Nottingham University Hospital 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.

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Overall summary

Queen's Medical Centre is an acute hospital managed by Nottingham University Hospitals NHS Trust. The trust is the fourth largest acute trust in England, and provides services to more than 2.5 million residents of Nottingham and its surrounding communities. It also provides specialist services to between three and four million people from neighbouring counties. There are 1,690 beds across the trust, and it has a budget of £824 million. Queen's Medical Centre is the emergency care site, where the emergency department, major trauma centre and the Nottingham Children's Hospital are located. There are 975 beds on this site.

The trust employs more than 14,000 people. Of the population of Nottingham, 34.6% belong to non-white minority groups.

We chose to inspect the acute services at Queen's Medical Centre as one of the Chief Inspector of Hospital's first new inspections because we were keen to visit a range of different types of hospital, from those considered to be high risk to those where the risk of poor care is likely to be lower. When we announced our inspection, we described the trust as a high risk provider. By the time we carried out the inspection, our risk methodology had revised that assessment to a medium risk provider. Queen's Medical Centre has been inspected six times since it was registered in October 2010.

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

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

The accident and emergency (A&E) department was seeing increasing numbers of patients, and it could not always maintain the privacy and dignity of all of its patients.

The trust calculated nurse staffing levels for services (with the exception of children's care services) using a recognised dependency tool. It was currently developing a staffing dependency tool for children's services.

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

The vast majority of people we spoke to said that their care had been positive, and we saw some good examples of staff delivering compassionate care to patients. Nevertheless, some people highlighted areas where they thought the hospital needed to improve.

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

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Services were safe in the hospital because there were systems for identifying, investigating and learning from patient safety incidents and there was an emphasis in the trust on reducing harm to patients. We found nurse staffing levels were calculated using a recognised dependency tool in the adult wards which we considered to be good practice. However, we were concerned that this was not the case on the children's wards.

Patients told us they felt safe while being treated at the Queen's Medical Centre.

Are services effective?

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

We did find some areas that were less effective. We found that there was a back log of maintenance of clinical equipment. The trust was already aware of this and it was on their risk register. We found they had taken steps to manage this risk by ensuring the highest risk equipment, such as ventilators which are used to breathe for patients, were serviced according to manufacturer's instructions. We also found that around 40% of staff were not up to date with their mandatory training. Again, the trust were already aware of this issue and had a plan in place to address the shortfall. We found they were making good progress against their plan and we did not find any impact on patient care. We found there were a significant number of follow-up appointments in the opthalmology department that had not been allocated. This meant there was a risk patients who had undergone surgery were not being checked to make sure there were no complications.

Are services caring?

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

Summary of findings

Are services responsive to people's needs?

In general, the Queen's Medical Centre responded to people's needs. Overall, patients were treated promptly. We found the hospital actively sought the views of patients and their families but they did not always inform children they wanted their views. We found that there was good access to interpreting services and all information leaflets could be requested in other languages.

There was a dedicated ward for patients who had dementia which was providing good person centred care. However, the trust recognised that patients with dementia were cared for in all areas of the hospitals and attempts were being made to offer the most appropriate care for these patients. Initiatives such as the completion of an "About me," document and access to a falls prevention team were in place. Some staff raised concerns about the difficulties they faced caring for patients with dementia on general wards and felt there was more work that could be done to improve the experience for these patients.

There were initiatives in place for the trust to work with the local community such as a partnership with a local school for young adults with learning disabilities and supporting the Princes Trust to offer work experience.

Are services well-led?

The hospital was well-led. The trust board showed a good understanding of the key issues facing the trust. The executive team was well respected by staff. There were clear organisational, governance and risk management structures in place. Most individual services in the Queen's Medical Centre were well-led, but there was some variability in some of the children's and outpatient services.

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

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

Summary of findings

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

Accident and emergency

Attendance at the A&E department was increasing year on year. In 2011/12, there were 184,745 attendances at A&E. This was an increase from 181,433 from the previous year. The department was built to treat 120,000 patients. When A&E became busy, patients on trolleys waited in the middle of the more public major treatment area. This area often became full with patients very close together on trolleys and wheelchairs. Staff told us that this had led to regular observations not being carried out, omissions in the provision of medication and treatment, and difficulty finding patients quickly. Staff also told us that some patients felt uncomfortable answering questions because of discomfort/embarrassment in this uncurtained public area. There was also a small waiting area nearby, and people in this area could overhear these conversations. There were short-term plans to improve the A&E environment by creating more space and proving additional cubicles.

Staff were observed to be caring and compassionate, and the Friends and Family Test results for the department were above the national average. Staffing levels seemed to be appropriate during our inspection. There were some nursing and medical vacancies, but there were plans to fill the gaps as soon as possible. Senior management told us they were looking for more staff for A&E, particularly the resuscitation area.

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies. The department had a number of clinical pathways for care. We saw that there were protocols displayed near the initial assessment triage area for the most frequent conditions that patents present with at A&E. We also saw NICE/Resuscitation Council guidelines clearly displayed in the resuscitation area.

We saw that emergency re-admissions following an A&E discharge were lower than the national average. However, we saw from the findings of audits carried out by the trust that patients' treatment was not always timely and effective. The College of Emergency Medicine fractured neck of femur audit stated that delivery of timely analgesia required improvement.

Trusts in England are tasked by the government to admit, transfer or discharge 95% of patients within four hours of their arrival in an A&E department. The data shows that the Nottingham University Hospitals NHS Trust performed consistently below the national average from April 2012 to May 2013 and that it did not meet the target of 95% for A&E admissions in less than four hours. However, from May to October 2013, the trust performed consistently better than the national average and frequently met the target of 95%. Between September and October 2013, the trust fell slightly below the national average to 92%.

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We saw that the trust had carried out lots of work with different external providers such as the East Midlands Ambulance Service and the Clinical Commissioning Group as well as within the hospital, to improve the time in which people were treated within A&E. Commissioners told us that there had been a vast improvement in the trust's A&E performance.

We saw staff wearing personal protective equipment and washing their hands appropriately. However, we saw some areas of concern. Parts of A&E, such as the patient toilets in the reception area, required refurbishment to ensure they can be cleaned effectively. We saw a sharps bin that was over-filled, and clinical waste was not stored securely at all times. We also saw that some alcohol gel dispensers were empty and there were not enough dispensers to ensure that effective infection control measures were taken at all times.

Some large clinical waste bins that were in corridors were unlocked. This meant there was a risk that people had unauthorised access to contaminated waste.

Staff explained how they would support people with learning disabilities or autism. They told us that they had specific plans of care in place for people who regularly attended A&E and that they could access support from a specialist learning disability team when required. This meant patients with specific needs received care that was more individualised for them.

We saw staff considering a person's capacity appropriately and discussing actions that would be taken in their best interests. Staff demonstrated a good knowledge of the Mental Capacity Act 2005. This meant staff were checking that patients could use and understand information to make an informed decision.

We found the A&E department to be an open and honest learning environment, and staff had an obvious respect for each other.

Medical care (including older people's care)

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

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

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

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

There was an effective hospital at night team in place at Queen's Medical Centre. The hospital at night team triaged referrals using the early warning score and the situation, background, assessment and recommendation tool to provide clinical advice. We observed the hospital at night handover at the end of a night shift, and we found that all the jobs were completed and feedback was given to the individual doctors about activity overnight. Doctors and nurses expressed satisfaction with the system.

Surgery

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

The trust provided the region's major trauma centre. People with major trauma were receiving safe care because their outcomes were better than the nationally calculated expected standards.

In patient records we found that staff had documented risk assessments to identify potential problems such as venous thromboembolism (VTE), falls and

pressure ulcers. Wards displayed information for patients and visitors about any falls or pressure ulcers that had occurred. There was a low incidence of falls within surgical services, even in the orthopaedic wards, where frail, elderly people were being cared for.

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

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

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

Intensive/critical care

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

We saw that there were systems to ensure that senior intensive care medical expertise was available to the critical care areas at all times. This is important because patients' conditions can deteriorate very rapidly. We saw that physiotherapy specialist support was available to patients seven days a week, which meant that patients received the optimal support to make progress.

The Intensive Care Unit was the base for a critical care outreach team which was able to provide expert advice to help ward staff manage patients whose conditions had deteriorated in the ward areas. This team provided support to 8,000 patients every year. The team was able to educate other staff in managing critically ill patients and also monitor trends in problems. It had identified that fluid management was often a contributing factor in patients becoming ill. The team was multi-professional and had specialist critical care skills. The team worked seven days a week from 8am until 10pm. Overnight deteriorating patients were managed by the hospital at night team.

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

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

Maternity and family planning

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

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

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

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

In the maternity service we found procedures and practice for infection prevention and control were not always effective. At the Queen's Medical Centre we found there was dust on low and high surfaces in patient bays and dust on equipment in labour suite. We also found specimens were not being stored in accordance with the trusts own policy.

Medicines were not always being managed appropriately in the maternity service. Not all entries in the controlled drugs book were recorded properly because there were some gaps. In a small number of cases we found missing signatures to say that controlled drugs had been administered by two members of staff.

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

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

Most staff we spoke to, including doctors in training, felt well supported by their managers. Staff also told us that the trust had encouraged them to develop professionally. However, we also spoke with some staff who felt that management had not always sought or listened to their opinions.

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

Services for children & young people

Children’s services were caring, and we saw some excellent examples of care. People’s views of the care they and their child had received were mainly very positive.

We found the flow of communication from ‘board to ward’ was inconsistent in children’s services, and this meant that there was a lack of assurance that key messages and learning were being communicated to frontline staff. Some wards were more proactive than others in sharing information. For example, information-sharing was good in the paediatric intensive care unit and paediatric outpatients, where there were regular team meetings. On the children’s assessment unit, nurses did not get any feedback following completion of an incident form. But on wards D33 and E39 nurses outlined how they received feedback and how changes had taken place as a result of incidents. Therefore, there was a lack of assurance that learning and key messages were being fully implemented. A further example was the inconsistent performance in relation to nursing indicator targets. For example, wards D33 and E37 and the neonatal intensive care unit scored ‘red’ or ‘amber’ for these targets in most months since April 2013. This indicated inadequate performance. In the small number of cases where performance had reached the required threshold to score ‘green’, this improvement had not been sustained the following month. This meant that the department was not implementing learning consistently to ensure patient safety.

Children’s A&E was open 24 hours a day and had good medical staffing arrangements in place. In general medical staffing was good across all of the children’s services. The department produced weekly rotas that included good assistance from consultants. Consultants were on call at night and over the weekend on the general wards. We had some concerns about the nursing staffing levels in some of the areas.

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In the Children's Assessment Unit Ward E38, the nursing to patient ratio was given as one nurse to four children during daytime and one nurse for six patients during the night. Although the daytime levels did meet national standards, the night time levels did not meet the 2013 Royal College of Nursing's standards. These standards state that there should be one registered children's nurse for every three children under the age of two, and one registered children's nurse for every four children over the age of two. The trust did not routinely adjust its staff numbers when caring for children under two, and there was no dependency tool in place to help with staff planning. However, the trust told us that they did adjust staffing numbers according to the need in all ward areas within the children's service. This was based on the judgement of the site matron. The clinical lead for nursing said that the trust was not yet using the Association of UK University Hospital staffing dependency tool to calculate minimum staff numbers. However, the trust was currently evaluating the use of a recognised children's dependency tool, and aimed to implement this within six months.

We visited a number of the children's wards during our unannounced visit to the hospital. We saw that ward E37 had two registered nurses for the night shift. The ward had eight babies under the age of two plus two older children to care for. They expected more admissions overnight as the children's A&E unit was very busy. The children under the age of two and all had breathing problems. We saw a baby who did not have any parents/guardians with them. This baby was crying and was very distressed. The crying of this baby was upsetting, not only for the child, but for the other parents and children on the ward. While this child did not require one to one care all of the time, they did require care when they were distressed. The trust told us they did not rely on children's parents or carers to be present at all times. One parent told us, "I feel so bad for the child. They do what they can, but they are busy. He needs someone with (them)." A parent of a child also told us they thought the staff were very good but said, "They rely a lot on the parents to do a lot." The trust promoted "negotiated care", which was to ensure that families and carers were involved in their child's care.

We were unable to talk with any of the nursing staff on ward E38 because they were too busy delivering patient care. Again, there were two registered nurses for the night shift on this ward. We saw a young baby who had been admitted from A&E with breathing problems. The baby had an oxygen mask to its face. The parents of the baby told us they had been on the ward for about half an hour but they had not seen any of the nurses or doctors as yet. We were concerned that staff were not actively monitoring this young baby. Young babies with breathing difficulties require careful monitoring, as they can deteriorate quickly. We raised this with the staff during our visit.

We visited the oncology ward during our unannounced visit and found there were two registered nurses on duty for the night shift. The staff told us they could meet the needs of the patients with that level of staff. We did not find evidence to suggest this was not the case.

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We found that there was generally good collaborative working across the paediatric areas. Our interviews with matrons and staff in the community nursing team showed good joint working with the community paediatricians and physiotherapists to keep children with complex needs out of hospital and facilitate early discharge of children requiring dressings, intravenous drugs or suture removal. However, the community team said it did not have access to the local authority's system to check on safeguarding issues, which it felt stopped them achieving the best outcomes for patients. The team had raised this with senior management who had been unable to resolve the concern because it was a national data sharing issue.

As a regional centre for specialist children's services, the trust treated a number of children from outside of the Nottingham area. In an attempt to reduce travel pressures on parents a pre-assessment service was offered by telephone, where feasible. Facilities for parents staying overnight were cramped, and nurses on wards D33 and CAU said it is not always possible to provide single sex sleeping arrangements for parents staying with their child. Those families that were from out of town spoke highly of the care their child received and of the staff. However, they said that they were unhappy that the hospital restaurant closed at 2.30pm on weekdays and that it was not open at all at weekends. This prevented them from obtaining freshly cooked food. One father said that he did not want to eat in front of his child if his child was not allowed to eat before undergoing a procedure. There was an alternative café in the hospital that served hot food, such as jacket potatoes, soup and toasted sandwiches. This was open until 11pm.

End of life care

We found some good examples of practice in end of life care at the hospital. There were no dedicated end of life inpatient wards at the Queen's Medical Centre. Patients were cared for on general wards and the palliative care team provided an effective outreach service where patients were reviewed on a daily basis. The specialist palliative care nurse did not express any concerns about the end of life care on general wards, but they told us that if there were any concerns they would provide feedback to the matron on the ward. They said they would on occasion arrange for the patient to be transferred from a general ward at Queen's Medical Centre to an oncology or the palliative care unit at City Hospital to ensure effective symptom control. This was because services at City Hospital had access to medication which would control symptoms but needed careful monitoring by the palliative care specialists. We were assured that patients were monitored to ensure effective symptom control when they were nearing the end of their life.

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

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

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

We were impressed with the care provided on the Lyn Jarrett unit at the Queen's Medical Centre where six weeks after every death in the emergency department, bereavement nurses sent a handwritten letter to relatives. This letter offered condolences and invited recipients to speak with a bereavement nurse or senior doctor, who would be able to answer any questions they may have. This was an area of real compassionate practice.

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

Outpatients

We received mixed feedback about the care patients received in outpatients. Many people were negative about the waiting times for appointments, and many patients were frustrated that they were not given information about how long they would have to wait once they were in the clinic. Some patients thought that, despite the wait, they received good care from the staff. Other patients felt less satisfied, and the term 'conveyor belt' was used a number of times to describe how services were run.

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

Trust data on reported outpatient incidents for May 2013 to October 2013 showed that there were twice as many incidents about patients being unhappy with delays at Queen's Medical Centre as City Hospital. Queen's Medical Centre also had a greater number of incidents in which clinicians were not present to cover clinics. Our interviews with senior managers from the

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trust provided evidence that waiting times when in outpatient clinics were not consistently monitored across the trust and was not seen as a key performance indicator for outpatient services. This meant that not all outpatient clinics kept patients informed of delays and the reasons delay.

There were a significant number of ophthalmology outpatient follow up appointments that were not allocated for patients which placed them at risk of not receiving effective care.

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What people who use the trust's services say

Nottingham University Hospitals NHS Trust scored 80 out of 100 in the October inpatient Friends and Family Test, which was above the national average. In the A&E department test, the trust scored 68, which was above the national average.

