University Hospitals Coventry and Warwickshire NHS Trust

Hospital of St Cross

Quality Report

Hospital of St Cross
Barby Road
Rugby CV22 5PX
Tel: 024 7696 4000
Website: www.uhcw.nhs.uk

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

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Hospital of St Cross, Rugby is part of University Hospitals Coventry and Warwickshire NHS Trust. It provides a small range of hospital services, including urgent care, general medicine including elderly care and rehabilitation, elective surgery including a surgical day unit, and a range of outpatient services.

University Hospitals Coventry and Warwickshire NHS Trust serves a population of about 1,000,000 across Coventry, Warwickshire and beyond. Inpatient services are provided from two hospital sites, University Hospital Coventry (the main site) and Hospital of St Cross, Rugby. In total, the trust has 1,250 beds.

We carried out this inspection as part of our comprehensive inspection programme between 10 and 13 March 2015.

Overall, we rated Hospital of St Cross, Rugby as good, although improvements were required to ensure that urgent and emergency care and medical services were safe, responsive and well-led. All services were judged to provide caring and effective care. We found that services were provided by dedicated, caring staff. Patients were treated with dignity and respect and were provided with appropriate emotional support.

Our key findings were as follows:

Cleanliness and infection control

- Patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.
- We observed good practices in relation to hand hygiene, with nursing staff regularly cleaning their hands with the disinfectant gel that was provided in dispensers in multiple locations. A large poster was displayed in the reception waiting area about the hand-cleansing charter and a board displaying information and instructions on effective hand decontamination were displayed along the corridor to the staff room.
- Adherence to 'Bare below the elbow' guidance and the appropriate use of personal protective equipment, such as gloves and aprons, while delivering care was observed in all clinical areas.
- Although the trust had seven cases of MRSA recorded from April 2013 to November 2014, none of these involved Hospital of St Cross. The records we reviewed showed that patients had been fully screened for hospital-acquired infections before being transferred to the hospital.
- In the urgent and emergency care centre there was an isolation room prepared and ready for use, with the appropriate personal protective clothing illustrated on the door. A copy of the trust's infection control policy was available. We saw stocks of high-level personal protection equipment and clothing in a cupboard nearby.
- In the outpatients department we saw that, although the consulting rooms had hard floors, the carpets in the corridors were stained and worn in some places. We moved a portable computer table and found accumulated dust underneath it, because it had not been moved when the department was cleaned. We saw ground-in dirt on the edges of some of the desks and on the doors where they were pushed open.

Records

- The standard of record completion varied across the services. In surgical services we found that medical and nursing notes were concise, legible, complete and up to date. However, in medical services, three out of 12 sets of records checked had the patient's surname recorded with no hospital number or date of birth.
- Both paper and electronic records were available in all departments.
- In medical services we found that 'comfort rounds' (checks on hydration, nutrition, continence, equipment, positioning, mobility and skin survey), which were meant to be completed two-hourly, were not always documented.
- We also found within the medical services that the daily fluids balance records were not totalled up in the records we read. This meant that staff caring for these patients could not identify adequate hydration and report any abnormalities in patients' fluid documented recordings.

Summary of findings

- In outpatients we were told that sometimes patients' records were not available for their outpatient appointments, particularly if patients with complex conditions were visiting both hospital sites within a short time. Clerical staff created a temporary set of notes; the electronic patient records system meant that the referral letter and any previous clinic letters and blood test and x-ray results were available.

Staffing levels

- The trust used the nationally recognised 'Safer Nursing Care Tool' along with National Institute for Health and Care Excellence (NICE) guidance to assess required nursing staff levels.
- High nursing vacancy rates were seen in the medical and surgery wards (13%), with the shortfall being filled by trust bank or agency nurses, who all received a ward-specific induction.
- On both our planned and unplanned inspections, staffing levels on the medical wards were below optimum levels, and staff raised concerns about the effect this had on patients' safety.
- It was recognised by ward-based staff that nursing recruitment was a major safety risk to the service and this was on the directorate risk register. Open recruitment days and overseas recruitment initiatives had been put in place and staff were aware of these initiatives and supported them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- Overall, medical treatment was delivered by sufficient numbers of skilled and committed medical staff.
- Although they had no training in paediatrics, there was a 'good Samaritan' arrangement agreed for junior medical staff at Hospital of St Cross to assist with any paediatric emergency in the urgent care centre until the ambulance service arrived to transfer the child to the emergency department at University Hospital Coventry.

Incidents

- Systems were in place for reporting and managing incidents. However, these were not followed consistently across all services; for example, not all staff who reported incidents felt that they received feedback after investigation.
- Staff on the medical wards said they knew how to report an incident. However, staff said they did not always report incidents of challenging behaviour or physical abuse by patients, such as kicks and bites. Staff said that it would make little difference and felt they were discouraged by the clinical leaders.
- Incidents reviewed demonstrated that investigations and root cause analysis took place and action plans were developed to reduce the risk of a similar incident reoccurring. For example, in response to a high number of incidents relating to pressure ulcers, the trust had introduced intentional rounding (where nursing and healthcare assistants check on patients every two hours) on all the medical and care of elderly wards.
- Staff in outpatients told us that learning from incidents was discussed at the daily team brief and regular departmental meetings. We saw various examples of minutes that showed learning was being discussed at meetings.

Nutrition and hydration

- Patients received a malnutrition universal screening tool (MUST) assessment on admission, and any patients with complex dietary needs were referred to and seen by dieticians. On the surgical wards, we saw evidence of the MUST assessments and dieticians' notes within the patient notes, but on the medical wards referrals to the dietician were seen not to have been actioned.
- On weekdays we saw that people were able to make choices regarding their meals and drinks and were able to select from a range of items. At weekends there were no catering facilities and patients were provided with snack boxes, which meant that only cold meals were available.
- On the medical wards, although there were protected meal times when visitors were not allowed, we observed visitors on wards during these times who told us they came during lunchtime to support their relative to eat. The visitors told us that they were concerned about how much assistance with drinking was provided for patients.

Summary of findings

Medicines management

- During our unannounced visit we found the temperature in treatment rooms on the medical wards, where medicines including antibiotics, controlled drugs and intravenous fluids were stored, were in excess of 24°C. This meant staff could not ensure medicines had been stored safely, which could put patients at risk. All the medicines stored in these areas had to be replaced and air-conditioning units were installed and daily temperature monitoring implemented.
- On the medical wards we found a bag of intravenous fluid and nutritional supplements that were past their 'use by' date, which if used could put patients at risk.
- We noted that drugs, including controlled drugs, were safely and appropriately stored in all others areas. The controlled drugs protocol was followed.
- There was a pharmacist on site from Monday to Friday.
- We saw that medication in one theatre had been drawn up for all patients on that day's list. The drugs had been placed in the anaesthetic room in separate piles corresponding to the patients on the list. This meant that incorrect medication could be used. Best practice would be to draw medication for each patient individually, thereby removing any possibility of error.

We saw several areas of outstanding practice including:

- University Hospital Coventry and Hospital of St Cross were working to improve the experience of older patients. Initiatives included blue pillowcases for patients with dementia, screening all patients aged 75 and over for dementia and the development of a 'care bundle'.
- The trust was adopting the VERA technique as a means of communicating with a person with later stage dementia. VERA stands for: valuing what the person says, emotional which looks at the feelings behind the person's words, reassurance and an activity that is helpful for the person. Staff were rolling out this technique across the trust.
- The trust was using the 'M' technique as a means of holistic communication through a system of touch on hands and feet for older adults. This included the repetition of stroking and conventional massage through slow, constant and rhythmical pressure.
- The endoscopy department responded to the needs of its patients by having separate lists for men and women so that each group had their dignity maintained.
- However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust MUST:

- Ensure that its systems to review equipment and audit compliance are effective so far as they relate to checking resuscitation equipment.
- Ensure that medicines are stored safely across the hospital.

Action the hospital SHOULD take to improve

- Nurse staffing levels comply with NICE's 'Safe staffing for nursing in adult inpatient wards in acute hospitals'.
- The trust should consider improving GP support within the RUCC.
- The trust should review the frequency of senior leader presence at the RUCC and assess its effectiveness in the monitoring of risk.
- The trust should define its vision and strategy for the RUCC, and more effectively inform the local public about the limitations of the service.
- The trust should ensure that all ENP staff at the RUCC undertake child safeguarding training at level three.
- Local people receive a clear message about what the RUCC offered.
- Fluid scores are completed and recorded appropriately so that patients who are at risk of dehydration are correctly escalated.
- Information leaflets and signs are available in other languages and easy read formats.

