled elective surgery due to lack of critical care beds has been successful. This is also an example of several departments working together to solve a problem.

Maternity and gynaecology

- A member of staff designed a maternity app specifically for the women at NUH called the 'Pocket Midwife'. The free 'app' had information about each stage of pregnancy, including leaflets and information. The service could add news flash information to the app for women to see, for example flu vaccinations alerts. Maternity leaflets and trust guidelines were easily accessed via a guideline app.
- Maternity services identified successful processes within the hospital and engaged with the staff who were involved. For example the 'breaking the cycle team' had been successful in reducing emergency waiting times. This team were invited to work with maternity services to improve the efficiency of the discharge process.

Outpatients and diagnostic imaging

- In recognition of the challenge to outpatient services, in July2014 the trust came together with five other NHS trusts from across the country to share good practice and highlight themes for development. This was reported in the Health Services Journal.

Areas for improvement

Action the hospital MUST take to improve

- The trust must take action to ensure that nursing staff working in the eye casualty receive training in the recognition and treatment of sick children.
- The trust must ensure 50% of nursing staff within critical care have completed the post registration critical care module. This is a minimum requirement as stated within the Core Standards for Intensive Care Units.
- In surgical services the trust must take action to ensure that the principles of the Mental Capacity Act 2005 are correctly and consistently applied in assessing the capacity of patients to make specific decisions.
- The trust must ensure midwives have appropriate training to provide safe care for high dependency women in an appropriate environment.
- The trust must ensure midwives have the appropriate competence and skills to provide the required care and treatment to women who are recovering from a general or local anaesthetic.
- The trust must be consistent in the documentation of checking of emergency equipment and ensure that the resuscitation trolleys, neonatal transport systems and resuscitation equipment are checked, properly maintained and fit for purpose in all clinical areas.
- The trust must take action to ensure Do Not Attempt Cardio-Respiratory Resuscitation decisions are documented legibly and fully in accordance with the trust's policy and the legal framework of the Mental Capacity Act 2005.

Action the hospital SHOULD take to improve

- The trust should consider holding major incident exercises in the emergency department and Ensure that staff in all specialities are familiar with emergency planning and major incident procedures.

Outstanding practice and areas for improvement

- The trust should consider improving the availability of patient information leaflets, including those in other languages and accessible formats.
- The trust should consider the appropriateness of the environment and facilities in the eye casualty waiting area for children and young people.
- The trust should consider nurse staffing levels and skill mix in the eye casualty department.
- The trust should consider availability of consultants to ensure direct admission and transferred major trauma patients are seen by a consultant within five minutes of arrival at the major trauma centre.
- Providers should ensure safe follow policies and procedures to ensure medicines are administered appropriately to make sure people are safe.
- The trust should consider measures to increase the number of nurses receiving appraisals in the emergency departments.
- The trust should consider the availability of hospital play specialists in the children's emergency department.
- The trust should ensure oxygen is prescribed in line with the trust's policy for patients who require it.
- The trust should ensure consistency in the completion of patient's nutritional screening and the completion of nutrition and fluid charts on ward B49.
- The trust should ensure all staff are aware of their responsibilities in relation to infection, prevention and control.
- The trust should consider placing hand washing facilities inside staff toilets to reduce the risk of the spread of infection.
- The trust should ensure patients on all of the health care of older people (HCOP) wards have equal access to meaningful activities.
- The trust should ensure pre-printed care plans are consistently personalised to each individual's needs.
- The trust should ensure care plans reflect how staff should support patients who present with complex and challenging behaviour.
- Consider extending the availability of the Learning Disability Liaison team to include weekends
- Ensure that ward temperatures are regulated and that a system is in place to date check equipment in a timely manner.
- Put patients at their ease before they go into theatre by providing a suitable waiting area with privacy.
- Continue to make efforts to help patients sleep by mitigating noise levels on wards at night.
- The trust should consider using the emergency planning boards on all wards to ensure important information is easily available for staff.
- The trust should consider improving the experience of patients at mealtimes by serving each course separately.
- The trust should consider extending the availability of the Learning Disability Liaison team to include weekends.
- The trust should work towards there being at least one nurse per shift in each clinical area (ward / department) within the children's and young people's service is trained in advanced paediatric life support or European paediatric life support.
- A lack of specialist radiology cover out of hours meant that babies had to be transferred to another hospital to receive this service. The trust should consider how the service can be improved to ensure radiology care could be delivered on site.
- The trust should ensure that staff in the maternity service have received up to date training for the safe operation of equipment.
- The trust should ensure that staffing within the neonatal unit follows the British Association of Perinatal Medicine standards.
- The trust should ensure that an accurate record is kept for each baby, child and young person which includes appropriate information and documents the care and treatment provided.