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

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

Areas for improvement

Action the trust MUST take to improve

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

Action the trust SHOULD take to improve

<Action here>

Action the trust COULD take to improve

- Review the staffing requirements for the paediatric wards and departments.
- Ensure action is taken to address the outpatient follow up appointments for ophthalmology.
- Address the privacy and dignity issues that patients may face when the A&E department has reached capacity and patients have to be cared for in corridor areas.
- Ensure all areas of the trust are free from dust and hand gel is always available in all dispensers.
- Review the length of time patients are waiting for outpatient appointments and ensure people are given information about how long they will have to wait.
- Review the facilities for visitors to have access to a hot meal after 2pm, particularly for those visitors who are further away from home and need to stay for long periods at the hospital to be with their relative.
- Review the availability of information so that it is accessible for people who find it difficult to access.
- Ensure children are given opportunities to give feedback on their experiences of care.
- Review the process for the recording of controlled drugs in the maternity and gynaecology departments so records are accurately maintained.

Good practice

Our inspection team highlighted the following areas of good practice in the hospital:

- The bereavement nurse on the Lyn Jarett Unit sending a hand-written letter to relatives of deceased patients. The letter was sent six weeks after a patient's death. It offered condolences and invited the family to speak with a bereavement nurse or senior doctor and ask any questions they had.
- The Hospital Threshold Comprehensive Geriatric Assessment for Frail Older People, which was providing an improved experience for people who were older, frail and vulnerable.
- The Queen's Medical Centre trauma centre, which was providing effective care delivered by a strong multidisciplinary team. This had improved outcomes for patients sustaining major trauma.

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- The effective care being provided by the critical care unit. Outcomes for patients were better than the national average, with the mortality rate for the department being significantly better than the national average.
- The care being provided to patients on the dementia ward was person centred and based on evidence based practice.
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work and felt proud of the trust and what they did. They understood the hospital's values.
- The bereavement care that was offered in the trust by the multi-faith centre and the compassion shown by the mortuary staff towards relatives/friends of deceased patients.
- The medical staffing levels within the trust and the support given to doctors in training by senior medical staff.
- The quality of the senior leadership was good, particularly that shown by the executive directors.

Queen's Medical Centre

Detailed findings

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

Our inspection team

Our inspection team was led by:

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

Team Leader: Carolyn Jenkinson, Care Quality Commission.

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

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Accident and emergency (A&E)

Detailed findings

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

As part of the inspection process, we looked at a variety of information we held about the trust and asked other organisations to share what they knew about it. We received information from Healthwatch, the medical Royal Colleges, The Trust Development Agency, the lead Clinical Commissioning Group and Health Education England.

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

We held two listening events where members of the public came and talked to us about their experiences of being cared for in the hospitals and shared their feedback on how they thought the trust needed to improve. We also held two events with specific focus groups from different community groups to get their views about using the trust's services.

We carried out an unannounced inspection on Sunday 8 December 2013. As part of this visit, we looked at how the hospital ran at night, what staff were available and how they cared for patients.

The team would like to thank all those who attended the focus groups and listening events and were open and balanced in the sharing of their experiences and their perceptions of the quality of care and treatment at the trust.

Are services safe?

Summary of findings

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

Our findings

Patient safety

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

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

Managing capacity

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

Medicines management

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

Whistleblowing

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

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

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

Staffing levels

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

Are services safe?

In the Children's Assessment Unit Ward E38, the nursing to patient ratio was given as one nurse to four children during daytime and one nurse for six patients during the night. Although the day time levels did meet national standards, the night time levels did not meet the 2013 Royal College of Nursing's standards. These standards state that there should be one registered children's nurse for every three children under the age of two and one registered children's nurse for every four children over the age of two. The trust did not routinely adjust its staff numbers when caring for children under two, and there was no dependency tool in place to help with staff planning. However, the trust told us that they did adjust staffing numbers according to the needs of children in all ward areas within the children's service. This was based on the judgement of the site matron. The clinical lead for nursing said that the trust was not yet using the Association of UK University Hospital staffing dependency tool to calculate minimum staff numbers. However, the trust was currently evaluating the use of a recognised children's dependency tool, and aimed to implement this within six months.

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

Reducing harm

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

Infection prevention and control

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

We saw good hand washing techniques in the operating theatres.

Safeguarding vulnerable adults

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

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

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

Are services effective?

(for example, treatment is effective)

Summary of findings

Services were generally effective. Outcomes for patients were mostly as expected, but in some cases they were better than expected. This meant that patients got either the same standard of treatment or better treatment at the hospital when compared with other hospitals in England.

The A&E department faced continuing challenges in meeting national targets.

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

Our findings

Intelligent monitoring data

Prior to our inspection, we reviewed the intelligent monitoring data we had about the effectiveness of the care provided at Queen's Medical Centre. The data showed that care was mostly effective.

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

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

Hospital at Night team

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

Policies and guidelines

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

Medical equipment

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

Mandatory training and induction

The trust had identified that not all staff had received mandatory training. This was because it had changed the way mandatory training was organised, but the new system

Are services effective?

(for example, treatment is effective)

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

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

Are services caring?

Summary of findings

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

Our findings

What people told us

The vast majority of patients we talked to in the hospital told us that staff were caring and that they treated patients with dignity and respect. However, many patients or relatives commented on how busy the staff were. We observed many examples of compassionate care during our inspection. We saw good interactions between staff and patients on most of the wards we visited.

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

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

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

Staff attitude

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

Trust-wide initiatives

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

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Most of the hospital was responsive to the needs of its patients. Overall, patients were treated promptly, but there were challenges due to the demand for services in accident and emergency (A&E).

Our findings

A&E

The trust was not consistently meeting the 95% A&E target for the percentage of patients admitted or discharged within four hours. In November 2013, the A&E department saw 88.7% of its patients within four hours. The trust told us this was due to the demand for services. Additional beds were re-opened to help ease the situation, but meeting the target continued to be an ongoing and difficult challenge for the trust. The percentage of patients whose ambulance handover time was more than 30 minutes was worse than expected. However, the executive team at the local ambulance trust told us that performance was improving and that, if the target was not met, it was only just not met. The trust scored better than expected for the time it took for patients to have their first conversation with a doctor or a nurse. Performance was as expected for the percentage of patients with unplanned re-attendance at A&E within seven days, which meant that care and treatment were effective.

Outpatients

Patients attending outpatients appointments, particularly in eye and fracture clinics, told us that the waiting times were lengthy and that they had not received information about how long they could expect to wait. We received some negative comments from patients about the eye clinic in terms of not feeling they were treated as individuals.

Patient feedback

The trust actively sought the views of patients and their families. The response rates for the Friends and Family Test were well above the national average, which indicated that the trust encouraged patients to give feedback. There were suggestion boxes on each of the wards we visited. However, there was a lack of information available to children, and the trust did not publicise the fact that it wanted to hear their opinions. There were no feedback forms available in a child-friendly format. In the children's outpatients department, we noted that suggestion boxes were located quite high up on the wall, which meant that small children would find it difficult to give feedback.

As a regional centre for specialist children's services, the trust treated a number of children from outside the Nottingham area. In an attempt to reduce travel pressures on parents, a pre-assessment service was offered by telephone, where feasible. Facilities for parents staying overnight were cramped, and nurses on wards D33 and the Children's Assessment Unit said it is not always possible to provide single sex sleeping arrangements for parents staying with their child. Those families that were from out of town spoke highly of staff and the care their child received. However, they said they were unhappy that the hospital restaurant closed at 2.30pm on weekdays and that it was not open at all on weekends; this prevented them from obtaining freshly cooked food. One father said that he did not want to eat in front of his child if the child was not allowed to eat before undergoing a procedure. The closure of the restaurant meant that there was nowhere nearby to get a meal.

Interpreting services

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

Discharges

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

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

Care of patients who have dementia

All of the medical wards used the trust's About Me document, which was completed by the patient's carer at admission and recorded information about their life, likes, dislikes and interests. It enabled health and social care

Are services responsive to people's needs?

(for example, to feedback?)

professionals to see the patient as an individual and deliver person-centred care that was tailored specifically to the person's needs. It could therefore help to reduce distress for people with dementia.

Patients with dementia or acute confusion were provided with a good standard of care on the specialised dementia ward.

Are services well-led?

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

Summary of findings

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

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

Our findings

Governance and leadership

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

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

Governance arrangements within children's services were not applied consistently. Some wards did not have team meetings to ensure that key messages, best practice and the learning from incidents were disseminated to staff and their implementation tracked. We found inconsistent performance month after month in the nursing dashboard indicators for children's services. For example, good performance in one area in one month was not sustained the following month. Furthermore, where the ward had scored 'red' in a specific month, there was no record of how leaders had disseminated key messages to improve performance. This was a particular issue on those wards that did not have regular team meetings. This increased the risk of adverse outcomes for patients.

Recruitment and retention of staff

Student nurses and doctors said that they wanted to work for the trust after they had qualified, but demand for nurses was exceeding supply.

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

Staff feedback

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

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

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

The East Midlands Deanery report from April 2013 identified two concerns relating to emergency medicine and general internal medicine. The trust had addressed both of these

Are services well-led?

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

concerns, and the Deanery was satisfied that improvements had been made and sustained over a period of time. This showed that the trust had responded to concerns.

We received information from staff either before or during our inspection. This told us some staff felt there were instances when they were not listened to. The vast majority of staff told us that they did feel listened to and that they could effect change. Nevertheless, it is important for all staff to feel they have the chance to he heard. We saw that the trust had a raising concerns policy in place and that all staff had access to a 24-hour telephone counselling service. Some of the ancillary staff told us they were concerned about the forthcoming changes to the portering services at the trust. They were worried about the impact changes would have on patient care. The trust told us that it would be monitoring this change in provider very closely to ensure that there was no negative impact on patient care.

Complaints

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

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

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

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

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

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

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

Some patients did not know how to make a complaint. We did see posters and information leaflets in many areas of the trust. However, we did not any information in alternative formats such as easy read, easy to reach or in languages other than English.

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

Accident and emergency

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The Accident and Emergency (A&E) department provides emergency care for over 2.5 million people in Nottingham and its surrounding communities. A&E services for this trust are located at the Queen's Medical Centre hospital only. A&E is open 24 hours a day, seven days a week. It is also the major trauma centre for the East Midlands area.

In 2011/12, there were 184,745 attendances at A&E. This was an increase from 181,433 from the previous year. The A&E department was originally built to provide care for 120,000 patients a year.

Within the A&E department, there are a number of areas. These include triage, resuscitation, minors, majors, major trauma, radiology, psychiatric assessment and the Lyn Jarrett Unit. The Lyn Jarrett Unit is a short stay observation unit located near the A&E department. Paediatric A&E is adjacent to but separate from adult A&E, and we have reported on this area in the children's care section of this report.

We inspected all areas of A&E and spoke with approximately 35 patients, 10 relatives and 50 staff, who included nurses, doctors, consultants, senior managers, therapists, security staff, support staff and ambulance staff. We observed care and treatment and looked at approximately 10 care records. We received comments from the listening events and from people who contacted us to tell us about their experiences, and we reviewed the trust's performance data.

Summary of findings

A&E had professional, caring, positive and enthusiastic staff. The department delivered innovative and effective multidisciplinary training guided by locally identified needs. Staff described an open and productive working environment with strong communication between colleagues. They had noticeable respect for one another and were clearly experienced working as a multidisciplinary team.

Patient experience was generally very positive. However, more support and attention is required to ensure that patients whose first language is not English are effectively supported within the department.

Care was good overall, but the department was unable to maintain this standard consistently under periods of increased demand, which were increasing in frequency and will increase further during the forthcoming months. This was due to pressures on the number of beds in the hospital and the limitations of the A&E environment, which was not fit for purpose.

Accident and emergency

Are accident and emergency services safe?

Patient safety

Staff identified patients who were at additional risk of falls and treated them in cubicles where they could be observed more closely. Staff also provided patients relatives/carers with a slip of paper to tell them that their relative was at risk of falls and to ask them to inform staff if they were going to leave their relative unattended at any time.

Deteriorating patients

Staff told us they undertook regular observations, directed by clinical need, in the majors and resuscitation area and that they used these to form an early warning score and detect deteriorating patients. We saw emergency department assistants informing nursing staff of patients' early warning scores as soon as they had been completed.

However, two nursing staff described difficulty maintaining regular intervals of observations during periods of increased demand, when the patient to staff ratio and availability of staff were a constraint. They also told us that regular observations were not always done when patients were waiting in the more public part of the majors area. We did not see evidence that patients were not getting observations recorded during our inspection. We did not see any evidence to demonstrate this was having an impact on patient care. We spoke with the clinical commissioning group as well as the National Trust Development Agency (NTDA). The clinical commissioning group (CCG) have a contract with the trust and purchase care for the population of Nottingham, they are also responsible for ensuring the care they purchase is of the right quality. The NTDA are responsible for providing oversight of NHS non foundation trusts and they monitor the performance of the hospitals. Both told us they had no concerns about the safety of the care that was being delivered in the A&E department.

Handover

Some staff told us that handover could be inconsistent if the nurse looking after a patient had to leave A&E or their shift finished before their patient was discharged or transferred to another department. We were told that the nurse would hand over to another nurse or an emergency department assistant, which could lead to a risk of inaccurate or incomplete information being handed over.

A&E staff completed a transfer proforma when transferring a patient. They retained this proforma when the transfer of a patient had been completed. It would be useful for a copy of this proforma to be left with the new department as well, to support the robust transfer of information.

Environment

When A&E became busy, patients on trolleys waited in the middle of the more public major treatment area. This area often became full with patients very close together on trolleys and wheelchairs. Staff told us that this had led to regular observations not being carried out, omissions in the provision of medication and treatment, and difficulty finding patients quickly. Staff also told us that some patients felt uncomfortable answering questions because of discomfort/embarrassment in this uncurtained public area. There was also a small waiting area nearby, and people in this area could overhear these conversations.

Patients with mental health needs

Staff told us that generally they could request quality rapid and comprehensive support from the mental health team. This service for patients needing a mental health assessment was run by a neighbouring mental health trust.

Infection control

We saw staff wearing personal protective equipment and washing their hands appropriately. However, we saw some areas of concern. Parts of A&E, such as the patient toilets in the reception area, required refurbishment to ensure they could be cleaned effectively. We saw a sharps bin that was over-filled, and clinical waste was not stored securely at all times. We also saw that some alcohol gel dispensers were empty and there were not enough dispensers to ensure that effective infection control measures were taken at all times.

Accident and emergency

Medicines management

We saw that medicines were stored securely and that arrangements were in place to ensure that they were stored at the correct temperature and that controlled drugs were handled appropriately. Staff told us they thought it was a very secure system.

Staffing

Staffing levels seemed to be appropriate during our inspection. There were some nursing and medical vacancies, but there were plans to fill the gaps as soon as possible. Senior management told us they were looking for more staff for A&E, particularly the resuscitation area.

There was effective induction, training and supervision for most staff, and junior staff felt particularly well supported. However, some nursing staff reported that poor service provision planning often led to their training being cancelled or cut short, as they were redeployed. Work pressure was also an issue for some staff, who described significant stress and concern that current working levels were not sustainable in the long term.

Staff on the Lyn Jarrett Unit felt particularly supported by the 'Better For You' team, which had analysed the patient pathways and redesigned them to become more efficient.

Learning from incidents

Between November 2012 and September 2013 there was one serious incident reported to the Strategic Executive Information System (STEIS), which records serious incidents and never events. There were no never events in the A&E service.

Staff told us that there was good learning from incidents and that they had multidisciplinary training scenarios based on actual incidents, which we considered to be good practice. We saw evidence of this taking place.

Care records

We looked at approximately 10 care records and saw that staff in A&E completed records promptly. Records contained appropriate information to ensure patients received safe care.

Safeguarding

A member of staff on one ward (which was part of the emergency department) told us that A&E automatically checked patients on admission for any signs which would indicate they may have been abused or neglected, such as marks on their body or signs of dehydration. The member of staff said they always referred such issues under safeguarding procedures and said they had good liaison with local safeguarding teams. We spoke with other staff who could describe what safeguarding was and the process to refer concerns. This meant the staff were aware of their responsibilities to record, report and refer any safeguarding issues they identified, to ensure patients were safe from abuse or harm.