Summary of findings

- The access and flow of medical patients is improved and delayed patient discharges are managed appropriately, including robust processes in place to meet the estimated discharge dates.
- They have robust arrangements in place to meet referral to treatment times.
- Learning from incidents is shared across all staff groups.
- The trust should ensure that patients accommodated over weekend periods have access to a choice of suitable and nutritious food and hydration. This should include the provision of hot meals where this is the patients preferred choice. This is something which is required as part of regulation 14(1)(a, b & c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Protecting patients from the risk of inadequate nutrition. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location.
- Review and reduce the number of patients who have their appointments cancelled for non-clinical reasons.
- Review the anomalous reporting structure within the radiology department, so that reporting lines are clear.
- Review the arrangements for communication within the radiology department to ensure that staff receive essential information in a more methodical and regular manner.
- Review the radiography arrangements for regular late operating lists, so that the on-call radiographer is not restricted or delayed in undertaking urgent x-rays. Review and update the environment in both outpatients and radiology.
- Consider the use of wasted space in the outpatients department, currently containing obsolete x-ray equipment.
- Review the anomalous reporting structure within the radiology department, so that reporting lines are clear.
- Review the arrangements for communication within the radiology department to ensure that staff receive essential information in a more methodical and regular manner.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The facilities at the Rugby Urgent Care Centre (RUCC), although valued by the local population, were underutilised by the trust and patients did not always understand the limits of what it offered. Access to urgent care and treatment for minor injuries was good and people did not generally have to wait long. However, the service was not functioning effectively in conjunction with other local services such as GP services and neighbouring NHS trusts and this had an impact on its ability to respond to some patients. Transfer of patients to the emergency department at University Hospital Coventry was not always timely and extended the patient care pathway. The trust had no clearly defined vision and strategy for the RUCC and there were few effective joint working arrangements and shared services in operation. The service was well led at a local level, but senior clinical leaders were not sufficiently visible at the RUCC. Quality was addressed through the trust systems and risks were escalated to corporate level when appropriate. Risks were not all effectively addressed in a timely manner. There was a strong focus on continuous learning and improvement for nursing staff.
Medical care	Requires improvement 	Medical care services required improvement in the safe domain. Concerns were identified about nursing staffing levels, monitoring and management of equipment, and safe storage of medicines. Trust infection rates were lower than average for Clostridium difficile. The records showed that MRSA rates were higher than average. However, there were no identified cases at Hospital of St Cross. The environment was clean. Patients whose condition deteriorated were appropriately escalated. The trust took action to promote harm-free care. There were appropriate procedures to provide effective and responsive care. Care was provided in line with national best practice guidance and outcomes for patients were better than average. Arrangements were in place to ensure that staff had the necessary skills and competence to look after

Summary of findings

patients. Patients had access to services seven days a week and were cared for by a multidisciplinary team working in a coordinated way. When patients lacked capacity to make decisions for themselves, staff acted in accordance with legal requirements. Patients received compassionate care that respected their privacy and dignity. They felt involved in decision-making about their care, although this was not always reflected in the records we read. Services were developed to meet the needs of the local population. There was specific care planning for patients living with dementia and mental health conditions. There were arrangements to meet the needs of patients with complex needs, including appropriate discharge arrangements. Governance arrangements were effective and staff felt supported by division and trust management. The culture within medical services was caring and supportive. Staff were actively engaged and the division supported innovation in clinical practices and professional development.

Surgery

Good

Patients told us that staff were kind, friendly and could not do enough for them. Patient safety was ensured through the completion of risk assessments on the wards and in theatres. Learning from incidents and listening to complaints were seen as opportunities for improvements to services.
We saw that patients had received care and treatment that had been based on nationally recognised care pathways and guidance.
Equipment was maintained and safe to use, although there were issues with storage, which meant some equipment was left in corridors. Wards, theatres and public areas were all kept clean and staff followed good infection prevention and control procedures.
Staff were knowledgeable and supported to provide their service by managers and systems that encouraged learning and openness. Senior management was provided remotely from the trust's sister site at Coventry. However, staff reported that senior managers visited on a regular basis, as did executive officers and board members.

Summary of findings

Outpatients and diagnostic imaging

Good 

The outpatient department's environment was poor. The walls were scuffed and the furniture was old and chipped. We noticed that some areas were not very clean and the carpets were stained. The radiology and endoscopy departments were clean but, again, dated. The dialysis unit appeared more modern and was clean and bright

Most staff had attended their mandatory training

Staff showed a commitment to patient-centred care. We found many examples of such care, and of attention to patients' conditions and preferences.

Many patients complained to us about waiting times in outpatient clinics.

Staff reported incidents via the trust's electronic reporting system. These were discussed at the clinical governance meetings within the directorates. Some learning was evident from incidents and complaints via staff meetings in outpatients and endoscopy. In radiology, it was not formalised

The trust had met its national targets and consistently performed higher than the national average with regard to radiology waiting times. Images were reported within 28 days, a national standard, even though this was done remotely from University Hospital, Coventry

Although a management restructure was underway, there was a disorganised and confusing reporting structure across both radiology and outpatients, particularly because some people were managed from the main hospital in Coventry

Hospital of St Cross

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Hospital of St Cross

University Hospitals Coventry and Warwickshire NHS Trust serves a population of about 1,000,000 across Coventry, Warwickshire and beyond. Inpatient services are provided from two hospital sites, University Hospital Coventry (the main site) and Hospital of St Cross, Rugby. In total, the trust has 1,250 beds.

Our inspection team

Our inspection team was led by: Chair: Peter Turkington, Medical Director, Salford Royal NHS Foundation Trust

Head of Hospital Inspections: Helen Richardson, Care Quality Commission

The team included 12 CQC inspectors and a variety of specialists including junior doctors, medical consultants, senior managers, child and adult safeguarding leads, trauma and orthopaedic nurses, paediatric nurses, an obstetrician, midwives, surgeons, an end of life care specialist and experts by experience who had experience of using services.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about University Hospitals Coventry and Warwickshire NHS Trust and asked other organisations to share what they knew about the hospitals. These included the clinical commissioning groups, the trust development authority, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

Detailed findings

We held a listening event in Rugby in the week leading up to the inspection where people shared their views and experiences of services provided by University Hospitals Coventry and Warwickshire NHS Trust. Some people also shared their experiences by email or telephone.

We carried out this inspection as part of our comprehensive inspection programme. We undertook an announced inspection of University Hospital Coventry and the Hospital of St Cross, Rugby between 10 and 13 March 2015.

We also undertook an unannounced inspection to the Hospital of St Cross on 29th March 2015

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, health visitors, trainee doctors, consultants, midwives, healthcare assistants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at University Hospitals Coventry and Warwickshire NHS Trust.

Facts and data about Hospital of St Cross

Hospital of St Cross, Rugby is part of University Hospitals Coventry and Warwickshire NHS Trust. It provides a small range of hospital services, including urgent care, general medicine including elderly care and rehabilitation, elective surgery including a surgical day unit, and a range of outpatient services

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Notes

Urgent and emergency services

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

Information about the service

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) is one of the UK's largest, serving a population of around 1,000,000 people from Coventry, Warwickshire and beyond, and specialising in cardiology, neurosurgery, stroke, joint replacements, in vitro fertilisation and maternal health, diabetes, cancer care and kidney transplants. The trust provides services from University Hospital, Coventry, and the Hospital of St Cross, Rugby, North Warwickshire. It provides both emergency and elective care at University Hospital and the Hospital of St Cross provides urgent care, general medicine, including elderly care and rehabilitation, elective surgery including a surgical day unit and a range of outpatients services.

At the Hospital of St Cross, Rugby, there is an urgent care centre (RUCC). This delivered a nurse-led minor injury and illness service. The RUCC was part of the trust-wide emergency medicine speciality group. The service is available 24 hours a day, 7 days a week. Between January and December 2014, 25,991 patients were seen.

Patients over the age of 5 attend the RUCC where nursing staff assess them and give advice and treatment. Patients are able to have x-rays and blood tests, and a pharmacy is available. Direct transfer arrangements with West Midlands Ambulance Service enable sicker patients to be taken to the University Hospital site at Coventry. Advice from the emergency medicine team at University Hospital is available to RUCC staff 24 hours a day, 7 days a week. There is a fracture clinic service at St Cross.

We visited the RUCC on a Thursday morning in March 2015. We spoke with 5 patients and their relatives and 10 trust staff, including nurses, and cleaning and reception staff. We looked at records, observed how the RUCC functioned and managed patients, and tracked the care pathways of five patients who had been transferred by ambulance to the University Hospital's emergency department (ED).

Urgent and emergency services

Summary of findings

We found that the RUCC services were safe and there was an open culture about safety. There were good examples of clearly embedded systems for keeping patients safe and minimising error. The centre was clean and staff followed hygiene procedures. The nursing staffing levels and skills were appropriate for the service provided. There was a low threshold for transferring sick children to the ED at Coventry by ambulance.

We found the RUCC services were effective. Patients' care and treatment were planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients' needs were assessed and they were offered pain relief. Staff were qualified with the skills to carry out their roles effectively, and they had access to training and development. There were no paediatrically trained staff on site; however protocols for the care of children had been developed with children's ED at University Hospital Coventry and oversight given from Paediatrics. There were arrangements in place to protect patients' rights.

We found the RUCC services were caring. Staff at all levels and in all roles were kind and caring to both patients and relatives, and treated them with respect. Patient feedback about the way staff treated them was very positive. Staff maintained patients' privacy and dignity. Patients were generally given good information about their treatment plans.