Outstanding practice and areas for improvement

- The trust should ensure that they have written formal arrangements in place with the children and adolescent mental health team so that the needs of children and young people with mental health problems are met.
- The trust should ensure that agreed care pathways and written guidance are in place to guide staff when caring for children and young people who have mental health conditions.
- The trust should ensure all midwifery guidelines are available for staff to use when providing care.
- The trust should work towards capturing the users' comments on the partners in maternity committee.
- The trust should review the home from home values of the midwife led unit.
- The trust should ensure medical staffing ratios in midwifery meet national recommendations.
- The trust should review the elective caesarean section pathway to improve the experience for women and families.
- The trust should consider formulating an overall strategy for end of life care across the trust which is disseminated to all staff across all divisions.
- The trust should consider increasing the number of consultants providing end of life care to reflect the recommendations of the National Council of Palliative Care.
- The trust should consider increasing the hours of the specialist palliative nursing team to ensure patients who require it can receive a face-to-face consultation seven days a week as per NICE (National Institute for Health and Care Excellence) Quality Standard number 10 published in 2011 for end of life care for adults.
- The trust should consider ensuring end of life 'champions' are allocated protected time to disseminate matters relating to good practice end-of life care to other staff in their team.
- The trust should consider updating the end of life care bundle to ensure a patient's preference for involvement of the pastoral care team is recorded.
- The trust should consider ensuring up to date information reflecting good practice at end of life is readily available in each area and staff are aware of its location.
- The trust should ensure all staff have access to on-going training for end of life care to ensure staff understand their roles in delivering quality care.
- The trust should ensure regular auditing of 'fast-track' discharging and patients preferred place of death is undertaken to identify any concerns and put actions in place to address the issues
- Ensure that all reports of radiation and maternity incidents are investigated in a timely manner, and ensure recommendations are put in place in a reasonable timescale.
- Ensure all staff are able to attend annual fire safety training.
- Ensure that small portable sanitising hand gel dispensers are safe to use in outpatient departments.
- Ensure that the risks of lone working are reviewed and managed in all relevant outpatient and diagnostic departments.
- Ensure that all clinical equipment is regularly serviced as required.
- Extend outpatient and diagnostic imaging services beyond working hours, Monday to Friday.
- Improve the outpatient appointment booking procedures to reduce the rate of cancelled appointments.
- Improve the visual environment in the eye centre.
- Provide varied seating in outpatient waiting areas to meet different people's requirements.
- Ensure that accurate patient records are maintained securely at all times.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Care and treatment of service users must only be provided with the consent of the relevant person. If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the Mental Capacity Act 2005. Staff in surgical services did not always understand or correctly apply the principles of the Mental Capacity Act 2005 (MCA).

Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Regulation 12 (2)(e) The trust must be consistent in the documentation of checking of emergency equipment and ensure that the resuscitation trolleys, neonatal transport systems and resuscitation equipment are checked, properly maintained and fit for purpose in all clinical areas.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider did not have robust audit systems in place to ensure 'Do Not Attempt Cardio-Respiratory Resuscitation' decisions were always documented legibly and fully in accordance with the trust's own policy and the legal framework of the Mental Capacity Act 2005.

This section is primarily information for the provider

Requirement notices

The trust was not meeting the national cancer waiting time standard of seeing at least 93% of patients urgently referred by their GP with a suspicion of cancer within two weeks of referral

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