Are accident and emergency services effective?

(for example, treatment is effective)

Clinical management and guidelines

The delivery of care and treatment was based on guidance issued by appropriate professional and expert bodies. The department had a number of clinical pathways for care. We saw that there were protocols displayed near the initial assessment triage area for the most frequent conditions that patents present with at A&E. We also saw NICE/Resuscitation Council guidelines clearly displayed in the resuscitation area.

We saw that emergency re-admissions following an A&E discharge were lower than the national average. However, we saw from the findings of audits carried out by the trust that patients' treatment was not always timely and effective. The College of Emergency Medicine fractured neck of femur audit stated that delivery of timely analgesia required improvement. The department had acted on these findings and had implemented changes to practice to improve outcomes for patients.

Clinic One

Clinic 1 is an ambulatory care department which received admissions to the hospital who have been sent in by their GP. The unit opens at 8am and aims to close by midnight, but due to service demands, is often open beyond midnight. Prior to our inspection, a new pathway had recently been introduced to improve the way patients were managed. A change in procedure had also been introduced which allowed ambulance crews to divert patients who were acutely unwell directly into the A&E department. All patients that arrived in Clinic 1 have an initial assessment by a nurse within 15 minutes of arrival to assess their Early Warning Score (EWS).

Accident and emergency

Staff told us they were concerned about how the clinic ran and that it could become extremely busy and was not fit for purpose. The clinic had a number of consulting rooms but these were only equipped to a very basic standard. For example, only two of the rooms had piped oxygen and some of the rooms had no computer terminals. However, we did note that portable oxygen cylinders were available. If patients required close observations they were placed adjacent to the 'nurses station' so they could be monitored by staff. However, this area is within the main waiting area of the clinic. We were concerned about the effect on patients' privacy and dignity because there were only curtains to pull around the trolleys. This was also a concern to staff. We were informed that the commissioners of this service were reviewing the patient pathway and the purpose of clinic 1.

Pressure area care

Staff risk-assessed patients' pressure care needs, and they put in place care plans to ensure that people's skin was protected from damage on the Lyn Jarrett Unit. We did see that the care plan for one person stated that they should change their position every two hours but this had not taken place consistently. Within the A&E unit we saw that patients' risk of developing pressure ulcers was risk assessed and where required appropriate care and equipment was provided.

Food and drink

Patients received appropriate food and drink on the Lyn Jarrett Unit. We saw that staff assessed nutrition and hydration needs and that they put in place and followed care plans if specific needs were identified, for example, if a patient required assistance at mealtimes.

Are accident and emergency services caring?

Patient feedback

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate NHS Friends and Family Tests for A&E and inpatient admissions. In August 2013, the trust scored 72 out of 100 for the A&E department, significantly above the national average of 56. The response rate was 19.2% for the department, which again was above the national average of 11.3%. In August, 1,461 people completed the test. Some 91.5% of patients were either 'likely' or 'extremely likely' to recommend the trust's A&E department to friends or family.

Patient Opinion is an independent non-profit feedback platform for health services. It aims to facilitate honest and meaningful conversations between patients and providers. The comments on the trust's section of the Patient Opinion website were positive regarding the quality of care provided by A&E.

Almost all patients told us that they felt they received good care. One patient said, "Staff were kind and ready to help with whatever I needed." Another patient said, "The nurses gave me all the help for my best recovery." Another patient said, "Doctors and nurses are very busy but they tried their best to assist my needs."

We saw staff providing care to patients with compassion and kindness. We observed that the end of life care provided on the Lyn Jarrett Unit was of a very high standard.

Being informed

Patients gave mixed feedback about whether they were kept fully informed about their journey through the A&E department. Some patients were aware of what would happen next and the reason behind waits (such as processing of blood tests), others were not. Two patients we spoke to wondered whether staff had forgotten them. Relatives told us that staff kept them well informed. Patients also told us that they often struggled to identify who staff were by their uniform. We did not see any posters in the department explaining how staff could be identified.

Privacy, dignity and respect

We saw that staff closed cubicle curtains and respected people's privacy when providing care. Patients told us that they were treated with dignity and respect. However, we saw that when A&E became busy, the environment did not support dignified care. Staff told us sufficient numbers of cubicles were available only 30% of the time. The rest of the time patients had to wait in areas that did not respect their privacy or dignity. The reception area was very small, and it was very difficult to preserve confidentiality when patients were waiting in line. We

noted that staff did their best to adapt and work around the difficulties the unsuitable environment created. There were short term plans in place to change the department to create more space for patients.

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

Environment

The A&E environment was not fit for purpose. The A&E department was originally built to provide care for 120,000 patients a year, however the unit was seeing approximately 50,000 more patients each year and data suggested this figure was increasing year on year.

There were long-term plans for redeveloping the whole of the floor where A&E is located to expand its capacity. However, this work will not be completed for three to five years.

The Lyn Jarrett Unit was spacious. However, there were no activities available to patients, some of who stay on the wards for a number of days. The television was not working, no radios were available and there were no windows for light or ventilation. A number of patients told us they were bored. There was also a lack of clocks, so patients were unable to orientate themselves.

The Lyn Jarrett Unit initially appeared to manage patients well when limited beds were available in the rest of the hospital. However, patients told us that there was a lack of urgency in moving them to other parts of the hospital, and we saw one patient who should have been moved in a timelier manner. We saw that the unit had good relationships with the medical team.

Speed of response

Trusts in England are tasked by the government to admit, transfer or discharge 95% of patients within four hours of their arrival in an A&E department. The data shows that the Nottingham University Hospitals NHS Trust performed consistently below the national average from April 2012 to May 2013 and that it did not meet the target of 95% for A&E admissions in less than 4 hours. However, from May to October 2013, the trust performed consistently better than the national average and frequently met the target of 95%. Between September and October 2013, the trust fell slightly below the national average to 92%.

We saw that the trust had carried out lots of work with different external providers such as the East Midlands Ambulance Service and the Clinical Commissioning Group as well as within the hospital, to improve the time in which people were treated within A&E. Commissioners told us that there had been a vast improvement in the trust's A&E performance.

The CQC analysis of Secondary Care in February 2013 rated the trust as 'low risk' for access to secondary care through A&E. It found that the trust scored 'worse than expected' in one question about waiting times in the NHS A&E survey. However, it did perform within expectations for six of the eight questions. The trust performed better than expected compared to other acute trusts for the question around 'first conversation with a doctor or nurse.'

The trust's percentage of patients whose ambulance handover time was greater than 30 minutes was worse than expected. Commissioners told us that performance had improved on this measure recently. Staff told us, and we saw, that when the department became busy patients queued on stretchers in a corridor adjacent to the ambulance handover bay. In this area, facilities were not in place to enable the administration of intravenous medicines or analgesia. Delay in receiving analgesia was identified as an issue in the department's fractured neck of femur results. A staff member told us they were considering a number of actions to address this issue and they had initiated the usage of pre-filled morphine syringes to increase the speed which patients received analgesia.

The A&E department was located close to an out-of-hours GP service run by another provider. We saw that the criteria in place for referring patients to this service were appropriate and would lead to patients receiving prompt care in line with their needs.

We saw that the department had an integrated radiology suite. This had a CT scanner to facilitate a quick response to any diagnostic requirements for patients in A&E.

The trust had a winter plan which had resulted in a small number of extra beds being opened. The trust faced

challenges with the staffing of this unit, and staff told us they were concerned about this. We talked with the Director of Nursing, who confirmed that the trust had undertaken a bespoke recruitment exercise and that more staff had been employed for these areas.

Patients with diverse needs

Staff explained how they would support people with learning disabilities or autism. They told us that they had specific plans of care in place for people who regularly attended A&E and that they could access support from a specialist learning disability team when required. This meant patients with specific needs received care that was more individualised for them.

We saw staff considering a person's capacity appropriately and discussing actions that would be taken in their best interests. Staff demonstrated a good knowledge of the Mental Capacity Act 2005. This meant staff were checking that patients could use and understand information to make an informed decision.

Before our inspection, one person told us, "I was not treated with respect in A&E." This person had self-harmed and overheard a comment made by a member of staff which was disrespectful. The person went on to tell us, "The comment made my feelings of depression and suicidal ideas worse."

Accessible information

Census data shows that Nottingham had a higher than average proportion of Black, Asian and Minority Ethnic (BAME) residents. In Nottingham 34.6% of people belong to non-white minorities. Of these, Asian Pakistani constitutes the largest ethnic group with 5.5% of the population.

Information was not readily available in a format that all patients could understand. All literature and signs (including signs for emergency treatment) were only in English. Staff told us that English was the first language for most people who attended A&E, but they also said that a significant number of Polish people and other people whose first language was not English used the service. We held a focus group with people whose first language was not English. They told us that the interpreting services at the hospital were very good but that there was a lack of written information in other languages for them to take away.

Are accident and emergency services well-led?

The A&E department at Queen's Medical Centre was well-led.

Leadership

We talked with staff about leadership in the department. We found the team was motivated, and we saw evidence of excellent multidisciplinary working and good communication between all staff. Most staff felt well supported. However, some staff told us that work pressure was leading to significant stress for some of them. We saw that sickness levels for the department were lower than average. However, levels for emergency department assistants were higher than average.

We spoke with nursing staff at a focus group, and they were very positive about the teamwork and the leadership within the department and from the trust executive directors. Executive directors had worked in the department and visited regularly to offer support to staff.

Training and support

The General Medical Council National Training Scheme Survey 2013 found that the trust scored 'similar to expected' in all areas except 'local teaching' where the trust scored 'worse than expected'.

Junior nurses and doctors were positive regarding learning within the department. We also saw that good induction processes were in place for staff joining the department. One member of staff currently on their induction told us, "My induction has been fantastic. I feel so supported and have learnt so much from working in A&E already."

We had mixed feedback from senior nurses regarding their support. Some were positive about the training that was available; some told us that they were not able to participate in team learning as frequently as other team members and that they were often withdrawn from planned training to facilitate service provision.

There was 24-hour consultant cover in the department so that advice and support could be accessed when required. Between 2am and 6am a regular locum consultant provided cover. However, there were plans in place to recruit more consultants.

Accident and emergency

Governance

Our discussion with senior managers showed us that they were aware of the main risks and challenges for the department and that they had identified actions to address these areas. We saw that there had been a wide range of audits and that the trust had taken action in response to them and feedback from patients. Clear clinical governance structures were in place.

A&E was an open and honest learning environment and staff had obvious respect for each other. Learning was directed by using scenarios based on previous incidents that had occurred within the department.

Medical care (including older people's care)

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Acute medical services at Queen's Medical Centre are provided on a number of wards and departments. There are eight wards that provide healthcare for older people, with one of these specialising in care for people who have dementia. In 2012/13 the Acute Medicine Directorate provided care and treatment to 106,295 patients and employed over 1,200 whole-time equivalent staff.

During out visit we spoke with patients, visitors and staff and used information from comment cards. We attended a number of focus groups, and we observed care being delivered on the wards.

Summary of findings

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

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

Medical care (including older people's care)

Are medical care services safe?

Managing risk

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

We saw 'safety huddles' and 'safety briefs' being used daily on the wards we visited. Ward B3 used safety huddles which were consultant led and used a multidisciplinary approach. Junior doctors, a pharmacist, receptionist, nurses and sister in charge took part at 9am every day. The consultant then delivered safety messages of the day. On ward C51 the staff had safety briefs to identify patients who were at risk of falls or pressure ulcers or patients who had an increased early warning score. Staff said that they felt that safety huddles and briefs were beneficial, as they enabled them to discuss patients who were most at risk. Decisions would be made regarding patients' care and treatment. Patients at high risk of falls would be placed in a bay where they could be closely observed. Information was disseminated to staff on the shift and added to the handover sheet for staff coming on duty for the next shift.

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

Falls prevention

An analysis of recent national patient safety alerts indicated that patient falls accounted for a significant number of notifications. We saw the trust had highlighted this on its risk register as an area needing improvement. During October 2013 there were 19 patient falls within the acute medicine directorate. Seven of the falls had resulted in harm. One patient had fallen more than once. The target for the directorate is fewer than five falls. The trust had analysed each of the incidents and found 12 of them were attributable to one ward (D57).

We identified from our data analysis of the trust, and the information displayed on the wards notice boards themselves showed, that some wards had higher numbers of falls than others. It is good practice for the wards to display this information for patients and visitors to see. We saw how different wards were aiming to reduce the number of patient falls. On ward D57, we saw they had introduced a new handover sheet which included information on whether the patient was at risk of falls. On ward C51, we saw the commitment to reducing falls was remarkable. The ward manager had a bay dedicated to keeping patients at risk of falls safe. Patients at high risk were nursed on a one-to-one basis. The ward manager told us, "We hardly have any falls on this ward. My staff are brilliant and very motivated." One member of staff told us that they were not always able to access the falls team, due to the high demand. The Director of Nursing told us she wanted to see it expand further into all inpatient areas.

The trust had a team dedicated to improving patient safety by reducing patient falls. The team consisted of 15 members of staff who worked on healthcare for older people wards. The team provided extra support to the nursing teams on the wards, which included caring for patients who are confused, frail and at a high risk of falls. The falls team provided one-to-one care for people. We saw that the team had a significant presence on several of the health care of the older people's wards we inspected.

The trust had identified that there were increased risks of falls for patients in side rooms, as they were not as immediately visible. The trust indicated that in such circumstances it would ensure the staffing levels would allow for greater observation levels. The staff we spoke with confirmed extra staff were allocated to observe the bays throughout the day and night to try and prevent falls from happening.

There was an Inpatient Falls Committee which met on a weekly basis. We saw the minutes of the last meeting at which there were 10 members of staff. The committee discussed a patient safety incident that had been reported as a serious incident: the patient had fallen while they were an inpatient and then subsequently died. The trust had undertaken a root cause analysis to ensure that it learned lessons.

Staff we spoke with knew about the importance of reducing falls within their ward environment, and it was seen as a priority.

Medical care (including older people's care)

Pressure ulcers

An analysis of recent National Patient Safety Alerts indicated that almost half of these notifications concerned pressure ulcers, grade 3 or above. Further analysis from the trust identified that there were twice as many patients developing pressure ulcers (grade 3 or above) at Queen's Medical Centre as at City Hospital. The trust provided a document to show how it had responded to these incidents and the steps it had taken to address this. It told us that it had introduced documents referred to as 'red skins' for patients who were most at risk of developing pressure ulcers. These were colour-coded document packs, which were graded according to risk, green being the lowest and red being the highest. This system provided all staff (including new, temporary or agency staff) with a visual sign to indicate whether the person needed extra help to prevent pressure ulcers.

We saw these were in place on the wards we inspected, and all of the ward based staff we spoke with referred to them, indicating they knew the system had been introduced and the reasons for this. This demonstrated that the steps the trust had taken to improve performance had been embedded on the wards treating patients who may be at risk of pressure ulcers.

The frequency of positional changes was recorded in the medical notes and on the 'red skins' of two patients we spoke with, and a senior member of ward staff knew which patients were on regular positional change charts. We saw equipment was in place to try to prevent pressure ulcers on two of the three wards we inspected, and the staff we spoke with told us that this was readily available and that it was delivered quickly. One patient commented, "They have looked after me very well."

Venous thromboembolism

Reducing the number of patients who develop venous thromboembolism (VTE) is a patient safety target for the trust.

We looked at the acute medicine performance minutes for October 2013. We saw that VTE risk assessments for the medical wards during September 2013 were at 92% compliance. The target was to reach 95% compliance. As a result of the review of compliance, two of the medical wards had sent more information to staff regarding the importance of completing the VTE assessments. There was a plan in place to carry out a case note review of all of the patients that did not have a risk assessment in place so that lessons could be learnt and performance improved. This meant the trust was being proactive to improve the overall rate of compliance with this target.

Staff we spoke with knew about the importance of risk assessment for the prevention of VTE and we saw these were being completed on the wards we visited.

Staffing levels

Staff on most of the medical wards felt that staffing levels were sufficient to allow them to provide safe care to patients, although the majority of staff mentioned how busy the wards were. They all recognised the importance of safe staffing and the impact it had on providing care. Areas we visited were using the safe staffing tool and we found staffing levels were in accordance with the required levels. The trust demonstrated transparency and good practice by displaying the funded whole-time equivalents on each ward/area and any vacant posts. The ratio of qualified staff to patients on duty was also available. We observed that staff on the wards were busy but kind, caring and respectful. We observed teamwork between staff. For example, on a ward for older people, we saw a patient trying to sit up in bed. The nurse was busy with another patient so a junior doctor went to help the patient to sit up.