We found the responsiveness of the RUCC required improvement. Its facilities, although valued by the local population, were underused by the trust and patients did not always understand the limits on what it offered. Access to urgent care and treatment for minor injuries was good, and people generally did not have to wait long. However, the service was not planned effectively with other local services, such as GPs and neighbouring NHS trusts, and this had an impact on its ability to respond to some patients. Transfer of patients to the ED at University Hospital, Coventry, was not always timely and so extended the patient's care pathway.

We found leadership of the RUCC required improvement. The trust had no clearly defined vision or strategy for the centre. There were few effective joint working arrangements or shared services commissioned. Local people were not always clear about what the RUCC offered and it could not always respond in an appropriate or timely way to some patients' needs. The service was well led at a local level but senior clinical leaders from the emergency and urgent care department were not sufficiently visible. Quality was addressed through the trust's systems and risks escalated to corporate level when appropriate. Not all risks were addressed effectively and in a timely manner. There was a strong focus on continuous learning and improvement for nursing staff.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We found the Rugby Urgent Care Centre (RUCC) services were safe.

There was an open culture about safety. Staff understood their responsibility to raise concerns and report incidents, and were supported in doing so. Local leaders were confident that the board was made aware of incidents.

Systems were in place within the RUCC to monitor and review activity levels. Staff and local leaders were aware of the current situation on safety, and were able to understand and evaluate risk.

There was a good track record in safety within the RUCC and we saw examples of how lessons learned led to improvements in practice.

There were clearly embedded systems for keeping patients safe and minimising error, and we saw good examples of these in record keeping, medicines management, and hygiene and infection control.

There were established systems and processes for child protection and vulnerable adult safeguarding, including mandatory staff training. Staff used these systems and processes.

Staffing levels at the RUCC were adequate, and the staff were experienced and qualified in emergency nursing. They were not, however, trained in paediatrics but their professional development arrangements were overseen by paediatric as well as ED consultants. There were no medical staff on duty in the RUCC and no significant GP presence.

Junior medical doctors at St Cross did not have training in paediatrics but the emergency nurse practitioners were qualified in advanced paediatric life support. Although discouraged, any self-presenting paediatric emergency would have to be transferred to University Hospital, Coventry, by West Midlands Ambulance Service. There was a Clinical Operating Procedure in place to support that outlined the process in place to support this transfer.

Patients were informed of typical symptoms or conditions that they should bring to the immediate attention of the receptionist when they arrived or while they waited.

The trust shared information with us before our visit.

Incidents

- No pressure ulcers, falls or urinary tract infections were reported in urgent and emergency medicine services from July 2013 to July 2014.
- The trust told us that reported incidents were managed through the trust's significant incident group, which met on a weekly basis to review all serious incidents, monitor ongoing investigations and approve investigation reports. Trust leads for root cause analysis were appointed to manage the investigations, and actions were assigned to address the issues. The urgent and emergency medicine services consultant governance lead, was a member of the significant incident group.
- The trust used a centralised web-based reporting system for staff to report incidents and 'near-misses'.
- Staff we spoke with during our visit confirmed that incidents were raised at the ED board, quality improvement and patient safety (QIPS) and staff meetings, when actions, outcomes and recommendations were discussed. Quarterly summary analyses of incidents and trends were reviewed at the specialty multidisciplinary QIPS meetings.
- There were noticeboards throughout urgent and emergency medicine services identifying the top two incidents; these were also mentioned in the QIPS newsletter, a recent innovation. Both the noticeboard information and the newsletter were updated monthly.
- Qualified staff we spoke with at the RUCC were aware of how to report incidents, but one healthcare assistant we spoke with knew nothing about it.
- Each incident submitted was reviewed and graded by the clinical nurse manager and lead consultant for governance.
- The trust told us that themes of inappropriate transfers and handovers had emerged from incident reporting, and there had been discussion and changes made to address these. The inter-hospital transfer and

communication cases were jointly investigated with the other hospitals involved, with the support of the local clinical commissioning group; joint learning was discussed and actions agreed.

Cleanliness, Infection Control and Hygiene

- The trust shared with us its November 2014 performance dashboard before our inspection. This showed the RUCC, was RAG rated for risk at green status, for MRSA bacteraemia and Clostridium difficile.
- The urgent and emergency medicine services had nominated link nurses and champions for infection control.
- Infection control nursing audits are undertaken monthly in the urgent and emergency medicine services.
- We noted during our visits that the RUCC was a clean environment in which to receive care. The design of the space and the surface materials enabled effective cleaning, and the department was clutter free.
- We observed nursing staff regularly cleaning their hands with the disinfectant gel that was provided in dispensers in multiple locations on the walls around the department.
- Personal protective clothing was readily available and we saw staff wearing it.
- All the staff we saw followed the trust's uniform policy and were 'bare below the elbow'.
- There was a large poster in the reception waiting area about the hand-cleansing charter.
- A board displaying information and instructions on effective hand decontamination was displayed along the staff room corridor.
- We noted a poster on the main door of the RUCC about the risk of Ebola.
- There was an isolation room prepared and ready for use with the appropriate personal protective clothing illustrated on the door. A copy of the trust's infection control policy was nearby. We saw stocks of high-level personal protection equipment and clothing in a cupboard nearby.

Environment and Equipment

- There were treatment cubicles, a triage consulting room and an isolation room. There was a quiet room available.
- There was an equipped resuscitation area.
- The St Cross Hospital site no longer received emergency ambulances because its status had been downgraded in 2013. This was made clear on the exterior signage.
- Staff told us that there was sufficient equipment in the RUCC. We observed that the equipment was in good repair, and regularly checked and serviced.
- We noted that there was sufficient car parking for access to the RUCC.

Medicines

- Any medicine errors were recorded directly using the incident reporting system. We were told by nursing and pharmacy staff trust wide that there was an open culture of reporting medicine errors. These were scrutinised and monitored by pharmacy staff, and then further discussed by the medicine management committee.
- We found the trust had a dedicated pharmacist for urgent and emergency medicine and the trust's pharmacy team carried out audits of drugs.
- We noted that drugs, including controlled drugs, were safely and appropriately stored on the premises at the RUCC. The controlled drugs protocol was followed.
- We noted a chart in the medicines cupboard for paediatric drug dosage.
- We observed an emergency nurse practitioner (ENP) receiving advice from the training mentor ENP on the most appropriate pain medication to prescribe to a child who was being treated.

Records

- The RUCC participated in an annual trust local audit to ensure that documented information relating to the care of patients was completed in accordance with both national and local recommendations. We reviewed two sets of patients' notes in the RUCC and found they were legible, complete and informative.

Safeguarding

- The trust had established systems and processes for child protection and vulnerable adult safeguarding, including mandatory staff training.
- The trust-wide target for compliance with training was 90% for levels 1 and 2 adult safeguarding. We noted that compliance at the time of our visit was 84% for level 1 and 79% for level 2, trust wide.

Urgent and emergency services

- The safeguarding team, trust wide for both sites, consisted of a trust lead for safeguarding, which incorporated the role of the named nurse for safeguarding children. There was also a named nurse for safeguarding vulnerable adults and a named doctor for safeguarding children, as well as the lead clinician for safeguarding adults. There was full-time administrative support for this function.
- Nursing staff in the RUCC were aware of what to do if they had a safeguarding concern. Staff were aware of the trust's policies and procedures.
- We noted a poster in the staff office called 'Know your safeguarding team', with photographs and phone numbers of local authority and trust officers.
- Patient records at the RUCC showed that staff routinely considered the general welfare and safety of a child.
- Local leaders confirmed that safeguarding children training at level one was mandatory. Safeguarding training compliance was reported at 98% for level 2, and 100% at level 3 which met intercollegiate guidance 2014.
- The urgent and emergency medicine services within the trust had an identified link nurse for domestic violence and safeguarding. They attended multi-agency forums and disseminated information to the department. The domestic violence pathway was available on the trust intranet for all staff to consult.
- All staff we spoke with at the RUCC understood their responsibility to escalate any concerns they had about a child or vulnerable adult to senior staff.

Mandatory Training

- The trust gave us data that showed that within the urgent and emergency medicine directorate, the compliance of mandatory training was good: as at January 2015, 87% of staff had completed their training in line with trust policy.
- We noted that information about training sessions on moving and handling, to be held in April 2015, was posted on the staff noticeboard at the RUCC. To prompt staff to sign up, there was also a list of those whose compliance was due to expire.

Assessing and Responding to Patient Risk

- We noted posters in the waiting area telling patients to make the receptionist aware immediately if they had certain symptoms such as chest pain.
- A triage nurse system was in operation.
- Emergency nurse practitioners told us they were supported by the hospital medical team at St Cross, which included an anaesthetist for emergencies.
- A band 7 tissue viability nurse was available.
- The RUCC had a well-equipped resuscitation room that staff told us was used only two or three times each month.
- Staff said that inappropriate patients sometimes attended and the RUCC booked them a transfer to the ED at University Hospital, Coventry. However, this extended the patients' time to treatment.
- Patients could not be referred outside the trust and on occasions this had led to patients self-discharging to re-attend elsewhere. This also extended their time to treatment.
- The RUCC acted as a place of first care for the University Hospital in Coventry. Patients were managed in the RUCC before transfer to the Coventry ED. This added an extra stage to their treatment plan and resulted in double work for the service as a whole.
- The trust had, at the end of 2014 improved the arrangements in place to address the risk of a very sick child arriving at the RUCC where no medical staff trained in paediatrics worked on site. The threshold for transfer arrangements for children was low.
- Although discouraged, any self-presenting paediatric emergency would have to be transferred to University Hospital, Coventry, by West Midlands Ambulance Service. There was a Clinical Operating Procedure in place to support that outlined the process in place to support this transfer.