We were told, and we observed, that some wards did not have ward clerks. However, some of the wards did make use of the discharge co-ordinator on some occasions. This meant that medical records, laboratory reports, radiological images and other patient records may not have been properly completed, which could result in patients not receiving optimal and safe patient care.

We spoke to several members of staff on the day of the inspection. One told us, "There is good team spirit and good teamwork. Care for patients has improved." Another told us, "Every consultant and every nurse has been good to work with. I would recommend the trust to friends."

We received mixed comments from patients and relatives about staffing levels prior to our inspection. Some people felt there were enough staff but almost everyone commented that staff were very busy. Some people did not feel that there were sufficient numbers of staff to meet people's needs. One person said, "I saw other patients waiting a long time to get help when they rang their

buzzer." Another patient said, "My granddad had Alzheimer's disease and they did not have enough staff to care for him, they were always asking for his family to come in to stay with him."

We saw staff working extremely hard on the wards, and they were clearly very busy. We did not find evidence that patients' needs were not being met. A ward sister/charge nurse told us, "My staff work so hard so that patients do get good care."

Training for staff

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

Infection prevention and control

Alcohol hand gel was available in several places on each of the wards we inspected, and we saw that all staff used it regularly. There were also ample hand washing facilities on each ward, and liquid soap and hand towel dispensers were adequately stocked. Two of the three wards we inspected were clean and hygienic; the other had an odour of urine when we visited in the morning, but this had disappeared by our second visit later in the day.

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

Management of deteriorating patients

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

Discharge planning

The wards had discharge co-ordinators to support the ward team. Discharge co-ordinators had responsibility for patient flow and discharges in their ward area.

Staff skills

On each of the wards we visited, staff were professional and competent in their interactions with patients. A junior doctor told us that training opportunities were very good and that consultants were very supportive. Another doctor told us that they enjoyed acute medicine and got to do lots of practical tasks such as lumbar punctures and pleural taps. It prepared them for their on-call duties.

Storage and management of patient records

Patient records were kept securely and could be located promptly when needed. Most patient records we looked at were accurate and fit for purpose. However there were some exceptions, and we did find some gaps in records. For example, on the accountability handover sheet there were drugs to be given, swabs that were required and a patient who needed daily weights. None had been ticked as completed. When we looked at the care plans, the tasks had all been completed.

Patient movement

There are occasions in hospitals when patients have to move wards. This is usually due to pressure on beds. Ward B3 is a short stay ward. A member of staff told us they had patients on the ward who were elderly and frail and required a longer stay in hospital. These patients were not being moved to other medical wards. The staff member told us that this resulted in them not being able to take short-stay medical patients and discharge as many patients as they usually would.

On ward D57 the ward manager told us, "There is a trust transfer team that works 10am to 10pm. We have relied too heavily on them in the past. I now allocate two members of staff per day to assist with transfers." This meant that some patient transfers could take place before the transfer team started at 10am. The ward manager told us they tried not to move patients off the ward after midnight, but it was dependant on whether the bed was required for a patient from the emergency department.

We found mixed evidence regarding the systems that were in place for the monitoring of patients who were being cared for on wards outside of their speciality. Some senior staff did not think there was a process, but we saw there was one in place. We were told there were attempts to reduce the number of moves a patient will experience when they are admitted to the Queen's Medical Centre and risks are taken into account. We received conflicting information from doctors and nurses about patient

movement, with some staff saying patients were rarely moved and others saying it was a more frequent occurrence. A member of staff on a gynaecology ward told us they had a patient on their ward who had a medical condition as opposed to a gynaecological one. They told us that although the patient was seen by their team "most days", sometimes there were delays. This staff member also told us it was harder for them to organise other care such as physiotherapy and occupational therapy because the gynaecology ward did not routinely access these services. There were no systems in place for allied health professional teams to know about patients who were placed on other wards and so they were reliant on ward staff alerting them.

We noted at our listening events people expressed concerns about patients being moved to different wards during the night and the impact this may have on their care and treatment.

Are medical care services caring?

Patient feedback

All the patients and visitors we spoke to said that they felt well cared for and that they thought staff were kind and caring. One patient told us," The nurses are nice. They maintained my privacy by pulling the curtains but you can still hear people talking." Another patient told us, "It is really good. I am well looked after. The nurses are really good especially the younger ones." A relative agreed and told us, "Staff are very helpful. I have been pleased with the care given to my relative."

On ward B54 a patient said that staff had cared for them "very well indeed, excellent". The patient's relative told us, "The nursing care is exemplary on this ward. Very individualised."

We spoke with three carers who told us that the ward was very clean, the staff were friendly and helpful and the ward seemed very organised.

There were feedback boards on each of the wards, which encouraged patients to write about the care they received. Comments included: "Everything 100% keep up the good work"; "My nurse was extremely caring and helpful"; and "Care has been fantastic, you are all wonderful. First class".

Interactions between staff and patients

On one of the wards, we heard staff talking to patients in a kind and caring manner. We heard one member of staff telling a patient "Well done, you are a star" after they had put a cannula into the patient's arm. Another member of staff went to examine a patient. They closed the curtain to maintain privacy and dignity. They introduced themselves to the patient and spoke in a respectful manner and made sure that the patient understood what was happening and how long they would be in hospital.

We observed the approach taken by a staff nurse to the care of a prisoner. The member of staff was kind and caring and ensured the patient had privacy and dignity. When we spoke with the prisoner, he felt he had not been treated any differently to any other patient.

On another ward a member of staff was seen to be excellent, showing compassion and dedication to her role. A doctor told us, "My consultant and I see all new patients and any other patients we are concerned about."

Care planning

Staff planned and delivered care in a way that took into account the wishes of the patient. We saw staff obtaining verbal consent when helping patient with personal care. For example, one patient had a catheter bag. Staff took time to help the patient change their clothes while ensuring privacy and dignity. We saw another interaction where a patient had been incontinent while in bed. The staff, although very busy, helped this patient quickly and were respectful of their dignity. We heard them talking with the patient to reassure them. The language they used indicated they had empathy with the patient about how it might feel to have been incontinent. This showed compassionate care.

Protected mealtimes

The trust had a 'Mealtimes Matter' initiative, which was a nutrition campaign that included protected mealtimes. This was a period over lunch and supper when all activities on the wards stopped, if it was safe for them to do so. It meant that the nurses, catering staff and volunteers were available to help serve food and assistance was given to those patients who needed help. We saw signs outside the ward announcing the initiative, and we observed protected mealtimes on two wards. On B47, the designated dementia ward, relatives were encouraged and welcomed to help their relatives to meet their nutritional needs.

Medical care (including older people's care)

We observed the use of mouth care trays for patient who had dry mouths or were unable to eat or drink. We did observe one patient whose mouth was very dry and was asking for a drink.

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

Meeting local needs
We were told that healthcare for older people was expanding in line with local needs. The trust had eight wards for healthcare for older people, with ward B47 dedicated to patients with dementia and delirium. We talked to the matron and found that they were dynamic and that they were able to demonstrate forward planning.

Support to maintain adequate nutrition and hydration
Staff had provided patients with the specialist equipment they needed. For example, patients with dementia had coloured utensils that helped identify them. We also saw patients being supported to eat and drink. On one ward we saw two members of staff helping patients with their meals. We saw that they sat down next to the patient and interacted with them while assisting them.

Care for patients with dementia
B47 is a ward for older people that demonstrated best practice. It had recruited additional staff with training in mental health and had multi-professional teams. It offered holistic care and had adopted a proactive approach to communicating with patients and carers. The ward environment was adapted to meet the needs of the patients. It had clear signs, had been decluttered and had reduced noise levels. There was an About Me document, which was completed by the patient's carer at admission and recorded information about their life, likes, dislikes and interests. This enabled health and social care professionals to see the person as an individual and deliver person-centred care that was tailored specifically to the person's needs. The trust was featured in a national newspaper in 2013 and was praised for providing excellent dementia and nursing care. It had also been nominated for a national dementia award.

Before our inspection, we received information about the care of patients with dementia. While we recognise the excellent care given on ward B47, patients with dementia are increasingly found on all wards within hospitals. We found that most wards (with the exception of B47) were not able to give the level of care they wanted to for patients with dementia. Not all staff had undertaken dementia training and ward environments were not suitable for patients with the condition. We noted that one of the wards for healthcare for older people was creating a space for a reminiscence area (an area that inspires memories for people with dementia). One of the nurses had been researching past scenes of Nottingham. The ward sister told us she was hoping to receive some funding to have comfortable seating in the area and to create a welcoming space for patients who had dementia. This meant staff were taking steps to respond to the needs of their patients.

We found that all the medical wards used the About Me document. This enabled health and social care professionals to see the patient as an individual and deliver person-centred care that is tailored specifically to the person's needs. It can therefore help to reduce distress for the person with dementia and their carer. It can also help to prevent issues with communication, or more serious conditions such as malnutrition and dehydration. We considered this to be good practice.

Patients with additional needs
The trust had set up the Learning Disability Acute Liaison Team in partnership with Nottinghamshire Healthcare NHS Trust (which is the local mental health trust). This team aimed to improve healthcare for patients with learning disabilities and to support staff treating them. Staff told us that the wards within the trust did not have learning disability champions but that safeguarding vulnerable adults champions provided necessary information.

Ward D57 used a programme called the Hospital Threshold Comprehensive Assessment for Frail Older people, which consisted of a rapid geriatric assessment on admission to an acute hospital. It was being run by the community programme with the aim of improving patient experience. We saw the Community Comprehensive Geriatric Assessment Team (CGA) on the ward. The team had a multidisciplinary approach to assessing and treating frail older people. It used an holistic assessment to set out a plan for treatment, rehabilitation and long-term support.

Medical care (including older people's care)

The ward manager told us, "Having the CGA team to focus on the frail older people on the ward, help us to plan their care and assist with discharge planning is great." We considered this to be good practice.

Discharge lounge

We visited the discharge lounge. Patients wait in this area for transport to take them home. A member of staff told us, "The patient is still a patient until they have left and they have been discharged." The discharge lounge had clear inclusion and exclusion criteria and a clear sense of purpose. The feedback forms from patients were mixed but in general positive, and patients valued staff for the care they gave. Staff on the discharge lounge provided vulnerable patients with basic supplies to take home. Staff told us that parking for relatives who were picking up relatives remained a challenge and was one area that required improvement.

Are medical care services well-led?

Care services for acute medical patients were well-led.

Visibility of senior management

Staff we spoke with told us that senior management of the trust were visible. Most senior staff were able to tell us when the Chief Executive and Director of Nursing did a walk round the wards and what a positive experience it was. One ward manager told us that they saw the Director of Nursing at least once a month and said, "We get fantastic support from the Director of Nursing, both personal and professional development."

The matrons and ward sisters/charge nurses had energy, compassion, direction, and they were aware of the trust's and their own priorities. One member of staff told us, "We have a new matron recently started. She is on the ward daily and it is a refreshing change. She is keen to be well known and support the ward." They went on to say that their ward was well-led. Their manager was "open to feedback and will work with you to make changes". Other staff agreed and told us that the ward was definitely well-led. There had been a dramatic change in the atmosphere, team spirit and teamwork. The manager was visible and had an open-door policy."

Staff feedback

One doctor told us they had never had better daytime support from senior clinicians and there were good levels of twilight and night medical cover. Another member of staff told us, "We have very good consultants who are engaged and keen to develop junior doctors. There is lots of development for junior doctors." A nurse told us, "The ward is crazily busy but a really good place to work. Good team players. Good outcomes for patients." A doctor told us, "This is an amazing teaching hospital. There are such a wide variety of conditions both wide and wonderful. There are a nice team of doctors on the ward. The consultants are a good team. Every consultant, every nurse have been good to work with."

On ward B54 we saw an example of strong leadership by the ward leader. A member of staff told us, "The best thing about the ward is our boss." The ward leader demonstrated how he was committed to supporting his team and the importance of having happy, motivated staff to deliver good levels of care.

Staff development

Staff were positive about training opportunities. One member of staff told us, "I am passionate to ensure staff get professional development. There are so many opportunities to develop, I have done my degree while working at this trust." The trust had acknowledged that it needed to improve its training and, in particular, to ensure all staff had completed their mandatory training so that they were suitably skilled and could meet the needs of the patients in their care competently. We identified concerns on one ward with the quality and availability of clinical supervision and appraisal, which presented risks to patients, as these systems enabled managers to ensure nursing and health care staff were performing their role to expected standards. If these essential early warning systems were not used effectively to monitor performance, there was a risk that patients would receive inappropriate care or treatment.

Quality and safety

'Better for You' is a campaign to improve quality safety and value for money at the trust. Launched in 2009, at the time of our inspection it had helped improve patient experience and outcomes. It had encouraged staff to challenge current practice, and to develop and try out new initiatives to improve patient, relative and staff experience.

Performance boards were visible on every ward. The focus for November was different for each ward. For example, on one ward the focus was falls and pressure ulcers. Next to

the focus was the performance charts for falls, acquired pressure ulcers, Clostridium difficile and MRSA. All had scored zero for November, except for falls, which had a figure of eight at the time of the inspection.

B3 had made a number of improvements through the wards unit practice council. This was an initiative using shared governance. 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. For example, the ward had reminded all clinical colleagues about wearing soft-soled shoes, offered ear plugs to patients on the 10pm ward round, been vigilant about visiting times and changed clinic waste bins to reduce the noise when closing the lid.

There was a staff wellbeing room on ward B3 which was available for all clinical and non-clinical staff and was designed to help staff relax, gather their thoughts and get some respite so that they could return to their patients refreshed and revitalised.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The acute surgical service at Queen's Medical Centre includes wards and operating theatres.

We inspected the acute surgical service, including operating theatres. We visited 14 wards and departments, and talked to patients, visitors and staff. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also reviewed the trust's performance data.

Summary of findings

Services for acute surgery, including operating theatres, were safe because the trust had provided good staffing levels, encouraged effective teamwork and developed arrangements to implement good practice and learn from any untoward incidents. Patients told us that staff were caring and supportive. We saw that patients were asked for their consent before procedures were performed and people's views were taken into account in improving services.

Surgery

Are surgery services safe?

Staffing arrangements

We saw that the trust decided on the number of staff in clinical areas according to a nationally accepted formula and local assessment of patients' needs. When staff vacancies occurred, managers arranged for cover to enable safe care. In ward areas, staff had designated sections where they could observe more vulnerable patients, such as frail people who were at risk of falls, more closely. Staff in operating theatres told us that safe staffing levels were ensured prior to commencing operating lists. We looked at staffing rotas which indicated staffing levels were safe. This meant that staff provided care safely and at appropriate times.

Risk of harm

Staff had documented patients' risk assessments to identify potential problems such as clot formation, falls and pressure sores. We saw that patients' care records included well completed documentation of risks and the care actions that were needed. Any incidents were recorded and analysis was made to identify causes of untoward incidents, near misses and trends in or across clinical areas. Senior managers had a good overview of this analysis, and lessons were distributed to all relevant teams. We saw that the trust always used the World Health Organization safer surgery checklist, and that every operating theatre had adopted it. This meant that staff carried out recognised safety checks for every patient.

Staff told us that they were aware that people having operations may be at risk of pressure ulcers during their anaesthetic or in their recovery. Staff gave examples of where they had identified specific risks and ensured that additional care was taken. Patients having spinal surgery were at risk of pressure damage to their mouth due to the position needed for surgery. Theatre staff explained that particular care was taken to protect a patient's mouth during surgery. This meant that risks from surgery were identified and the patient's health and welfare was protected.

In the operating theatres, there were screens that displayed safety information. This included the learning that had been identified from any incidents or near misses at both of the hospitals within the trust. This meant that learning was disseminated across the trust and was not confined to one particular theatre.

Notice boards also provided staff with information about ways to improve efficiency, such as ensuring that specialist supplies were available so that operations did not have to be cancelled. Staff told us that communication was good in the operating theatres. There were regular meetings to enable monitoring and discuss safety improvements. This effective governance system meant that the care of people in the perioperative period was safe and efficient.

Service provision

Care for people admitted with major injuries was safe. The trust had invested in an additional clinical area for this specialty. The major trauma ward meant that people received care for safely, with the necessary equipment and specialist staff focusing their efforts on saving lives, stabilisation, recovery and planning for rehabilitation. Our intelligent monitoring of the trust told us that in 2013 at least 34 people had survived when they would have been expected to die from their injuries had the service not been in place.

The trust provided some specialist services from purpose-built facilities that were designed with the speciality in mind. Staff also specialised in their particular branch of care. Both ear, nose and throat (ENT) and eye services were provided in a dedicated building. We spoke with the ward manager in this area and found that staff were trained with the skills to look after patients with both ENT or eye conditions.

An eye casualty service was available during the day in the eye department. However, this service did not run at night. Staff told us that the night service for eye casualty was provided by nursing staff in the main ward area. Some nursing staff who were expected to provide this service had not had recent training to enable them to manage all eye casualties. This meant that some patients with eye injuries could receive late or incorrect care, as they would not see an eye specialist doctor until the following day.

Surgery

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

Infection prevention and control
Ward and theatre areas were visibly clean and well maintained, although some floors looked dated and had the potential to be difficult to keep clean. There were effective cleaning arrangements in all clinical areas. Hand sanitizers were available outside the wards, bays and side rooms, and we did not find any empty dispensers. We observed staff using appropriate hand-washing techniques.

On ward C32, a gynaecology ward, we found infected tissue material stored in a fridge that did not close properly. The material was labelled in accordance with the trust's policy, but it did not contain a biohazard warning. This material had been stored for three days prior to our inspection. Staff took action to address the problem when we brought it to their attention.

There were appropriate arrangements for nursing patients with infections in side rooms. Warnings and instructions for staff and visitors were clearly displayed on the side room doors. We observed staff using the appropriate personal protective equipment (such as gloves and aprons) before entering the rooms. We also observed staff washing their hands in between treating patients.

Medicines management
On ward C32 we found that there were some instances where staff had crossed out some entries in the controlled drugs register. Controlled drugs are a group of medicines that have the potential to be abused. For this reason, the handling of these drugs is subject to certain controls set out in law. When amendments are made they should be signed and a record made for the reason for the amendment. We could not see a clear indication of when and why the amendments had been made and by whom. The majority of the records were satisfactory but it did mean not all staff had consistently followed the trust's procedures for recording the management of controlled drugs. With the exception of the labour suite we did not find this was replicated on other wards that we visited.

We also found that ward was not recording fridge temperatures on a daily basis. Nor was it ever checking the temperature of the room where medicines were stored. This meant there were no robust systems in place to ensure that the environment was not affecting the efficacy of the medication.

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

Teamwork
Multidisciplinary teams worked well together to ensure coordinated care for patients. We saw that some teams met in the morning to review patient care and plan for discharge. For more complex cases such as burn injuries, the team met weekly to plan support for the patient and family. We found that there were good handover arrangements between staff at shift changes.

Staff in operating theatres told us they were well supported by managers. This meant that they were also able to support each other in developing skills in different aspects of operating theatre work and on improvement projects. A 'Well Organised Theatre' project had been extended to the ward areas to improve efficiency and safety for patients. Senior clinical staff from the Queen's Medical Centre site met with those from Nottingham City Hospital regularly to share experience of practice and learn lessons from each other.

Performance information
We saw that wards displayed information for patients and visitors. The wards displayed their staffing levels, which we considered to be good practice. The wards also displayed information about their incidence of falls or pressure ulcers in the previous month. We saw that in all areas there was a low incidence of falls and pressure ulcers. This was also the case for patients who were at increased risk of falls and/or acquiring pressure ulcers, such as the elderly and orthopaedic patients.

Are surgery services caring?

What patients told us
We saw that patients were well cared for in the surgical wards. We observed some good examples of very caring and compassionate care. We spoke with two relatives of

patients who had been in hospital for over two months. They said they were "very satisfied." Ward areas appeared calm and well organised, which created a suitable environment for people to recover.

We spoke with one patient who had just been given some painkillers. They told us they were very satisfied with their care on the ward. Patients told us that staff came quickly enough when they rang the call bell. One patient said, "Staff know what they're doing and they've been very helpful. When I've rung the bell, they've come quickly."

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

We spoke with some nurses who worked in the theatres at the hospital. The nurses described how they were passionate about giving patients a good experience in theatre and the high level of care they aimed to deliver for everyone.

Patients on surgical wards told us that they had been clear about their surgical procedure. Staff had explained treatment and care before patients had signed their consent forms. In the records we examined, we saw that there had been clear documentation of the consent discussion. Patients and relatives told us that they were very satisfied with their care and that they felt staff were "kind and considerate" and supportive to families. Staff told us that although family visiting times were strict to reduce the risk of cross infection, this would be relaxed in cases where a patient was gravely ill.

Before our inspection, we received many positive comments about the surgical services from patients. One person said, "I was impressed by the bedside manner of all of the staff (doctors and nurses). I was well informed about my operation and I felt comfortable asking questions."

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

Care planning
We saw that there were systems to ensure that discharge arrangements met the needs of patients. The trust had reviewed the causes of early readmissions for the same diagnosis and implemented improvements to discharge planning. Staff with specific responsibilities to manage the discharge process were available throughout the surgical service. In addition, we found that on orthopaedic wards there were also nursing staff designated as interface nurses to maintain good contact with other services in the community, which promoted effective discharge. We saw that staff had discussed the care of a child with learning disabilities with their family to agree on support for post-operative recovery. This meant that staff provided care according to people's specific needs.

Clinical areas
Staff told us about improvements that had been made, or were planned, to waiting areas, treatment rooms and separate toilet facilities in response to feedback from patients. We saw some of the improvements that had been made. This meant that patients in surgical services received treatment in suitable environments that helped to respect their dignity.

Improved trauma service for the region
The trust had invested in a trauma ward and supporting arrangements to provide a trauma care service to meet the needs of the wider geographic population. Improvements in the way patients with life threatening multiple injuries were being treated had enabled more people to survive their trauma.

Care of people with dementia
We found that the trust had supported staff in developing skills for caring for people with dementia who may be admitted to surgical services. All staff were able to explain the implications of the Mental Capacity Act and how they would make decisions in the best interests of a patient. Ward and department teams had dementia link nurses to provide guidance to other staff and communicate between teams about new developments. Staff had developed a video training tool to explain to staff how to support people who may be confused.

Interpreting services
One person told us they had experienced difficulties getting timely access to a British Sign Language Interpreter. The person told us, "Sometimes the doctors would come when the interpreter had not arrived and would try and communicate with me without an interpreter. Can you imagine trying to communicate with a person and not being able to hear or understand what they are saying?"

Surgery

Patients who needed language interpreters told us the service was good.

Are surgery services well-led?

Surgical services were well-led.

Management arrangements

Surgical services had good arrangements to recognise problems and make improvements to protect patients' health and welfare. Staff told us that they were involved in the audit of clinical records. We examined patient records in ward and theatre areas. Risk assessments were completed and plans included records of patient consent to treatment and agreement with other decisions about care. Managers told us that audits of the early warning system to identify patients who may be deteriorating had showed up some gaps in documentation and that the service acted quickly to educate and remind staff of the importance of the observations and recording. This meant managers were using audit findings to identify areas where practice needed to improve. The inspection team considered this to be good practice.

In some wards, the matron had dedicated administration support to enable them to provide direct patient care and work with their ward staff team. This meant that management arrangements were directed at promoting good quality of care and that the trust was using people's skills in the most appropriate way.

Clinical teams

Teams in operating theatres worked well together and with other departments. There was good organisation and arrangements to deal with unforeseen emergencies. Anaesthetic staff were available to provide support across the operating theatres. The operating department (OD) team had developed its own dashboard of performance information, which was displayed for all staff using television monitors. This gave the staff information about the results from audits such as the surgical check list audit. It was also used to share lessons learnt from incidents or near misses. We considered this to be an area of good practice. The department was proactively carrying out weekly audits and identifying areas where performance needed further improvement. We heard some of the OD team talk with great enthusiasm about this work and how it was having a direct effect on patient care.

Intensive/critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The critical care services at Queen's Medical Centre are provided in an Adult Intensive Care Unit, Surgical High Dependency Unit and Medical High Dependency Unit. The hospital also has a Paediatric Intensive Care Unit, which we have commented on in our Children's Services section of this report.

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

Summary of findings

The provider met all standards. We found there were outstanding systems to analyse incidents, improve services and ensure that all staff were aware of the learning. There were also systems to monitor and assess aspects of clinical practice over time to make significant improvements to outcomes for patients. These systems were benefitting patients across the whole trust. We saw that staff were well supported and competent to provide advanced treatment where appropriate.

Intensive/critical care

Are intensive/critical services safe?

Learning from incidents

We saw that there were robust systems in place to learn from incidents. We saw that staff and departments were open about discussing and learning from incidents. There were clear arrangements for recording and reporting untoward incidents. The trust included staff in root cause analysis of the reports, and staff took ownership of the process by developing plans to reduce the possibility of recurrence. We saw that departments had changed practice in the management of arterial lines following learning from an incident in another department. This meant that safety was continually being improved.

Capacity

There were a total of 77 critical care beds across the trust. The bed occupancy rate for the trust was 95.1% between April and June 2013; this was higher than the national average which is 83%. This meant that critical care beds were in use most of the time.

Staffing

We spoke with staff in critical and intensive care departments. One of the departments was newly opened, and we found that the trust had recruited staff with appropriate skills and that experienced staff were managing the unit. Staff told us that they rotated with intensive care to gain experience in caring for critically ill patients. They showed us their accountability handover sheet, which they used alongside clinical records to communicate the needs of patients. This meant that staff were aware of their patients' needs. In most departments there were staff available as 'runners' to support those staff who were providing one-to-one care to critically ill patients. There were certain staff with specific responsibilities or interests, such as infection control or end of life care.

Services were staffed appropriately to ensure safe care for critically ill people. Staff told us that they had closed a bed temporarily on one unit because they had a patient who required very intensive support and the staff would not be able to provide safe care for any further patients. This meant that safety was the priority for the unit. There was one trained nurse for every patient who was assessed to be at level 3 and one trained nurse for two patients for those assessed at level 2. This meant patients were being cared for in accordance with national guidelines for critical care.

We saw that senior intensive care medical expertise was available to the critical care areas at all times. This is important because patients' conditions can deteriorate very rapidly. We saw that physiotherapy specialist support was available to patients seven days a week, which meant that patients received the optimal support to make progress.

Critical care outreach

The Intensive Care Unit was the base for a critical care outreach team which was able to provide expert advice to help ward staff manage patients whose conditions had deteriorated in the ward areas. This team provided support to 8,000 patients every year. The team was able to educate other staff in managing critically ill patients and also monitor trends in problems. It had identified that fluid management was often a contributing factor in patients becoming ill. The team was multi-professional and had specialist critical care skills. The team worked seven days a week from 8am until 10pm. Overnight deteriorating patients were managed by the hospital at night team. A ward nurse told us, "It's good to have the critical care outreach team. They support us if we have someone going off and deteriorating. I have learnt from them, and it makes me feel safer when they arrive."

Specialist training

Nursing staff had education and training to undertake additional roles, which allowed prompt action or more efficient working.

There was a good induction package for new nurses to the departments. Nurses told us they felt extremely well supported and had lots of opportunities for ongoing professional development and supervision.

The service ensured that it was clear which medical staff were accountable for the care of specific patients who had major trauma with complex patterns of injury.

Infection prevention and control

The trust's rates for healthcare acquired infections such as MRSA and Clostridium difficile were within an acceptable range, suggesting that infection control policies were in place and followed in practice. The trust provided evidence of the systems it had in place to reduce the infections. These included weekly clinical case reviews by the infection

prevention and control doctor, checks to see if cross infection was a factor and a rigorous approach to hand hygiene. These steps had resulted in a significant reduction in healthcare acquired infections over a five-year period.

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

Services within the critical care department were effective.

Audit data

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

Queen's Medical centre is the East Midlands' major trauma centre. Patients with serious multiple injuries are taken to this hospital instead of their local accident and emergency department. The major trauma team is made up of specialist clinicians to enable patients to get the best possible recovery from their injuries. There was a patient pathway in place for major trauma.

Are intensive/critical services caring?

Patients received compassionate care.

Patient care

We spoke with patients and relatives in intensive care departments. Patients told us that staff cared for them well and that they were kind and supportive. One relative said that the staff were "fantastic." Critical care areas were clean and well organised and patients looked comfortable.

We saw interactions between patients and staff which showed patients who were unconscious were treated with dignity and respect.

In the Surgical High Dependency Unit we saw a nurse help a patient to have a drink. The patient had undergone major abdominal surgery. We saw that two nurses helped to reposition the patient and that they were very caring in their approach. They explained what they were doing and reassured the patient throughout.

We had no concerns about the care being provided in the critical care units.

Support for patients

Staff were interested in ensuring that care was based on patients' needs and wishes. Documentation showed not only that staff had carried out and recorded medical risk assessments but also that they had recorded people's wishes or discussed them with relatives, where necessary. The service provided good nutritional support and help with eating for people who could not eat normally due to their critical illness. We saw nurses providing mouth care appropriately and sensitively. This meant that care was efficient and compassionate.

Are intensive/critical services responsive to people's needs? (for example, to feedback?)

Services were responsive to the needs of patients.

Patient views

Critical care staff showed us an electronic survey pad that patients completed to provide feedback on their care. We saw that the results of the survey were positive and that the department displayed them in the staff rest room. Staff told us that they had responded to patients' comments about privacy by ensuring that all staff entering curtained-off bays checked with the patients inside first. In addition the visiting times had been adapted to meet patient expectations, and they were accommodating for those families with patients being cared for at end of life. Some staff had responsibility for co-ordinating patient and public involvement so that patient feedback could be included in improving and planning services. Visitors to clinical areas were able to see displays of information about how the department had taken patient views into account in improving the service.

A relative of a patient who had been critically ill in the Intensive Care Unit told us they did not think the relatives' waiting room provided a suitable environment. They felt it

was in need of decoration and was not a suitable environment for relatives who might be given bad news. Our observations confirmed this area was in great need of improvement, and the trust told us that it already had plans in place to improve the room.

Bed provision

The trust had invested in a larger high-dependency unit with 20 beds. It told us that more beds were planned. There had also been investment in the major trauma ward, which allowed for more effective care of people with multiple injuries. Staff told us that medical specialties worked well together to ensure rapid and appropriate care for people with major trauma. This meant that the trust had developed facilities and was continuing to plan improvements in capacity so that people could receive appropriate trauma and critical care.

Are intensive/critical services well-led?

The critical care services were well-led.

Clinical leadership

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

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

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

Clinical teams

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

Maternity and family planning

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The trust had a single maternity service with maternity units located on both hospital campuses. In addition, the trust also provided community midwifery services. Maternity services at the Queen's Medical Centre cared for women from the local area. There were more than 5,500 births at this hospital every year. The department consisted of a labour suite, a delivery theatre, a foetal maternal care unit and a neonatal unit.

The labour suite consisted of three midwife-led delivery rooms, two of which were in use during our inspection. The third midwife-led delivery room was under refurbishment when we inspected. The midwife-led delivery rooms were used for patients with low-risk pregnancies or patients who had expressed a preference for water births. There were a total of 12 consultant-led delivery rooms within the labour suite. In addition, there were two maternity theatres, which were located next to the labour suite.

During our inspection, we visited the labour suite, antenatal clinic, antenatal and postnatal wards, and the foetal maternal care unit. We spoke with patients and relatives as well as staff from a range of different roles. We observed care and treatment and looked at care records. We received comments from our listening events and from people who contacted us to tell us about their experiences, and we reviewed the trust's performance data.

Summary of findings

Maternity care was generally safe and effective. Feedback from patients and their relatives was mostly positive but a recent national maternity survey suggested that in some areas care was worse than expected. Most staff felt supported by their managers but the staff survey scores suggested this was not always the case.

Services provided care in line with patients' needs. The trust had responded to identified areas of improvement relating to care and treatment. The maternity service provided a multidisciplinary approach to providing professional, supportive and sensitive care to patients.

However, the department had not always appropriately managed and followed procedures for managing medicines and preventing or controlling infection.