Nursing Staffing

- Local leaders told us that the RUCC had 21 emergency nurse practitioners (ENPs) at bands 5 to 7 and support from healthcare assistants. They were led by a senior sister and a matron.
- The centre had an average attendance of 60 to 70 patients each day; the maximum recorded was 110.
- We noted on the day of our visit that the duty roster board showed four ENPs on duty for a 12-hour shift through the day led by a senior sister, and one band 7 ENP on duty through the night with a site coordinator. We saw four ENPs on duty.
- The ENPs were supported by healthcare assistants who also undertook the role of receptionist at night.

- The ENPs had no training in paediatrics. However the ENP training mentor on site confirmed that all staff undertook an annual update of advanced paediatric life support training (APLS) as per the RCN standards for that type of service.
- The ENP professional development arrangements were overseen by paediatric and ED consultants within the trust.
- Local leaders told us that the service rarely had to rely on agency staff; staff from the Coventry ED helped out if necessary.

Medical Staffing

- There were no doctors rostered on duty at the RUCC: it was a nurse-led service.
- There was no GP presence except for an out-of hours GP service run by an independent healthcare provider.
- The trust told us that RUCC staff had 24-hour telephone access to consultant advice from the Coventry ED.
- The whiteboard roster near the treatment area showed the named consultants on duty at the Coventry ED. This matched the roster that we had seen in the Coventry ED for that date.
- Although they had no training in paediatrics, there was an informal agreement in place for junior medical staff at St Cross Hospital to assist with any paediatric emergency until the ambulance service arrived to transfer the child to the Coventry ED.
- There was a low threshold for transfer of children to the ED at University Hospital Coventry.
- We noted this issue was on the ED and trust level risk register. The trust had worked with the West Midlands Ambulance Service and achieved agreement in late 2014 that ambulances would respond to a call out for a child from RUCC staff within eight minutes to transfer to Coventry.

Major Incident Awareness and Training

- We noted a major emergency whiteboard displayed on the wall waiting for use, and a copy of the urgent and emergency care directorate policy in the event of a major emergency.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

We found the Rugby urgent care centre (RUCC) services were effective.

Patients' care and treatment were planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.

The trust had established monitoring arrangements in the urgent and emergency medicine directorate to ensure consistency of practice. It had also collected data to show patient outcomes, and contributed to national audits.

Patients' needs were assessed when they arrived. There were arrangements in place to protect patients' rights. Pain relief was addressed.

Staff were qualified, had the skills needed to carry out their roles effectively, and had access to further training and development.

Multidisciplinary working was good within the RUCC and with teams within St Cross.

The RUCC provided a 24-hour, 7-day a week nurse-led service. However, lack of an integral GP service sometimes contributed to a disjointed and untimely care pathway.

Evidence-based Care and Treatment

- The trust told us guidelines were based on local need and practice, and on national best practice guidance from the National Institute for Health and Care Excellence (NICE). These were all available from the e-library on the trust intranet. Staff we spoke with confirmed that they had access to this guidance.
- The urgent and emergency care services had a dedicated clinical audit lead who worked with the clinical audit facilitator to develop and approve the audit programmes and monitor clinical audit performance. This person acted as a champion for clinical audit within their clinical area, setting a culture for clinical improvement and encouraging involvement in clinical audits by staff at all levels working within the specialty.
- Local nursing leaders we spoke with in the RUCC confirmed that they were involved with clinical audit.
- Clinical audit findings were shared via presentation at quality improvement and patient safety (QIPS)

meetings. This allowed the audit results to be debated within the clinical team, lessons learned to be shared, improvements to practice identified and action agreed. Progress against audit action plans was reported at QIPS meetings via quality and patient safety (QPS) reports, and also at specialty quarterly performance reviews.

- We noted that regular QIPS meeting dates were posted on a noticeboard for staff attention in the RUCC.
- The trust had participated in 15 of the 16 national audits undertaken by the Royal College of Emergency Medicine (RCEM) since 2009.
- Since 2012, urgent and emergency care services had participated in three RCEM audits, which included standards relating to pain relief. Two of these were relevant to the RUCC: renal colic and fractured neck of femur. The trust reported to us prior to the inspection that actions in relation to these audits included raising awareness about the importance of re-evaluation of pain in patients with renal colic and fractured neck of femur.
- The trust reported to us prior to the inspection that urgent and emergency care services had shown a general improvement in performance since the 2012 RCEM septic shock audit. Recommendations on how improvements could be made had been summarised as a result of the audit. Actions taken in relation to sepsis included the introduction of, and updates to standardised systems for the identification and management of sepsis including staff training, sepsis champions and a trust-wide sepsis campaign.
- Staff we spoke with confirmed their awareness of sepsis, the sepsis pathway and the over-65 pathway for fracture. They said they had received training on these pathways, which they considered robust.
- There was a training mentor emergency nurse practitioner (ENP) who told us they undertook monthly training events with urgent and emergency care services consultants on, for example, limb injury, abdominal pain and burns.

Care plans and Pathways

- We looked at the patient journey for four patients including a child. Pathways and plans included referral to see a GP, including one at the GP assessment unit at University Hospital, Coventry.
- One patient with a possible fracture had a clinic appointment immediately arranged on site.

Pain Relief

- The trust scored the same as other trusts for the Care Quality Commission A&E survey November 2014, trust wide for both sites. The topics for the questions included pain relief.
- We heard a discussion between two ENPs on the pain management of a child patient they were treating.

Nutrition and Hydration

- The trust scored the same as other trusts for the Care Quality Commission A&E November 2014, trust wide for both sites. The topics for the questions included food and drinks.

Patient Outcomes

- The unplanned re-attendance rate in urgent and emergency care services within 7 days was higher than the England average. The trust told us the local reporting methodology had assessed this indicator to be significantly lower. A review of the data measure and capture process was taking place at the time of our inspection.
- The RUCC acted as a place of first care for the University Hospital, Coventry, ED and this created an extra step in the care pathways for some patients.

Competent Staff

- Emergency Nurse Practitioners (ENP's) can prescribe and administer drugs including intravenous antibiotics and fluids. Nurses were able to read electrocardiograms (ECGs) provide plaster casts and review x-ray film.
- The ENP nurses at the RUCC told us they had an average of 18–20 years' nursing experience.
- There were no paediatrically trained staff at the RUCC but staff told us they had direct contact with Paediatrics at the Coventry Hospital site.
- There was a band 7 training mentor who confirmed that as per 2013 RCN standards the ENP's had advanced paediatric life support (APLS) training and this was updated annually.
- The in house ENP training that was provided by medical staff includes both care of children and adults. The training mentor confirmed there was monthly training for ENP's by ED consultants and this programme was overseen by a lead consultant for training.

- Local leaders confirmed the default threshold to transfer children to the Coventry Hospital site was low but said that a paediatric nurse at RUCC was on their wish list.
- Some ENPs told us the training was not as consistently provided as they had hoped for. Also they had requested some further training in paediatrics from the trust but this was yet to be arranged.
- Local leaders told us that junior medical staff at St Cross were available to the RUCC 24 hours a day, 7 days a week.
- The junior medical staff and anaesthetist at St Cross did not have training in paediatrics. Staff assisting with paediatric anaesthesia must be adequately trained.
- Trust data showed that within the urgent and emergency medicine services, 95.3% of non-medical staff had appraisals conducted in 2014/15. Staff we spoke with during our visit to the RUCC confirmed they had appraisals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a consent to treatment policy, and an information-sharing policy. These policies included the processes for consent, consent refusal, lasting power of attorney's guidance and consent to treatment by children. Information on the use of interpreters was incorporated within the consent policy.
- We noted that consent to treatment was noted in the patients' records that we looked at in the RUCC.
- The safeguarding vulnerable adults' policy contained information relating to mental capacity, consent and Deprivation of Liberty Safeguards (DoLS). Information on how to contact independent mental capacity advocates was also in this policy.
- There was a programme of training dates for the Mental Capacity Act (MCA) 2005, DoLS and mental health to be delivered by staff and the clinical commissioning group, trust wide for both sites.
- The adult mental health team was to deliver one of the sessions in the programme. The agenda also included PREVENT awareness raising. This is a government initiative to provide practical help to prevent people from being drawn into terrorism through radicalisation and ensure they are given appropriate advice and support.
- Staff we spoke with at RUCC confirmed that they had undertaken safeguarding, MCA and DoLS training.
- An urgent and emergency medicine services consultant at the University Hospital, Coventry, showed us some software they had developed with a member of IT to help assess mental capacity. It was due to be launched trust wide within weeks of our visit, initially in the ED at Coventry and then throughout the trust. It had an assessment flow chart within it that gave different outcomes depending on the data inputted.