The service had clear management and governance structures in place. However, audit procedures were not always completed or evaluated effectively.

Maternity and family planning

Are maternity and family planning services safe?

The women we spoke with told us they felt safe at the hospital. One woman said, "I felt they [the staff] knew what they were doing and kept me and my baby safe. I had a difficult delivery, but they supported me all the way and we had a happy ending."

Incident reporting

Maternity services used the trust's incident reporting system. We spoke with staff who were fully aware of the system and how to report incidents. Staff told us about an incident which had occurred three days before our inspection and showed us the incident report which had been submitted. This meant that staff followed the trust's incident reporting procedures in a timely manner.

Maternity clinical governance staff told us that nominated individuals investigated and reviewed reported incidents. The department acknowledged that it had not fully completed the review and investigation process for many incidents. We were told that the maternity clinical governance team had recently recruited more staff and was taking action to address the backlog of reported incidents on the incident reporting system. This meant the trust had responded to difficulties with the system but the back log in the review and investigation of incidents meant there was a risk that staff were not learning from what had happened to prevent it reoccurring.

Staffing and skill mix

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

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

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

Key safety indicators

The labour suite and wards displayed information related to key safety indicators, including rates of infection, falls and pressure ulcers. We noted that infection rates for MRSA and Clostridium difficile were well controlled.

Infection prevention and control

Procedures and practice related to the prevention and control of infection were not always effective. We found dust on low and high surfaces in patients' bays and dust on equipment used within the labour suite. We also found high-level dust in the labour suite clean utility room, where staff prepared medicines that were administered to patients. This meant medicines were not being prepared in a clean and hygienic environment.

We checked that procedures for the safe storage and disposal of specimens and waste materials were followed appropriately. We checked the dirty utility room on labour suite and found tubs containing waste material. We noted that not all of the tubs had been labelled appropriately with dates confirming when they had been used. Staff had not always signed these tubs in accordance with trust policy and guidance. We also found several tubs containing waste material which had not been collected from the labour suite quickly enough. This meant that staff had not appropriately followed procedures for managing the risk of infection.

Medicines management

Staff had not appropriately recorded information relating to medicines management in the labour suite.

We checked the controlled drugs books on the labour suite. Controlled drugs are a group of medicines that have the potential to be abused. For this reason, the handling of

these drugs is subject to certain controls set out in law. On the labour suite we saw there were a small number of records where the time the drug was administered was omitted and at least two patients' first and last names were not recorded. This meant that staff were not always accurately recording information on the administration of controlled drugs to individual patients. Two members of staff had signed most entries in the controlled drugs books, which indicated that staff had completed appropriate checks before medicines were administered. However, this practice was not evident for all entries in the controlled drugs book in the labour suite, and staff had not consistently followed trust policy on record keeping.

There were gaps in the daily recording of fridge temperatures on the labour suite. Staff confirmed that they did not check room temperatures. This meant they were not taking appropriate action to check that medicines were stored safely.

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

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

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

Handover
We observed two multi-professional team handovers on the labour suite, one morning obstetrics handover and an evening midwifery handover. We saw that maternity staff discussed individual patients and their care needs and that staff were able to plan the delivery of care accordingly. Staff confirmed that the handover process worked well and that it provided them with useful information for each shift. This meant staff were aware of patients' needs and the care they required.

Care plans
We looked at five care plans during our inspection and found that staff had assessed patients' individual needs and documented information relevant to their care.

Antenatal care
The service offered active birth workshops to patients and their relatives. The workshops gave information, advice and guidance to patients before admission to the maternity service. This meant that the department was providing patients with appropriate information and guidance.

Equipment and resources
Staff had access to appropriate equipment to help them care for patients. This included single-use stock items and equipment which was used on a regular basis. We found that stock items were stored in an organised manner and were available to staff when needed.

Training, learning and development
The maternity service senior management team told us there were monthly divisional learning days for all staff. These learning days provided staff with learning and governance updates. We were also told that dedicated training sessions were held weekly as part of the training programme for doctors. This meant that staff had opportunities to attend learning days and training sessions to help them care for patients.

However, we found the completion of mandatory training was significantly below required trust rates. The trust had identified mandatory training as an issue for all services and had issued a mandatory training package in the form of a DVD. Staff could access this in various ways and could watch it independently or attend a session with staff from the training department, who would be able to answer any questions.

Maternity and family planning

Are maternity and family planning services caring?

Provision of care

The majority of patients and their relatives said they were happy with the care they had received. Patients told us that they felt involved in their care and spoke very highly of the "excellent" care provided by maternity services. Staff in all the areas we visited were welcoming towards patients and supported them in a professional, sensitive manner.

One patient said, "The care on labour ward has been brilliant and almost one to one, they have told me what is happening." This patient told us they had not had the same experience on the ante natal ward and said, "I would have liked more explanation from the doctor about what was happening."

Another patient told us, "I was frightened, they looked after me, but I felt alone at times."

Privacy, dignity and respect

We saw staff treated patients with dignity and respect. They were respectful of patients' needs, ensured that patients were not disturbed and interacted with them courteously to maintain their dignity.

Maternity Survey

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

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

Information for patients

Information of interest to patients and their families was on display within the maternity service. This included information on visiting times and details of other organisations that could provide support. There were also information leaflets about antenatal care, breastfeeding and how to report concerns and complaints to the trust. The information we saw was printed mostly in English. This meant that there was limited information available for patients whose first language was not English.

Equality and diversity

We spoke with staff about the needs of patients whose first language was not English, and we asked how staff communicated with them and provided them with information about their care. 34.6% of the population of Nottingham belong to non-white minority groups. Staff told us that the service used the trust's telephone translation services to arrange for translators to attend appointments with patients. They said that these systems worked well to ensure that patients were able to understand and staff could communicate effectively with women. We held a focus group with women whose first language was not always English. They told us that the trust had good interpreting services but there was a lack of printed information. We saw that all information leaflets had information in other languages and large print about how to request the leaflet in an alternative format.

Before our inspection, we received a comment from a woman who had used the maternity service. She told us that her same sex partner had not been given the same rights to visit the maternity ward as she would have received if her partner were male. This meant this person felt that she was not treated with dignity and respect.

Ward improvements and relocations

The department was being refurbished to provide a main reception desk at the entrance to the labour suite and delivery theatres. We were told that the reception desk would be staffed at all times and would provide a single contact and entry point for all patients and relatives coming to the labour suite and delivery theatres.

Bereavement facilities

There were limited facilities for supporting bereaved patients. The labour suite did not have a dedicated bereavement room where patients could be offered support and care in a suitable environment. Staff told us they tried to accommodate the needs of bereaved parents and relatives by using the generic facilities within the suite. We discussed this with the maternity service senior management team, who acknowledged this issue. They told us that they did not have any specific action plans to address this issue, but the service was hoping to get charity funding to improve bereavement facilities at the hospital.

However, we did note that the trust employed bereavement nurses and a specialist bereavement midwife who could refer parents whose babies had died for counselling services. We also saw that the trust did offer a service and either a cremation or woodland burial to women who miscarried their baby before 24 weeks. Women who miscarried after 24 weeks were offered a multi-faith funeral service, if required. This was an exceptionally compassionate and caring approach towards grieving parents.

Patient confidentiality

Maternity services had considered patient confidentiality, and they had posters and signage in clinical areas to remind staff about the need to maintain confidentiality. The labour suite had a white board with sides which could be folded to maintain patient confidentiality. This meant patients' names and other information related to their care were not always on display but could be viewed when required. When we spoke with staff, they discussed patients with us in a confidential manner.

Are maternity and family planning services well-led?

Leadership and governance

Maternity services had clear management and governance structures in place. There were monthly clinical governance meetings, and key staff attended trust committee meetings on behalf of the service. Minutes of the clinical governance meetings showed that information from local and directorate level was considered. For example, attendees at the meetings had discussed incidents, investigations and subsequent action plans and any key risks that had been identified.

We looked at the key risks that the department had identified and noted that the risks continued to be monitored and reported to the trust's clinical risk committee.

Staff told us senior managers were available and visible to staff. This included ward and directorate managers. Most staff we spoke with said they felt supported by their local management teams, but some staff told us that they felt less supported by the trust's senior management.

Quality monitoring

Every month, the midwifery managers and domestic cleaning supervisors carried out a cleanliness audit of the labour suite. The audit results for October 2013 and November 2013 showed results above 90%. During our inspection we found high and low level dust in patient areas, clinical rooms and on equipment. We saw no evidence that this had been noted during the cleanliness audits. This meant the process of auditing the cleaning within the labour suite had failed to identify potential risks to patient safety.

Culture, communication and cross site working

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

Staff told us that communication continued to be an issue between community midwives and those based at the hospital. They said that the working culture and communication had improved but work was still in progress.

Staff also told us that there was a difference in the working cultures between QMC and City Hospital maternity services. The maternity service senior management team acknowledged these issues and confirmed that key managers and staff in identified roles had fostered closer working relationships more recently by working across both sites.

We noted that staff in the Maternity service at QMC and City Hospital campuses received email updates which provided information, including changes to guidelines. The maternity service also regularly published communication magazines which provided information and updates on best practice, risk management and governance topics within the service. Two members of staff told us that they felt that their managers listened to them but that directorate level managers and those above them did not

always appreciate their opinions. Some staff also told us they did not always receive feedback from local and senior management teams. This meant staff did not always feel that their views were fully respected.

Many staff told us that they provided care using a multi-disciplinary team approach, which meant that staff with specific roles were able to support patients appropriately. We noted there were good working relationships between different professional groups, and there was an apparent mutual respect between staff. One doctor told us, "The consultants are very supportive and there's always someone I can contact if I need to."

Staff survey

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

Services for children & young people

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Paediatric services at Nottingham University Hospitals NHS Trust are known as the Nottingham Children's Hospital and are based at Queen's Medical Centre. This is a regional centre for children's care in the wider East Midlands area, and it cares for up to 40,000 children each year. Services include:

- 24-hour accident and emergency (A&E)
- outpatients
- oncology
- haematology
- intensive care and high dependency units
- neonatal care
- dialysis
- burns services.

The Nottingham Children's Hospital also offers a complementary therapy service as part of its programme of care.

We visited and observed care in 16 ward areas, and we spoke with over 70 staff and 36 patients and their parents or carers over the course of a three-day inspection. We also used information provided by the trust and information that we requested, which included feedback from people using the service.

Summary of findings

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Services for children & young people

Are services for children & young people safe?

Patients were very complimentary about how safe they considered the service to be. They told us that they were comfortable in raising any issues with staff. According to feedback in the trust's regular customer survey, patients and their families said they felt safe on the wards.

Incident reporting and learning

Staff told us that there was an open culture at the trust and that they were encouraged to report incidents and 'near misses'. There had been a total of 861 incidents reported via the National Reporting and Learning System (NRLS) between November 2012 and October 2013. This showed a healthy reporting culture. However, we found that the highest number of medication errors in the trust between 01 July 2012 and 30 June 2013 had occurred in paediatrics.

The flow of communication from 'board to ward' was inconsistent in paediatrics, and this meant that there was a lack of assurance that key messages and learning were being disseminated to frontline staff. Some wards were more proactive than others in sharing information. For example, information-sharing was good in the paediatric intensive care unit and paediatric outpatients, where there were regular team meetings. The clinical lead for paediatrics told us that team meetings for ward staff were not compulsory, and this was confirmed by staff in some of the ward areas we visited. On the children's assessment unit, nurses did not get any feedback following completion of an incident form. But on wards D33 and E39 nurses outlined how they received feedback and how changes had taken place as a result of incidents.

Therefore, there was a lack of assurance that learning and key messages were being fully communicated. A further example was the inconsistent performance in relation to nursing indicator targets. For example, wards D33 and E37 and the neonatal intensive care unit scored 'red' or 'amber' for these targets in most months since April 2013. This indicated inadequate performance. In the small number of cases where performance had reached the required threshold to score 'green', this improvement had not been sustained the following month. This meant that the department was not implementing learning consistently to ensure patient safety.

Staffing

Children's A&E was open 24 hours a day and had good medical staffing arrangements in place. In general medical staffing was good. The department produced weekly rotas that included good assistance from consultants. Consultants were on call at night and over the weekend on the general wards.

In the Children's Assessment Unit Ward E38, the nursing to patient ratio was given as one nurse to four children during daytime and one nurse for six patients during the night. Although the day time levels did meet national standards, the night time levels did not meet the 2013 Royal College of Nursing's standards. These standards state that there should be one registered children's nurse for every three children under the age of two and one registered children's nurse for every four children over the age of two. The trust did not routinely adjust its staff numbers when caring for children under two, and there was no dependency tool in place to help with staff planning. However, the trust told us that they did adjust staffing numbers according to the needs of children in all ward areas. This was based on the judgement of the site matron. The clinical lead for nursing said that the trust was not yet using the Association of UK University Hospital staffing dependency tool to calculate minimum staff numbers. However, the trust was currently evaluating the use of a recognised children's dependency tool, and aimed to implement this within six months.

We visited a number of the children's wards during our unannounced visit to the hospital. We saw that ward E37 had two registered nurses for the night shift. The ward had eight babies under the age of two plus two older children to care for. They expected more admissions overnight as the children's A&E unit was very busy. The children under the age of two and all had breathing problems. We saw a baby who did not have any parents/guardians with them. This baby was crying and was very distressed. The crying of this baby was distressing, not only for the child, but for the other parents and children on the ward. While this child did not require one to one care all of the time, they did require care when they were distressed. The trust told us they did not rely on children's parents or carers to be present at all times. One parent told us, "I feel so bad for the child. They do what they can, but they are busy. He needs someone with (them)." A parent of a child also told us they thought

the staff were very good but said, “They rely a lot on the parents to do a lot.” The trust promoted “negotiated care”, which was to ensure that families and carers were involved in their child’s care.

We were unable to talk with any of the nursing staff on ward E38 because they were too busy delivering patient care. Again, there were two registered nurses for the night shift on this ward. We saw a young baby who had been admitted from A&E with breathing problems. The baby had an oxygen mask to its face. The parents of the baby told us they had been on the ward for about half an hour but they had not seen any of the nurses or doctors as yet. We were concerned that staff were not actively monitoring this young baby and raised this with the staff. Young babies with breathing difficulties require careful monitoring, as they can deteriorate quickly.

We visited the oncology ward during our unannounced visit and found there were two registered nurses on duty for the night shift. The staff told us they could meet the needs of the patients with that level of staff. We did not find evidence to suggest this was not the case but the staffing levels did not meet with Royal College of Nursing standards

During our unannounced, out of hours visit we did not find any concerns about the levels of medical staff cover for the paediatric wards or department.

Cleanliness

We found that some areas in the children’s service were not clean. For example, parts of the Neonatal Intensive Care Unit were dusty, and we found dirty medical equipment, such as monitors and cable junctions. In the Neonatal Intensive Care Unit and Children’s Assessment Unit, we saw paediatric resuscitation trolleys that had not been checked daily.

We found some of the toys in Ward E37’s playroom appeared dirty, although they were being wiped with antiseptic wipes.

Safeguarding

The trust’s safeguarding children team was proactive in visiting each ward daily, regardless of whether staff had raised concerns or made referrals. This helped to focus staff on safeguarding matters. We saw an incident report that showed that a patient with a mental health problem had displayed disruptive behaviour and had been physically restrained by staff. We were concerned that the restraint had been conducted by ward staff who had received no training in control and restraint.

Are services for children & young people effective?

(for example, treatment is effective)

Implementing national guidance

There was a lack of implementation of national guidance in children’s A&E, which could reduce the effectiveness of care. This included NICE guidance regarding the recognition of a sick child and the recognition of maltreatment of children.

There was good joint working between the community paediatricians and physiotherapists to keep children with complex needs out of hospital and facilitate early discharge of children requiring dressings, intravenous drugs or suture removal. However, the community nursing team said that it did not have access to the local authority’s system to check on safeguarding issues, which it felt was an obstruction to achieving the best outcomes for patients. The team had raised this with senior management who had been unable to resolve the concern because it was a national data sharing issue.

Staff training and welfare

Staff were not receiving all of their mandatory training in a timely manner. The training reports for the paediatric department showed a compliance level of between 35% and 40% for nurses. Induction processes were in place, and staff spoke highly of them. This was also the case for the preceptorship programme, in which newly qualified staff received valuable support for six months. However, once staff came out of preceptorship they were able to access clinical supervision, but this was optional and meant that they were not receiving ongoing professional support and development.

Staff said that the trust was a good and caring employer. We found examples where staff had been supported in their role following illness and where they had had a period of support to go back to work, which included working in a supernumerary capacity until they felt able to return to full-time work.

Services for children & young people

Care of patients with special needs

The trust had a policy of caring for child and adolescent mental health service (CAMHS) patients who required acute care on its general wards. Nursing staff described how they managed care for these patients without disrupting care for other children. We found that one patient was not receiving care in the most appropriate place due to a shortage of specialist CAMHS beds in England.

Are services for children & young people caring?

Patient feedback and information

The trust actively sought the views of patients and their families. We saw data for April 2013 to October 2013 that had been obtained from the regular inpatient survey. Results were good for questions about whether people felt they were included in decisions about care and treatment; whether they felt they had received the right amount of emotional support and whether staff were friendly, caring and polite.

There were suggestion boxes on each of the wards we visited. However, there was a lack of information for children, and the trust did not publicise the fact that it wanted to hear children's views. Feedback forms were not available in a child-friendly format. In the children's outpatients department, suggestion boxes were high up on the wall, which meant that small children would find it difficult to give feedback. Also, there was a lack of information in languages other than English.

Some feedback was displayed on dedicated message boards in each clinical area. These all contained positive comments. When we asked staff how they would respond if someone gave negative feedback, they said that the ward manager would discuss the person's concerns with them and act on them.

Patient views of care

People's views of the care they and their child had received were mainly very positive.

We observed some good doctor/parent interaction about care and discharge planning and saw that staff sought the parent's views before taking any decisions. When the doctor had left, the parent of the patient told us that the care they had received had been "fantastic".

On the oncology ward, we spoke with the parents of a young child who had come to the hospital from out of town. They said that all the staff they had dealt with at the hospital had been "amazing". They said that at their local hospital that they had received little information from consultants, but at Queen's Medical Centre nursing staff and the consultant came into the room, sat down and spent a considerable amount of time discussing care and treatment with them and making sure they were involved and well informed.

We spoke with another young patient on the oncology ward who said they were looking for the receptionist, as they wanted to play with them. We later saw the receptionist playing with the patient. They had clearly built up a good relationship, and this demonstrated how all staff on the ward created a caring atmosphere.

We observed a very good interaction between a consultant and a patient and their parents. On the morning ward round, the consultant went to talk to the parents of a baby who had been in hospital for between 36 and 48 hours. They approached the cot, washed their hands, introduced themselves to the parents by name and role and explained what they wanted to do at that time. They started by asking the parents what had happened over the weekend and listened to their account, asking relevant questions and prompting them for information to help inform a judgement. They asked permission to examine the baby and did this in a caring and gentle manner. They responded to parental questions, gave them information and set out a plan of care. They also gave the parents the information that they would be on duty all week.

One parent in A&E, whose child was being transferred to a ward, asked the inspectors if they could give feedback. They told us that the care had been "'excellent."

Before our inspection, we received a comment from the mother of a child who had used the inpatient services at the hospital. They told us, "My son presents as challenging due to lack of understanding. The doctors and nurses went out of their way to make him feel safe."

There was some negative feedback provided about care, however. We spoke with one parent whose child was on the paediatric high dependency unit and who had come to the hospital from out of town. This was their second stay in the hospital in the last six months. Their child required 24-hour care, and they were very positive about the care and

support the child and family had received in the Paediatric Intensive Care Unit and the Paediatric High Dependency Unit. However, they said they were "relieved" about being transferred back to their local hospital rather than being moved to a general paediatric ward at Queen's Medical Centre, as had happened during their child's previous admission. They felt that the general ward and nursing staff were not set up to care properly for children with special needs. They said that staff were happy to have the parent give the child medication and see to their care needs, tasks which they felt should have been done by the nurses. They said that at one point a nurse had woken them up to ask them to give their child their medication and food.

Ward activities

Play specialists told us about their work on the wards. We observed them setting up activities for children and providing care at the bedside.

We saw that play specialists made a point to visit all the patients before they did anything else to see if any of the children were alone. This was good prioritisation of care, as they recognised that those children without any parents/ visitors would require most support or might be worried. Play specialists also talked about spending time with adolescents with mental health needs. A housekeeper on one ward had bought white tiles and, along with play specialists, had spent time with the children, helping them to paint the tiles. They had the tiles fired with a view to placing them on a new design board in the playroom. This was a very good initiative.

Staff treated older children on the same wards as younger children and babies, and there were often fewer activities available for teenagers than there was for younger children. However, on some wards there was a dedicated teenagers' relaxation room with a television, music and books. We saw confirmed plans for the refurbishment of the oncology ward that would incorporate a five-bedded teenage cancer unit, which showed that the trust had considered patients' comfort, dignity and respect when care was planned.

Are services for children & young people responsive to people's needs?

(for example, to feedback?)

Working with stakeholders

There was a good community planning system to co-ordinate discharges, people with long-term health conditions and those receiving end of life care. We found good collaborative working between matrons and the community teams to keep children with complex needs out of the hospital and facilitate early discharge. This complemented the trust's Winter Plan, which had been agreed. Matrons told us that capacity to increase the number of children's beds had been built into the plan. The community teams were confident that admissions would be well managed over the coming winter.

Information in special formats

There was a lack of information in languages other than English. Staff in all areas were aware of the availability of telephone translation services (Language Line), and they also told us about internet translation services. There was a learning disabilities resource pack for staff to use when caring for patients with a learning disability. However, there were no signs to let people know that information was available in special formats for people with special educational needs or who did not have English as a first language.

Responding to the specific needs of children

Children's A&E was open 24 hours a day. It was properly staffed and good arrangements were in place to ensure that appropriate medical cover was available overnight. The doctors providing this cover had the appropriate paediatric training to ensure that the service was safe. The A&E environment was set up well and was comfortable and stimulating for children. Each child received an initial triage from an advanced paediatric life-support-trained nurse at the entrance of the children's A&E. They carried out initial checks on the child, gave pain relief if required and flagged up very ill patients. Although this was good practice, there were no signs in the waiting area to remind parents to notify staff if they felt their child was deteriorating. In addition, staff could not see part of the waiting area from the reception desk, so it was difficult for them to observe people who were waiting there. There was very helpful

information on the wall to explain the stages of triage and consultation and where people might go for onward referral. However, again, this information was only available in English.

We saw that the children's A&E and Children's Assessment Unit were not located next to each other, which increased the amount of moves ill patients had to make. This had an impact on care and staff workload.

Education and stimulation

The trust was proactive in the use of play specialists on the wards, and this was a system that was working well. Separate play facilities and rooms were available, and activities also took place at the children's bedsides. Play facilities were also used in clinics for distraction therapy, if a child was undergoing a procedure or having bloods taken.

The trust had good links with the local education authority and had an established and effective school programme for inpatients. This service had been rated as 'outstanding' at the last Ofsted inspection. Facilities included the use of classrooms, but lessons were provided on a one-to-one basis for patients who were susceptible to infections, such as those children with cystic fibrosis. The service had an overview of the national curriculum and teaching staff had training to inform them of any changes. There was internet access at the children's bedsides to facilitate learning.

Facilities for parents and relatives

As a regional centre for specialist children's services, the trust treated a number of children from outside of the Nottingham area. In an attempt to reduce travel pressures on parents a pre-assessment service was offered by telephone, where feasible. Facilities for parents staying overnight were cramped, and nurses on wards D33 and CAU said it is not always possible to provide single sex sleeping arrangements for parents staying with their child. Those families that were from out of town spoke highly of the care their child received and of the staff. However, they said that they were unhappy that the hospital restaurant closed at 2.30pm on weekdays and that it was not open at all at weekends. This prevented them from obtaining freshly cooked food. One father said that he did not want to eat in front of his child if his child was not allowed to eat before undergoing a procedure. There was an alternative café in the hospital that served hot food, such as jacket potatoes, soup and toasted sandwiches. This was open until 11pm.

Are services for children & young people well-led?

Leadership at ward level

We found examples of good leadership and others that showed that improvement was required. Leadership in ward areas was generally good, and teams felt well supported by their manager. We received positive feedback about the level of consultant support available to junior doctors and observed good nursing leadership in the children's outpatient department. Here, the trust had already recognised that performance needed to be improved and had made changes to facilitate this. This was demonstrated by improved waiting times for patients. There was good support for new staff through induction and preceptorship. However, as previously state, once preceptorship had finished, there was no mandatory clinical supervision to guide and develop staff. There was a good programme for identifying and developing potential leaders.

Senior leadership and governance

Governance arrangements within paediatrics were not applied consistently. Some wards did not have team meetings to ensure that key messages, best practice and the learning from incidents were disseminated to staff and their implementation tracked. Other ward areas were far more proactive and held governance days and team meetings. Staff said they did not see much of the senior management team on the wards, and there was an accepted and shared view among many of the frontline staff that the executive team was too senior to visit the wards. Furthermore, staff in the Neonatal Intensive Care Unity and Children's Assessment Unit said they did not see many staff above matron level in their respective areas. This indicated disconnect between the executive team and frontline staff.

Some risks on the trust's risk register had been raised by staff, which indicated an 'open' culture of reporting, but not all risks had been reviewed by the required stated date. The clinical lead for nursing admitted that this was an area that could be improved. We found that the person who raised the risk was allocated the work to address the risk. However, oversight of the register was lacking, as some risks were assigned to staff who no longer worked for the trust.

Services for children & young people

The nursing dashboard was in place on the wards but, as discussed previously, monthly performance was inconsistent. Good performance in one area in one month was not sustained the following month. This was a particular issue on those wards that did not have regular team meetings. This increased the risk of adverse outcomes for patients.

End of life care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Acute oncology services are provided at the Queen's Medical Centre. Between the hours of 8am and 5pm Monday to Friday there is an acute oncology team of specialist nurses who provide emergency triage and assessment of acutely ill patients at both City Hospital and Queen's Medical Centre.

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

Queen's Medical Centre does not have any wards which are specifically established to provide end of life care. However, there is the potential for many of the wards to provide care and treatment for people receiving palliative care.

We inspected four wards at Queen's Medical Centre (Lyn Jarrett, B49, C5 and E17). Three of these were providing end of life care and treatment to patients at the time of our visit. We also inspected a number of end of life support services, including the multi-faith centre, chaplaincy service, the bereavement centre, the mortuary and chapels of rest. We spoke with two patients, five relatives, seven volunteers and 21 staff, including nurses, doctors, consultants, senior managers, faith leaders, mortuary staff, a bereavement nurse who was based in the emergency department and other support staff.

We observed care and treatment and looked at care records to make sure patients received safe, effective, and responsive care and support.

Summary of findings

Overall, patients received safe end of life care, and patients and relatives we spoke with reported high levels of satisfaction. However, we had concerns about whether staff on all wards received the training and supervision they needed make sure they did their job to expected standards and met patients' needs.

Patients received effective care and treatment on most of the wards we inspected, and we saw some good practice and support services for people nearing the end of their life.

All of the patients and relatives we spoke with told us that staff were caring, informative and compassionate. We observed and were told about some outstanding practice, in particular from the bereavement service, the Lyn Jarrett Unit and the multi-faith and chaplain services.

The response to patients' end of life care wishes was very positive. The staff and the trust were responsive to suggestions about improvements which would enable patients to die in comfort, in their preferred place and in a dignified manner.

There was evidence of an open and honest appraisal of the quality of the end of life services being provided across the trust. There were robust audits taking place with clear feedback to governance leads indicating what improvements needed to be made.

End of life care

Are end of life care services safe?

Do Not Attempt Cardio-pulmonary Resuscitation orders

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

The doctor and the nursing staff on the wards we visited confirmed that the trust had systems in place to audit all DNACPR forms. The resuscitation team undertook this audit and any concerns were fed back to the relevant consultant. Consultants were invited to reflect on the DNACPR form they had completed and review the order to make sure it met the expected standards. On one ward, we saw evidence that the consultant put a new DNACPR order in place, as the previous order had been completed by community-based doctors and did not meet the required standards. Nurses said this was not uncommon practice and it ensured that patients and relatives were clear about exactly what treatment would be withheld and why.

One family we spoke with understood that the patient was at the end of their life and was receiving palliative care. This meant staff caring for this patient had followed General medical Council guidelines and had made sure the patient knew that they would not receive CPR in an emergency situation and why this had been decided.

Protecting patients, staff and visitors against the risk of acquiring infections

We saw that the risk register for end of life care services actively considered the risk of patients with compromised immune systems coming into contact with infections. It highlighted steps for staff to take to protect patients against such risks.

Some of the staff we spoke with (such as mortuary and pathology staff) were more likely to come into contact with infections such as tuberculosis or **Creutzfeldt-Jakob disease** (CJD). These staff told us they had regular occupational health checks and regular tests and injections to make sure their health and safety were protected.

Staffing levels and supporting workers

The staffing levels for two of the three wards were on display, indicating the ration of qualified nurses to patients for each shift. One member of staff raised some concerns about staffing levels, although this related to the hospital rather than to a specific ward.

Two patients gave us conflicting views about the staffing levels at the hospital. One told us that the response time to call alarms was “variable but it is better at night”. Another said, “Staff are always around to help me when I need it.” We did not find any evidence that staffing levels on the ward had a negative impact on patient safety.

On one ward, we had concerns about the clinical supervision and appraisal systems in place. A senior nurse did not understand what clinical supervision was when we asked them about this, although they said they received support from their manager. When we looked at three appraisals, we saw the objectives for one nurse were weak for their level and responsibilities. In another case we saw that the member of staff had raised concerns about some staff failing to provide good quality care. There was very little evidence of this member of staff receiving any feedback in relation to their concern.

From these appraisals, we also discovered that two out of the three staff members had not completed their mandatory training updates to make sure their knowledge was current and reflected best practice. We looked at the database for mandatory training on the ward and saw there were many gaps, meaning that staff were not up to date with key training. There were also gaps on mentor updates. We saw the ‘rescue’ training was out of date for all staff, and when we asked a senior nurse on the ward about this training, they did not know what it was. This indicated that the structures and systems in place to support staff on the ward were not effective and the trust could not be assured that they enabled staff to deliver care and treatment to patients safely and to an appropriate standard.

End of life care

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

Mortality rates

The trust's Oncology and Radiotherapy Action Plan 2011–2016 indicated that mortality rates were below the national average and that they were broadly similar to other local trusts. This meant that the effectiveness of oncology and radiotherapy services was as expected.

28 day readmission rates and rapid discharge

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

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

We spoke with a specialist palliative care nurse and the head of palliative care about these issues. They both reinforced their commitment to ensuring that patients' symptoms could be stabilised and patients could be discharged quickly to ensure that they were able to end their life in a place they had identified in their end of life plan. All of the staff we spoke with said that they had established close links with the community-based services to enable patients' end of life wishes to be met.

We spoke with two relatives of a patient receiving end of life care. They told us that they understood the patient's prognosis was very poor and that they had decided to arrange for the patient to spend the end of their life at home. Staff were making arrangements to meet these wishes. We saw from the patient's records that staff had clearly documented the relative's wishes and advice they had given about risks to the patient in being transported back home so near to the end of their life. The relatives said that the care their parent had received at the hospital was "very good. We have been very pleased with the care [the relative] is receiving".

Staff satisfaction and commitment

Staff survey results showed that staff satisfaction for the end of life speciality were very high. The service was ranked sixth out of 31 specialities in terms of job satisfaction. Many of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed to end their life with dignity and without pain.

National guidance for end of life care

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

NICE guidance indicates that physical symptoms such as pain, breathlessness, nausea and fatigue must be properly managed by collaborative multidisciplinary working. The trust end of life team had developed a formula for prescribing to manage these symptoms regardless of whether the patient was under the care of a specialist or generalist consultant. The Head of Palliative Care told us that the palliative care team kept a daily overview of patients receiving end of life care at the trust. Staff on the wards and the specialist palliative care nurse confirmed this arrangement was in place to ensure patients' symptoms were properly controlled.

We looked at the notes of a person who was on an end of life care pathway, and we saw that the consultant had prescribed medication to help them sleep and to manage their pain. Staff gave the patient this medication while we were speaking with the patient and their relatives. Another patient receiving end of life care described their pain control as "excellent".