Multidisciplinary Working

- Senior nurses at the RUCC told us that they had daily contact with the matron at St Cross, and that the ED matron from University Hospital, Coventry, visited the centre once or twice each month. They saw their named urgent and emergency medicine services consultant approximately six times a year.
- ANPs gave us examples of good multidisciplinary working, including with the acute medical team at St Cross.

Seven-Day Services

- **T**he RUCC delivered a service through which patients could access some of the urgent care services they needed. This service was available 24 hours a day, 7 days a week.
- At University Hospital, Coventry, the trust provided a 24-hour, 7-day a week comprehensive emergency service with senior accident and emergency staff, ENPs, a trauma team, operating department technicians, CT scanning, a cardiac arrest team, decontamination facilities and specialist opinion from all major specialties. The RUCC could transfer patients to this service by direct transfer through West Midlands Ambulance Service.
- Consultants were rostered and available to the urgent and emergency medicine services overnight (trust wide for both sites) on site at University Hospital, sleeping in after 1am. Staff at the RUCC had 24-hour phone access to them for advice.
- An out-of-hours GP service was situated within the RUCC and provided by an independent healthcare organisation. Nursing leaders told us that GPs were infrequently on site and they therefore had difficulty getting second opinions.

Mandatory Training

Urgent and emergency services

- In November 2014, trust data showed that urgent and emergency services was RAG-rated green for uptake of the following training: mandatory cardio-pulmonary resuscitation (CPR) (registered nurses), 89%; mandatory CPR (healthcare support workers), 84%; and mandatory handling and moving, 94%.
- Staff we spoke with during our visit to the RUCC told us they were up to date with their mandatory training.
- There was a system in place to identify when mandatory training was due to be updated and refreshed. We saw, for example, lists on the staff noticeboard reminding staff that their compliance with moving and handling training was due to expire, and offering a number of course dates in April 2015.

Access to information

- We noted that all staff had good access to the information they needed to treat and care for patients and carry out their role.
- Information was available in paper from patient's notes and assessments, on the electronic patient care tracking system and through the e library.

Are urgent and emergency services caring?

Good

We found the Rugby urgent care centre (RUCC) services were caring.

Staff at all levels and in all roles were kind and caring to both patients and relatives, and treated them with respect. Feedback from patients about the way staff treated them was very positive.

Patients' privacy and dignity were maintained.

Patients were kept informed and generally given good information about their treatment plans.

There was some provision to support people emotionally and offer them a quiet and private space.

Compassionate Care

- In the Care Quality Commission A&E survey November 2014, the trust was around the national average for both sites on most of the questions (33) and better than average on 2. The questions for this core service were about privacy and length of stay.
- All the staff at the RUCC whom we saw working with patients in different roles were friendly, kind and interested in their patients.
- All the patients and relatives/friends that we spoke with confirmed this, including parents of young children.
- Some toys had been provided in the waiting area to distract children while they were waiting.
- We noted that patients' privacy and dignity were supported when they were being assessed and treated.

Patient Understanding and Involvement

- The trust told us prior to our inspection that urgent and emergency care services users had commented that improvements could be made with regard to communication with patients around treatment, plans and progress. In response, staff had been reminded of the importance of keeping patients and families informed.
- Patients we spoke with told us they were kept well informed.

Emotional Support

- We noted there was a 'quiet' room to give people privacy in the breaking of bad news or if they were distressed, and for providing emotional support to families or friends who may need it.

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

Requires improvement

We found the responsiveness of the Rugby urgent care centre (RUCC) required improvement.

Although valued by the local population, the facilities at the RUCC alleviated some pressures from the University Hospital Coventry site and patients did not always understand the limits on what it offered.

Urgent and emergency services

Access to urgent care and treatment for minor injuries was good, and people generally did not have to wait long.

The service was not functioning effectively with other local services, such as GP services and neighbouring NHS trusts, and this had an impact on its ability to respond to some patients.

Transfer of patients to the emergency department (ED) at University Hospital, Coventry, was not always timely and so extended the patient's care pathway.

We found there was a proactive approach in the ED, trust wide across both sites, to encouraging and learning from patients' complaints.

Service Planning and Delivery to Meet the Needs of Local People

- The RUCC delivered a service whereby patients could access some of the urgent care services they needed. This service was available 24 hours a day, 7 days a week.
- The centre delivered a nurse-led minor injury and illness service.
- There was an independent healthcare provider out-of-hours GP service operating within the building.
- There was no integrated GP service in operation at the centre.
- The Hospital of St Cross lost its accident and emergency department (A&E) status in 2013 and no ambulances were accepted there.
- Patients over the age of 5 attended the RUCC where nursing staff assessed them, and gave advice and treatment.
- Patients were able to have x-rays and blood tests, and a pharmacy was available.
- Direct transfer arrangements with West Midlands Ambulance Service enabled sicker patients to be taken to the University Hospital site at Coventry.
- Advice from the emergency medicine team at the University Hospital ED was available to RUCC staff 24 hours a day, 7 days a week.
- There was a fracture clinic service at St Cross.
- Patients we spoke with said they valued the services at St Cross, including the RUCC.
- The trust shared data with us before the inspection which showed the RUCC had on average between 60 and 70 attendances each day.
- Some staff told us they were concerned that the local population didn't know the difference between an ED and an urgent care service.

Taking account of the needs of individual people

- Information given to us by the trust prior to the inspection described the availability of an e-library that had a wide range of patient information leaflets available for staff to print out and give to patients. Patients could also ask the health information centre via email, phone or face to face to search for further information if needed.
- We noted a good range of leaflets and posters in the waiting area providing information on health-related issues for patients.
- Staff told us there was a psychiatric liaison service available to patients.
- The trust had a contract with a telephone translation service, trust wide at both sites.
- We noted an objective in the trust-wide equality and diversity plan for 2014/15 to consult within the community on how the trust could improve the understanding of staff in front- line services of people with learning disabilities.

Access to timely care

- When we visited the RUCC on a Thursday morning, we found it was not very busy.
- Although the waiting time information posted in the reception area said '1 hour', patients we saw at the RUCC that morning told us they had only waited a few minutes to be seen.
- We noted that one patient who was referred to the fracture clinic on site did not wait long and was returned to the RUCC within 30 minutes with their assessment.
- Staff told us that up to eight referrals a night were made to the University Hospital ED in Coventry. It could take up to 50 minutes for an ambulance to respond if someone presented with chest pain in the middle of the night. All referrals had to be made via the ED doctor's bleep and this could take an hour. If the matter was urgent, the patient would be seen by the medical cover at St Cross.
- Local leaders told us there were between four and five transfers on average each day.

Urgent and emergency services

- Senior leaders told us the length of time that ambulances took to respond to the RUCC depended on whether it was an urgent matter or not.
- The trust kept electronic records and we looked at transfers from 1 February 2015 to 11 March 2015. We noted that on 2 days there were 4 transfers; on all other days there were fewer, and on some days there were none recorded.
- In a sample of five patients transferred during the week before our inspection, records showed that one delay in getting a patient to the ED at University Hospital was caused by staff not being able to get hold of a member of the medical team in Coventry for telephone advice before the decision was made to transfer.
- We noted that paediatric transfer from the RUCC to the University Hospital was identified as a 'red' (high) risk by the trust during May 2014. This was a result of delay in treatment for two unwell children self-presenting at the RUCC.
- Doctors available to assist at St Cross had no paediatric training. This situation remained under negotiation with West Midlands Ambulance Service, who considered St Cross as a place of safety, until it agreed in November 2014 to an 8-minute response time.
- Nursing staff told us that the RUCC potentially saw patients from three local NHS trust areas but could only refer on to the University Hospital in Coventry.
- All attendees were triaged at RUCC before onward referral to more appropriate care. At times this caused unnecessary delay because the patients were triaged again when they arrived at the University Hospital ED or at their own NHS trust ED if they self-discharged from the RUCC.

Complaints Handling and Learning from Feedback

- We noted that information was available for patients on how to raise concerns or make a complaint. Leaflets and the information contained on the website signposted patients and carers to advocacy services and the Parliamentary and Health Service Ombudsman (PHSO).
- There was a large poster in the reception waiting area – 'Did we get it right or could we improve?' – With an invitation to visit the trust's website.
- Senior leaders told us an urgent and emergency care services complaint had been presented to the trust board in 2014/15 as part of the 'patient voices' programme in which actions were discussed. After the complaint, the urgent and emergency care services implemented a system of emergency nurse practitioner (ENP) peer review of notes – a set of notes was identified, randomly and anonymously, for the ENPs to review and reflect on as a group.
- ENPs at the RUCC confirmed that they conducted peer reviews of notes.
- The urgent and emergency care services had a dedicated complaints and Patient Advice and Liaison Service (PALS) officer, and received information on complaints monthly.

Are urgent and emergency services well-led?

Requires improvement

We found the leadership of the Rugby urgent care centre (RUCC) services required improvement.

The trust had no clearly defined vision or strategy for the RUCC. There were few effective joint working arrangements or shared services commissioned.