The specialist palliative care nurse did not express any concerns about the end of life care on general wards, but they told us if there were any concerns these would be fed back to the matron on the ward. This staff member said they would on occasion arrange for the patient to be transferred from a general ward at Queen's Medical Centre

to an oncology or the Palliative Care Unit at City Hospital to ensure effective symptom control. This was because patients would then have access to medication which would control symptoms but needed careful monitoring by palliative care specialists. We could see that staff were monitoring patients to ensure effective symptom control when they were nearing the end of their life.

NICE guidance states that patients' needs and preferences should be captured and shared between different services to so that staff can meet them. There is also reference to clinicians reducing unplanned hospital admissions which may result in a person ending their life in hospital where this was against their wishes. We looked at the notes of a person receiving end of life care on a ward close to the emergency department and saw that the patient's and carer's wishes were clearly documented and had been passed over to the new staff and consultants when the patient moved wards. There was also evidence of liaison with the ambulance service, which would be returning the patient to their home to end their life in line with their (and their relative's) expressed wishes. This indicated that staff respected the patients' wishes and preferences and were implementing best practice guidelines.

Nutrition and hydration

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

We saw on one ward that there was a clear plan in place for a patient to receive oral care. Staff said they were happy to teach relatives how to do this if they wished to be involved in making the patient comfortable. The relatives of the patient told us they were very happy with the quality of care their relative had experienced.

However, we were concerned about a patient on another ward who had just been placed on an end of life care pathway. When we spoke with the patient they told us their mouth was "so dry I cannot speak." We made sure that staff gave the patient a drink.

Staff handovers

There was a comprehensive record of staff handover on one of the wards which was linked to the accident and emergency (A&E) department. The records which had been made in A&E had been printed out and were placed in the patient's file as well as being available on the computer.

Religious support

Queen's Medical Centre had a purpose-built facility that provided multi-faith and bereavement services in one place. This made it very easy for relatives to access different support services.

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

Staff we spoke with on two wards were aware of the multi-faith centre and the spiritual and emotional support it could provide to grieving relatives or to patients who were nearing the end of their life. Many staff had a clear understanding of the need to make sure religious rituals were observed when people died. A member of staff from A&E told us of instances where they had liaised with the police to ensure the family of a patient could observe their religious rites of passage by washing their relative after they had passed away.

Are end of life care services caring?

Patient satisfaction and complaints

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

Two patients receiving end of life care told us they were treated with care and compassion. One patient

commented, “The general care is excellent.” Another patient told us, “The staff have looked after me very well.” We observed good interactions between staff and patients on most of the wards we visited.

A senior nurse on a ward attached to the emergency department told us that one of the main motivations in opening the ward was to enable patients at the very end of their life to die in a calm environment and in a private and dignified manner. Patients would be transferred to a single room on the ward if they needed end of life care. However, they were able to remain on the ward until they passed away, if they so wished. This demonstrated a compassionate and responsive approach towards patients.

All of the relatives we spoke with were very happy with the quality of the care their loved ones had received on the wards we inspected. One relative commented, “We are very pleased with the care, it is very good. We have been kept well informed and we are aware of the prognosis.”

Support services at the end of life

We spoke with two staff and a volunteer from the bereavement service. We also spoke with a bereavement nurse who worked in the emergency department to identify what support patients received at the end of their life and what support their relatives received following their death.

The bereavement staff told us they worked with patients as they were nearing the end of their life when asked to do so. They also offered support to families at any time. The faith leaders and chaplain staff demonstrated a caring and compassionate approach towards relatives and also to staff who may be distressed.

All of the staff we spoke with told us there were specialist bereavement nursing staff who focussed on providing support to children and young people who were either nearing the end of their lives or who had lost their parent. The bereavement nurse and social work staff would assist families or take the lead in breaking bad news to children in a compassionate manner. Several staff we spoke with were highly complimentary about this specialist support. Bereavement staff told us that there were age appropriate information packs, books and memory boxes available for children who had been bereaved and these could be filled with (for example) handprints, locks of hair, key rings or candles as well as personal items selected by children themselves. The staff would also refer children or adults who were struggling to cope with their loss to counselling services. This service was also available for parents whose babies had died.

We saw some exemplary practice. For example, the trust offered women who miscarried before 24 weeks a service and either a cremation or a woodland burial. Women who miscarried after 24 weeks were offered a multi-faith funeral service, if required. This was an exceptionally compassionate and caring approach to supporting grieving parents.

Staff told us that six weeks after every death in the emergency department, bereavement nurses sent a handwritten letter to relatives. This letter offered condolences and invited recipients to speak with a bereavement nurse or senior doctor, who would be able to answer any questions they may have. This was an area of outstanding and compassionate practice.

Arrangements following a patient’s death

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

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

End of life care

Are end of life care services responsive to people's needs?
(for example, to feedback?)

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

Where patients needed to be admitted to specialist oncology or palliative care beds for symptom control, staff arranged this with minimal delays. The trust gave us information from a data sample of 100 patients at the end of their life between February 2012 and May 2012. It showed that patients waited an average of 1.5 days for a palliative bed if they were a trust in patient on a general ward and an average of 2.7 days if they were admitted from the community. This indicated the service responded quickly when patients were in crisis or when they were inappropriately placed and needed specialised support.

Emergency staff gave us a recent example of a patient who was receiving palliative care and was struggling with symptoms in spite of the best efforts of clinicians in A&E. The palliative care team arranged for the patient to be transferred to the specialist wards at City Hospital with a minimal delay so that the patient could receive the specialist care they needed.

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

All of the staff we spoke with reported excellent relationships and liaison with other agencies, such as the ambulance service, adult social care services in the community, district nurses and Macmillan nurses. In addition, the palliative care team would contact the patient in the community once they had left to ensure that they received the care, treatment and support they needed at the end of their life and to try and prevent further unplanned admissions to hospital, where possible.

Records showed that there had been close liaison with the community-based social and health care services in the case of one patient who wished to be discharged home towards the end of their life. This meant that staff were co-ordinating care properly to ensure the patient could be discharged in line with their end of life wishes.

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

Spiritual support
The National Bereavement Survey 2011 indicated that patients did not feel they received the spiritual support they needed in the last two days of their life. We saw that the trust had taken robust action to address this, and staff we spoke with in all areas of the hospital told us about the availability of spiritual support for people of many different faiths. This was further evidence that the trust had improved services based on feedback from patients.

Staff on a ward which was part of the emergency department showed us a checklist which was used after a patient died. This included checking whether the patient or their relative had a religious affiliation, whether the chaplain or multi-faith centre had been contacted and whether patients' relatives needed support from the bereavement centre. They told us that the chaplaincy service and multi-faith centre were always very responsive and had hospital and community-based volunteers available to support patients and their relatives. Staff could contact them at any time during the day and night. We looked at some completed checklists and saw that staff had given consideration to each area.

The staff we spoke with in the chaplaincy and multi-faith services told us they had introduced a DVD for staff to explain and publicise their service. They said that the DVD had significantly increased awareness among staff. They told us that they were involved in training doctors, administrative staff and student nurses on end of life care, managing difficult conversations and breaking bad news. The staff in these services provided support for a very wide

range of patients, from children to older people. They also provided support for staff who were in need of spiritual guidance. Staff were kind, calm, dedicated and compassionate.

Are end of life care services well-led?

Clinical governance

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

There were trust-wide and speciality-specific risk registers which identified areas of high, medium and low risk to patients and staff. The trust had used data from national patient safety alerts to identify risks, as falls and pressure ulcers featured on the end of life risk register. We saw evidence that actions the trust had taken had been understood and embedded in practice on most of the wards we inspected. This had had a positive impact on patient safety.

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

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

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

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

Outpatients

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Nottingham University Hospitals NHS trust provides outpatient services from three separate sites: Queen's Medical Centre, City Hospital and The Ropewalk House. In total, there are eight distinct outpatient clinics for adults at Queen's Medical Centre, but the therapies outpatient clinic runs from two different clinic bases.

This is the first time we have inspected the outpatient service for this trust. We inspected four of the outpatient clinics (the maxillofacial, fracture, general outpatient and eye clinics) over two days, and we spoke with 15 patients, 3 relatives and 13 staff.

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

Summary of findings

Overall, patient received a safe service in outpatients. Treatment was generally effective. However some of the rates for attendance at clinics were high. Patients were frustrated with the waiting times for some clinics and services such as the fracture clinic and outpatients pharmacy. Some patients, particularly those attending the eye clinic, did not always feel they were treated as an individual. We found that there was no one person at the trust who had overall responsibility for assessing and monitoring the quality and consistency of the service across the trust. This resulted in a lack of shared learning and consistency across clinics and across the trust. This needed to be addressed.

Outpatients

Are outpatients services safe?

Falls prevention

An analysis of recent national patient safety alerts indicated that patient falls accounted for a significant number of notifications. The trust had highlighted this on its risk register as an area needing improvement. When we analysed data for reported outpatient incidents between May 2013 and October 2013 we saw that there had been five falls in outpatient clinics during this period. Many of the falls occurred in specific clinics, and in some instances the incidence was likely to be linked to the reasons the patient was attending the clinic.

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

Protection against infections

CQC's 2011 Outpatient Survey indicated that patients found the outpatients department clean but did not feel the patient toilets were maintained to the same standards of cleanliness. We did not have any concerns about the cleanliness of the clinics we visited.

The outpatient risk register identified that patients with compromised immune systems (such as clinical haematology patients) were at risk of harm from hospital acquired infections. The trust's rates for healthcare acquired infections such as MRSA and Clostridium difficile were within an acceptable range, suggesting that infection control policies were in place and followed in practice. The trust provided evidence of the systems it had in place to reduce the incidence of healthcare acquired infections. These systems included weekly clinical case reviews by the infection prevention and control doctor, checks for cross infection and a rigorous approach to hand hygiene. These steps had resulted in a significant reduction in healthcare acquired infections over a five-year period.

Staffing levels and supporting workers

The outpatient risk register identified that patients were at risk because of difficulties recruiting and retaining cardiology staff. Recruitment problems had resulted in an increased pressure on existing staff to provide on-call services. The trust was trying to address this by continuing to try to recruit to its vacant posts. When we analysed data on reported outpatient incidents between May 2013 and October 2013, we found that no specific incidents had been recorded. This indicated the control measure they had put in place to mitigate this risk were effective.

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

Outpatient Survey 2011

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

Follow-up appointments

At the Queens Medical Centre, we were told that the ophthalmology department had not allocated a significant number of follow-up appointments. This meant people who had undergone ophthalmic surgery may not have been checked to make sure the surgery had been successful and there were no complications. Patients with macular changes could experience a significant deterioration in their sight while waiting to be seen by a specialist consultant. The trust had a risk assessment and action plan in place to address this, and progress against the plan was monitored monthly. We spoke with a person at one of our listening events who raised concerns about the process for ophthalmic follow-up appointments.

Are outpatients services caring?

Outpatient Survey 2011

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

The trust performed less well when it came to treating patients with dignity. Many patients reported that doctors

or nurses spoke in front of them as if they were not there, and they said that they were not always afforded privacy when discussing their condition or treatment. We did not see any example of this during our inspection.

We received mixed feedback about the care people received in outpatients. Many patients were frustrated with the waiting times. Some patients thought that, despite the wait, they received good care from the staff. Other patients felt less satisfied, and the term 'conveyor belt' was used a number of times to describe how services were run. One person told us, "You go knowing you're going to have to sit and wait, but when you do get seen the doctors are great." Another person said, "My consultant is fantastic. He has done so much for me and treats me very well."

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

Appointment times and delays

In the 2011 outpatient survey, the trust got good results for the time it took to offer patients an appointment, its choice of appointment times and explaining to patients what would happen at their appointment. Results were verging on worse than expected for informing patients of delays and explaining how long they would have to wait to be seen in the outpatient department.

Trust data on reported outpatient incidents for May 2013 to October 2013 showed that there were twice as many incidents about patients being unhappy with delays at Queen's Medical Centre as City Hospital. Queen's Medical Centre also had a greater number of incidents in which clinicians were not present to cover clinics.

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

We analysed the number and type of formal complaints received about outpatient services and identified the eye clinic (five complaints) and the spinal outpatient clinics (11 complaints) received the most complaints over the year.

Most of the complaints about the eye clinic were to do with the standard of medical assessment or treatment We also noted that the eye clinic received a number of negative comments from patients in feedback we received before our inspection. This clinic was also raised as an issue at one of our listening events. Two patients told us that they felt they got inconsistent care and advice from this clinic, and they complained that staff did not always treat them as individuals. Most of the complaints about the spinal outpatients department were about waiting times for an appointment and cancellations of outpatient clinics. This was also reflected in comments we received before our inspection. One person in fracture clinic who was attending with their child said, "The waiting times are awful, the time I have waited here is shocking."

It was not clear from documents supplied by the trust what action it had taken to ensure patients in eye outpatient clinics received a good quality of care and treatment.

At our listening events, a number of patients told us that they had experienced long waits and a lack of information about what time they would be seen.

Patients who miss appointments

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

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

Are outpatients services well-led?

Records

Three members of staff told us that they felt the clinic preparation rooms at Queen's Medical Centre were inadequate environments, with insufficient computer access for staff. They raised concerns that patient files being transported through the hospital were at risk of being lost.

We analysed the trust's data for reported outpatient incidents between May 2013 and October 2013. Queen's Medical Centre had over twice as many reported incidents of missing or inaccurate records as City Hospital. Some of these issues were raised and reported following internal

audits and others were reported by consultants who felt ill-prepared when seeing patients without full access to their records. In at least one case, a patient had had to rearrange their appointment. There were also a number of incidents of information about patients being located in the wrong file. This meant there was a risk of important information going missing, which could affect diagnosis and treatment.

It also highlighted concerns about the confidentiality of patients' medical information. There was evidence to show that the trust had responded in each instance, but this had not stopped further incidents taking place. This led us to question the efficacy of the systems for ensuring that patient records are stored securely and are easily retrievable.

Good practice and areas for improvement

Introduction

<Start text here...>

Areas of good practice

- The bereavement nurse on the Lyn Jarett Unit sending a hand-written letter to relatives of deceased patients. The letter was sent six weeks after a patient's death. It offered condolences and invited the family to speak with a bereavement nurse or senior doctor and ask any questions they had.
- The Hospital Threshold Comprehensive Geriatric Assessment for Frail Older People, which was providing an improved experience for people who were older, frail and vulnerable.
- The Queen's Medical Centre trauma centre, which was providing effective care delivered by a strong multidisciplinary team. This had improved outcomes for patients sustaining major trauma.
- The effective care being provided by the critical care unit. Outcomes for patients were better than the national average, with the mortality rate for the department being significantly better than the national average.
- The care being provided to patients on the dementia ward was person centred and based on evidence based practice.
- The commitment of staff to provide the best care they could. Staff spoke with passion about their work and felt proud of the trust and what it did. They understood the hospital's values.
- The bereavement care that was offered in the trust by the multi-faith centre and the compassion shown by the mortuary staff towards relatives/friends of deceased patients.
- The medical staffing levels within the trust and the support given to doctors in training by senior medical staff.
- The quality of the senior leadership was good, particularly that shown by the executive directors.

Areas in need of improvement

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

<Start text here...>

Action the hospital COULD take to improve

- Review the staffing requirements for the paediatric wards and departments.
- Ensure action is taken to address the outpatient follow up appointments for ophthalmology.
- Address the privacy and dignity issues that patients may face when the A&E department has reached capacity and patients have to be cared for in corridor areas.
- Ensure all areas of the trust are free from dust and hand gel is always available in all dispensers.
- Review the length of time patients are waiting for outpatient appointments and ensure people are given information about how long they will have to wait.
- Review the facilities for visitors to have access to a hot meal after 2pm, particularly for those visitors who are further away from home and need to stay for long periods at the hospital to be with their relative.
- Review the availability of information so that it is accessible for people who find it difficult to access.
- Ensure children are given opportunities to give feedback on their experiences of care.
- Review the process for the recording of controlled drugs in the maternity and gynaecology departments so records are accurately maintained.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

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

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

Regulated activity	Regulation
	<Regulation 3>

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
	<Regulation 1>

Regulated activity	Regulation
	<Regulation 2>

Regulated activity	Regulation
	<Regulation 3>