Local people were not always clear about what the RUCC offered and it could not always respond in an appropriate or timely way to some patients' needs.

Although controlled by the University Hospital, Coventry, emergency department (ED), senior clinical leaders were not sufficiently visible at the RUCC.

Nursing staff collaboration between roles and levels of experience was effective and the service was well-led at a local level. The RUCC operated in an open, friendly and inclusive manner, and staff were happy to work there.

Quality was addressed through the trust's systems and governance structures, and local leaders were involved. Risks were escalated to corporate level when appropriate. Current and future risks were identified but not all were effectively addressed in a timely manner by the trust.

We found a strong focus on continuous learning and improvement for nursing staff.

Vision and Strategy for This Service

- The service had been functioning as an urgent care centre for 18 months before our inspection when it was downgraded from an emergency department (ED).

Urgent and emergency services

- Controlled by the University Hospital, Coventry, ED, there was no specific vision or strategy for the service.
- Patients we spoke with said they valued the services at St Cross including the RUCC.
- Staff told us they were concerned that the local population didn't know the difference between an ED and an urgent care service: "When the unit opened there was a public relations educational drive to inform but there could do with being another one"; "Flyers and efforts were made more with GPs in the Coventry catchment area even though patients from three trusts' catchment areas use this service."
- We noted a number of posters around the entrance to the RUCC giving information on 'Getting the Right Care in Rugby' and advising people to go to Coventry if they had 'a severe illness or injury'.
- Patients could not be referred to a trust ED other than the one at University Hospital, and this led to some patients self-discharging to re-attend somewhere else.
- Although open 24 hours each day and well equipped, staff told us they rarely saw any patients after midnight.
- We observed that the facilities were underused. There was no effective GP input commissioned.
- The plan for two patients who were seen while we were visiting the centre was for them to see a GP.
- There were no formal arrangements with primary care although commissioners locally told us that as part of wider piece of work reviewing out of hours; walk in centre and admission avoidance, this would be taken into account.
- Senior urgent and emergency care services leaders were clear that the RUCC should not be used to alleviate pressure on the ED, "Diverting patients [from Coventry ED] is the wrong thing to do. This is a hospital for Coventry. The RUCC sees 26,000 patients a year and this is not insignificant. These patients would come here [Coventry ED]. We have discussed diverting attenders from here [to RUCC] to take some of the pressure off Coventry but the population of Rugby wouldn't allow it."

Service Improvements in ED

- We had no information from the trust about any planned service improvements in the RUCC.
- Some staff believed that more work needed to be done to inform the local community of the limits of the services on offer at the RUCC.

Governance, Risk Management and Quality Measurement

- The RUCC was part of the trust-wide emergency medicine specialty group led by a senior management team, comprising a clinical director, modern matron and group manager.
- Nursing leaders were part of the monthly emergency department QIPS meeting forum that addressed risk and quality.
- Some risks were specific to the remoteness of the RUCC from the main site of the ED at Coventry.
- For example, all referrals to the ED at University Hospital Coventry had to be made via the ED doctor's bleep. Staff at RUCC told us this could take an hour. If the matter was urgent, the patient would be seen by the medical cover at St Cross Hospital.
- The paediatric transfer policy from RUCC to University Hospital, Coventry, had been identified as a high risk in May 2014, because of a delay in treatment for two unwell children self-presenting at the RUCC.
- It was then closed on the risk register when West Midlands Ambulance Service (WMAS) would not agree to enhance their response time for transfer to Coventry. It was re-opened by the deputy medical director at the end of October 2014 because of the potential for a similar occurrence in the future.
- WMAS agreed to enhance its response rate for paediatric alerts from the RUCC on 7 November 2014.
- This transfer policy was presented at a quality improvement and patient safety (QIPS) meeting and approved as a more acceptable control to reduce the risk than providing paediatric training to junior medical staff at St Cross.

Leadership of Service

- We found that team leadership was strong within the RUCC. The emergency nurse practitioners (ENPs) were experienced nurses who were confident and had good communication with each other and other members of the team.
- Staff were highly motivated and there was good staff morale.
- Staff told us the emergency medicine trust-wide senior leadership was not sufficiently visible at the RUCC nor engaged in developing its future.

Urgent and emergency services

- Senior leaders told us the trust executive team was reactive to crisis within the emergency and urgent care services and not proactive in planning the future effective use of the RUCC.

Culture Within the Department

- Staff told us the RUCC operated in an open, friendly and inclusive manner. There was a learning approach used with respect to complaints, incidents and errors. They all told us they enjoyed working there.
- We noted positive professional interactions between staff at the RUCC, and effective communication with patients and their families including children.

Public and Staff Engagement

- Local leaders told us, "People in Rugby love this hospital."
- Patients told us that they valued the service.
- Staff told us that the public were not clear about the function of the RUCC.
- The trust told us in information submitted prior to our inspection that public engagement was encouraged through feedback cards, the NHS Friends and Family Test, and the trust's 'impressions survey'. We saw no evidence of the Friends and Family Test in use at the RUCC as, in line with national FFT guidance, it was not required to be collected in urgent care centres until April 2015.
- The trust told us that the emergency medicine QIPS meetings were open to all staff, and that medical and nursing groups had information and feedback meetings.
- The trust had held a number of listening events for staff in April and May 2014 to get the views of staff on their thoughts about achieving the 'world class services' programme. Staff were also asked to volunteer themselves to be 'Change Makers' for the programme.

Innovation, Improvement and Sustainability

- The emergency and urgent care department trust wide had recently employed a research nurse. There were several portfolio trials underway at the time of our inspection.
- The department had collaborated with the IT services within the trust to develop software to help assess mental capacity. It was initially to be launched in the ED at the University Hospital Coventry and then rolled out across the trust if it worked effectively.

Medical care (including older people's care)

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

Information about the service

University Hospitals Coventry and Warwickshire NHS Trust is one of the UK's largest teaching trusts. The trust provides local acute hospital services to 1,000,000 people from Coventry and Warwickshire. The two main hospital sites are University Hospital in Coventry and the Hospital of St Cross in Rugby.

The Hospital of St Cross in Rugby has 132 beds. Hoskyn ward had 25 sub-acute medical beds and 44 rehabilitation beds, Cedar ward had 41 inpatient orthopaedic beds and 22 day surgery beds and provides a range of services to the population of Rugby, as well as additional capacity for elective surgery, in patient care and rehabilitation. It provides Magnetic resonance imaging (MRI) and computerised tomography (CT) scanning within its radiology services.

Patients from Rugby, who have completed their initial care at University Hospital, Coventry, are repatriated to St Cross to conclude their clinical care. Hoskyn ward also received GP direct admissions. Rehabilitation is provided within the Mulberry Unit and Oak Ward. The wards are supported by physiotherapists, occupational therapists, dieticians, audiologists and speech and language therapists from the team based at St Cross. Cardiac Rehabilitation is available at St Cross to all patients who have recently undergone treatment for a heart attack, angina, heart failure and heart surgery. The Hospital of St Cross in Rugby provides a range of services by offering local access for the population of Rugby, as well as additional capacity for elective surgery, in-patient care, and rehabilitation.

We inspected Hoskyn and Mulberry Wards. We spoke with 11 patients, four family member's and18 staff members; including clinical leads, service managers and ward staff. We observed interactions between patients and staff, inspected the environment on both wards, looked at 13 care records and attended a handover. We reviewed other documentation from stakeholders and performance information from the trust.

Medical care (including older people's care)

Summary of findings

Medical care services at this hospital required improvement in some aspects of patient safety. Concerns were identified about nursing staffing levels, monitoring and management of equipment and safe storage of medicines. The trust infection rates were lower than average for clostridium difficile (C.diff) aside from a small rise between November 2013 and January 2014. The trust had a zero rating for Methicillin Resistant Staphylococcus Aureus (MRSA) at St Cross hospital. The records showed the trust had reported seven incidents for the period April 2013 to November 2014. We saw the environment was clean. Patients whose condition deteriorated were appropriately escalated. The trust took action to promote harm-free care.

There were appropriate procedures to provide effective and responsive care. Care was provided in line with national best practice guidance. Training and professional arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. Patients had access to services 7 days a week and were cared for by a multidisciplinary team working in a coordinated way. When patients lacked capacity to make decisions for themselves staff acted in accordance with legal requirements.

Staff had received training and demonstrated awareness of the Mental Capacity Act2005 and the Deprivation of Liberty Safeguards (DoLS) but some were unaware of the recent changes to DoLS.

Patients told us that staff treated them in a caring and compassionate way. However, we found that the records did not always identify patient's involvement in the treatment received. We saw patients were treated with dignity and respect.

Services were developed to meet the needs of the local population.. St Cross Hospital did not receive direct admissions with the exception of a limited number of GP admissions. There was specific care plans for patients with dementia and other mental health conditions. Arrangements were in place to meet the needs of patients with complex needs, including appropriate discharge arrangements.

Governance arrangements were effective and staff felt supported by division and trust management. The culture within medical services was caring and supportive. Staff were actively engaged and the division supported innovation in clinical practice and professional development.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Medical services at the hospital of St Cross required improvement for safety. Incidents were reported, but the learning from incidents was not always shared among the staff. There was a shortage of nursing staff on all the medical wards. Although the trust was using a high number of agency and bank nurses, they did have a good induction to the wards. Medical staffing, particularly consultant-level cover for emergency care, was appropriate.

Patients were appropriately escalated if their condition deteriorated. Equipment was not checked regularly. For example, we found gaps in checks of resuscitation equipment on some medical wards. Medicines were not stored appropriately. Medicines were not stored appropriately. During our unannounced inspection we found the temperature levels in the areas where medicines were stored, on Hoskyn, Mulberry and Oak Wards to be above the acceptable levels. This resulted in the on-call pharmacist deciding to quarantine the treatment areas by restricting the use of these rooms. Patients current medicines were destroyed and new medicines were delivered to an allocated room whose temperature had been checked to ensure it was within the accepted levels.

Action was being taken to promote harm-free care and reduce the incidence of avoidable harms such as falls and pressure ulcers. As part of the Commissioning for Quality and Innovations payment framework, the trust had to keep the incidences of hospital acquired pressure ulcers to 0.5% or below and a reduction of below 3% for falls. The records showed that the Hospital at St Cross had achieved both of these.

The trust's infection rates for Clostridium difficile were low. On the day of our visit to Mulberry ward, one bay was closed due to the contamination of Clostridium difficile. Appropriate guidance was in place to prevent entry to the bay. The trust had a zero rating for MRSA. The records showed that St Cross had obtained a zero rating for MRSA. The environment was clean and staff followed the trust's infection control policy. We observed staff regularly washing their hands after attending the patients. Staff had access to the use of personal protective equipment such as gloves and aprons.

Staff had good knowledge about safeguarding of patients and were aware of the procedures for managing major incidents, winter pressures and fire safety incidents.

Incidents

- We saw information about a recent never event on display in the staff room that involved a wrong implant/ prosthesis in the orthopaedic speciality. A Never Event is a mistake that is so serious that it should never happen. Staff said the information regarding never events were not routinely shared.
- Staff said they knew how to report an incident. However, staff said they did not always report incidents of challenging behaviour or physical abuse by patients such as kicks and bites. Staff said that it would make little difference and felt they were discouraged by the clinical leaders. Some staff reported limited access to computers because of their use by doctors. However, during our visit we observed computers being freely available for nursing staff to use.
- Staff said that investigations, root cause analysis took place and action plans were developed, when required, to reduce the risk of a similar incident reoccurring. For example, in response to a high number of incidents relating to pressure ulcers, the trust had introduced intentional rounding (where nursing and health care assistant staff regularly checks on patients every two hours) on all the medical and care of elderly wards. We saw evidence of this in place during our visit to St Cross Hospital.
- The trust had robust systems and processes for Central Alerting System (CAS) alerts. CAS is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance. Medicine care groups received CAS alerts from the trust's central source. The health and safety lead nurse logged these alerts on a data-base and took specified action, for example, they provided all the ward managers with clear updates. Each ward manager detailed the actions required regarding the alert and any outcomes for their ward in response.

Safety Thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harms that includes new pressure ulcers, catheter-related urinary tract infections, venous thromboembolism, and falls.

Medical care (including older people's care)

- NHS Safety Thermometer information was displayed at the entrance to each ward so that all staff were aware of the performance in their ward or department.
- For medical services, rates of all grades of pressure ulcers and catheter-related urinary tract infections remained consistently low. For example, the incidence of catheter-related urinary tract infections was at zero, except in October when it was 0.6 per 100 patients surveyed. Pressure ulcers stayed at 0.5 per 100 patients surveyed.
- Falls had remained low throughout July 2013 to July 2014 with none reported from November 2013 to January 2014. There was a small rise between March and May 2014 of 0.4 per 100 patients surveyed. We saw there was a steady decrease thereafter.
- In response to the number of falls, the trust had developed a 'falls care bundle' for all patients identified as being at risk of falls. This included early identification by using a 'Falls Risk Assessment Tool' and developing comprehensive action plans. We found that patients at high risk of falls were clearly identified and actions were taken to minimise risks, whenever possible, including the use of low-level beds.

Cleanliness, infection control and hygiene

- We saw care environments were clean and well maintained. All of the wards we visited were clean and cleaning schedules were clearly displayed on the wards. Equipment was cleaned and was marked as ready for use with 'I am clean' labels.
- Staff followed the trust's infection control policy. Staff were "bare below the elbow" meaning that staff in contact with patients could wash their hands and wrists effectively without the restrictions of cuffs, watches and jewellery. Staff had access to personal protective equipment such as aprons and gloves.
- Instructions and advice on infection control were displayed in the ward entrances for patients and visitors.
- On the day of our visit to Mulberry Ward, two bays were closed to admittance due to the contamination of diarrhoea and vomiting and Clostridium difficile. We saw appropriate instructions within the ward preventing entry to these bays. The ward had allocated dedicated nurses to attend to these patients' needs.
- Staff followed the trust's policy on infection control, demonstrating their awareness of the policy. During our visits we observed staff washing their hands and using hand gel between patients. There was adherence to 'bare below the elbow' policy in clinical areas.
- We observed four patients' blood being taken and cross infection procedures were being followed.
- In each ward area, staff had audited performance on adherence to infection prevention and control measures. Reports were shared with staff at meetings and on noticeboards.
- Although the trust had seven cases of MRSA recorded from April 2013 to November 2014 none, of these involved the hospital of St Cross. The records viewed showed that patients had been fully screened for hospital-acquired infections before being transferred to the hospital..

Environment and equipment

- Each ward area had sufficient moving and handling equipment to enable patients to be cared for safely. Equipment was maintained and checked regularly to ensure it continued to be safe to use. The equipment was clearly labelled stating the date when the next service was due.
- We inspected two resuscitation trolleys on Hoskyn Ward. They were centrally located and clean, and the defibrillators had been serviced. We found that staff had not documented daily equipment testing for these trolleys to ensure equipment was fit-for-purpose.
- One resuscitation trolley we checked had out-of-date equipment including a laryngeal mask airway for which the use by date had expired, while the other had items that should not have been on the trolley for example; patient glasses. We reported this to nursing staff who removed the equipment.
- We found a door from the ward into a dialysis room that had no lock. We entered this room unchallenged by staff and had access to equipment such as syringes and Niprocart (bicarbonate powder for haemodialysis). This meant that equipment such as syringes and dressing packs were not stored safely and securely to prevent theft, damage or misuse.
- We found an open equipment store room on Hoskyn Ward. This meant that equipment such as syringes and dressing packs were not stored safely and securely to prevent theft, damage or misuse.

- We found out-of-date equipment including an arterial leader catheter and syringe and Terumo needles. These were dated 2012 and 2014 respectively. We reported these to nursing staff, who disposed of the equipment and reported that there was no formal system in place to check equipment regularly.
- Staff told us they made requests to an external company for equipment for example; mattresses and pressure reliving cushions. Staff said the company responded quickly and efficiently to their request with no delays identified. We saw sufficient equipment on the wards to maintain safe and effective care.
- Adequate storage space was a problem on Hoskyn Ward which made the area look cluttered.
- The trust used blue pillowcases to identify dementia patients. Some staff there could be difficulties in obtaining blue pillowcases. However, during our visit we observed patients, with a diagnosis of dementia, had blue pillowcases allocated.

Medicines

- A pharmacist visited all wards at St Cross each weekday.
- The medicines refrigerator on Hoskyn Ward showed that the temperature was recorded daily and was within the required range.
- We found medical solution in the sepsis box that had expired in 2014 which we reported to nursing staff who disposed of it. Nursing staff reported that there were no formal systems in place to check the box regularly.
- We found oral nutritional supplements and a cake that had exceeded their use by dates in the ward kitchen. This put patients at risk of consuming products that were out of date.
- The temperature of the treatment rooms was discussed with the chief pharmacist during the announced inspection. During our unannounced visit we found the treatment room on Hoskyn Ward, where medicines including antibiotics, controlled drugs and intravenous fluids were stored, had a recorded temperature of 27.3ºC. The treatment room on Mulberry Ward was at 24.2ºC and on Oak Ward was 25.6ºC. This meant staff could not ensure medicines had been stored safely which could put patients at risk.
- We reported this to the nurse coordinator who contacted the on-call pharmacy. This resulted in the pharmacist deciding to quarantine the treatment areas by restricting the use of these rooms. Patients' current medicines were destroyed and new medicines delivered. Arrangements were made for medicines to be obtained from the University Hospital Coventry as an initial strategy to overcome the issue. The medicines were delivered to an allocated room whose temperature had been checked to ensure it was within the accepted levels. The ºinformation provided outlined that the medicines were transferred to St Cross by taxi. We did not see evidence of a risk assessment for the transportation of a large amount of medicines to ensure their safe keeping during transport.
- Guidance was subsequently received from the director of pharmacy regarding the clinical rooms and the actions taken. As an immediate response to the temperature deviations seen at St Cross, air conditioning units and temperature probes were put in place. Ward staff have been asked to monitor these probes daily and record temperatures.
- A general risk assessment was created for the storage of medicines temperature control.
- We reviewed the medicine administration records (MAR) and found that one patient's medicines may not have been administered on 28 March 2015. Another patient's record stated the administration of medicines six times a day; we found that they had been given the medicines five times a day since 27 March 2015, but four times for the previous days. We found no evidence that the medicines had been reviewed with the required daily amount amended. We observed that one patient's medicines had been pre-signed. We reported these to nursing staff who said they would complete the necessary incident reports.

Records

- We looked at 12 patients records. We saw that three of these records had the patient's surname recorded with no hospital number or date of birth. Records were in both paper and electronic format. We saw the records were stored safely and securely.
- The patients' records were completed with clear dates, times and designation of the person documenting. The records had appropriate risk assessments for patients at risk of pressure ulcers or falls.
- Staff did various checks on patients such as comfort checks, hydration, nutrition, continence, equipment, positioning, mobility and skin survey. Patient records showed that not all of these checks were carried out in accordance with trust policy. Comfort rounds were due to be undertaken every 2 hours. This included change of

position and pressure area care as required. The documentation for these rounds did not consistently record all aspects of the care provided. We saw that one patient's intentional rounding had not been recorded for five and a half hours before we assessed their care plan.
- A patient transfer checklist was completed for all patients transferred internally; this information was filed in the patient's notes. We saw a checklist that had been completed, which included information to ensure they continued to receive appropriate care and minimise any risks.
- We found the daily fluids balance records were not totalled up in the records we read. This meant that staff caring for these patients could not identify adequate hydration and report any abnormalities in patients' fluid documented recordings.
- The medical records identified that patients were reviewed regularly by medical consultants and junior doctors.
- Patient information and records were available alongside the nurses' station. However, we found that the storage arrangements for these were not secure. This meant they were easily accessible to others visiting the wards.

Safeguarding

- The ward manager on Mulberry Ward said the trust had a rolling programme to ensure staff kept up to date with their Deprivation of Liberty Safeguarding (DoLS) training. The trust's quality account for 2013-14 had a training strategy in place to achieve 90% compliance for 2014/15.
- Adult safeguarding training was delivered at level 1 through the induction package with refresher training every three years. Staff received children safeguarding training at level 2. Updates were available on-line or at face-to-face sessions. The training records within the wards visited identified that both medical and nursing staff had attended safeguarding training. We saw that staff had achieved 100% for level 1 and 80% for level 2.
- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns.

Mandatory training

- Staff were aware of the need to attend mandatory training in issues, for example in moving and handling and safeguarding. They told us most of their training was up to date and they were sent reminders by e-mail of any outstanding training.
- The records showed that compliance with mandatory training was variable across the wards and ranged between 68% and 100%. Areas of additional training provided included information governance updates, conflict resolution and infection control.
- Ward managers kept good records of the training needs of staff, and were prompted by personnel department reports regarding completion and performance.
- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling and hand hygiene. The ward manager on Mulberry Ward said staff had access to the education centre's computers, which was located within the hospital grounds, to complete their e-learning training.
- The trust had a 10 minute power training available for staff on "FOCUS ON FIVE – A.S.K.I.N (Access, Surface, Keep Moving, Incontinence and Nutrition). This was provided at a time that suited the demands of the wards. We saw posters and processes on display on the FOCUS training within the wards we visited.
- Staff felt that they needed appropriate prevention and management of aggression training to support them to care for patients with complex needs and displaying challenging behaviour
- Occasionally training was cancelled because of staffing shortages, but staff were given a choice of how they completed their annual mandatory training, such as, e-learning, face-to-face and ad-hoc sessions for practical sessions.

Assessing and responding to patient risk

- Risk assessments were undertaken for individual patients in relation to venous thromboembolism, falls, malnutrition and pressure sores. These were documented in the patient's records and included actions to mitigate the risks identified.
- We saw one patient's records that identified them as being aggressive and abusive towards staff. However, there was no behavioural care plan in place for the patient concerned.

Medical care (including older people's care)

- There were clear strategies for minimising the risk of patient falls. Staff on the wards demonstrated a good understanding of the causes of falls and how to avoid the.
- The medical wards used the National Early Warning Score (NEWS). This is a scoring system that identifies patients at risk of deterioration or needing urgent review. Medical and nursing staff told us they were aware of the appropriate action to be taken if patients scored higher than expected.
- The trust had replaced the paper-based observation system with the Vital PAC recording system. This touch screen technology enabled quick and reliable recording of observations and automated EWS calculations at the bedside. If a patient's deterioration was detected, an urgent alert was generated to enable appropriate escalations to be made to duty clinicians and hospital-wide teams.
- Nursing staff felt well supported by doctors when a patient's deterioration resulted in an emergency.
- There was a bed management system that aimed to ensure patients' needs were met when there was an increased demand on beds.

Nursing staffing

- Nursing numbers were assessed using the national safer nursing care tool and there were identified minimum staffing levels. The safe staffing levels were displayed at the entrance of every ward, including planned and actual numbers.
- Staff told us the optimum/agreed ratio for nursing staff was one staff member to eight patients. On the day of our unannounced visit to Hoskyn Ward, the ratio was one staff member to ten patients.
- All staff we spoke with, from the management team to health-care assistants, recognised nursing recruitment as a major safety risk to the service. It was captured on the directorate risk register. The management team told of various measures, such as open recruitment days and overseas recruitment initiatives, they had put in place in an effort to decrease the vacancy factor. All ward-based staff were aware of these initiatives and were supportive of them. There was general agreement that recruitment and retention of nursing staff was seen as a priority by the trust.
- When shortfalls in nursing numbers were identified temporary staff from the National Healthcare service Professionals or an agency were used to ensure that there were adequate numbers of registered nurses to meet patients' needs.
- Some staff said they felt stressed because of the shortage of staff and having to deal with the complexity of patients admitted.
- During our unannounced visit on 29 March 2015 we found the nursing staffing levels were not met at Hoskyn ward. The Ward was one nurse staff down and had also borrowed a staff member from another ward to ensure adequate staffing levels. Staff felt that these staffing levels were "inadequate" and "unsafe" for the patients
- Patients told us the staff and the wards were busy but the nursing staff looked after them well and they did not have to wait long for help or care.
- The nursing handovers which we observed were good. There was a thorough discussion of each patient, which included information about their progress and potential concerns.

Medical staffing

- Staff told us there were sufficient consultants and doctors on the wards during the week. Junior doctors felt there were adequate numbers of doctors on the wards.
- Out of hours there was a senior house officer on site and a consultant on call.
- Consultant ward rounds took place daily. During the day all new patients were seen by a consultant after their admission.
- Handovers were consistently formal and structured. During our announced visit we observed a medical handover. The handover covered care of patients based on the severity of their condition and any anticipated problems.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents, winter pressures on bed capacity and fire safety incidents.
- Emergency plans and evacuation procedures were in place and on display. Staff were trained in how to respond to major incidents.

Are medical care services effective?

Medical care (including older people's care)

Good

The service demonstrated that care was provided in accordance with evidence-based national guidance. National guidelines and pathways were used extensively, to ensure that best practice in patient' care was followed. Policies and procedures were accessible for staff and they were able to guide us to the relevant information. Care was monitored to demonstrate compliance with standards and there were good outcomes for patients.

There were arrangements for ensuring patients received timely pain relief. Patients at risk of malnutrition or dehydration were risk assessed by appropriately trained and competent staff and referrals to and assessments by dieticians or speech and language therapists were made within expected timescales. Staff had access to specialist training but clinical supervision was not embedded.

Multidisciplinary working was evident to coordinate patient care. Overall, staff had access to training and had received regular supervision and annual appraisal.. Staff received a good level of training and this included training to support people living with dementia.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) but some were unaware of the recent changes to DoLS. The education team confirmed they were continuing to roll out the training in relation to MCA and DoLS.

Evidence-based care and treatment

- The medical services participated in all national clinical audits that it was required to. The directorate had a formal clinical audit programme in which compliance with NICE guidance was assessed and the areas that had partial compliance were reviewed and action plans were made.
- There were care pathways based on NICE guidance for stroke, heart failure, diabetes and respiratory conditions. The trust had a pathway for patients with sepsis to enable early recognition, prompt treatment and clinical stabilisation.
- Local policies such as the pressure ulcer prevention and management policies were written in line with national guidance and staff we spoke with were aware of these policies. The trust launched the "100 days free from pressure ulcer" initiative. Each ward and department was given a target of 100 days without a pressure ulcer. Particular emphasis was placed on nursing and therapy staff that had a direct role in assessing risk factors and repositioning patients.
- The records showed that both Hoskyn and Mulberry Wards had achieved over 300 days free of pressure ulcers.
- We saw completed catheter and cannula audits which showed that both Hoskyn and Mulberry Wards were 100% compliant.
- The Infection Control Nurses Association (ICNA) audit had been completed with no issues or concerns identified. The ICNA audit tool is used to monitor infection control guidelines. The records seen provided objective data on compliance with trust policies.
- We spoke with two therapists who confirmed they did not use a recovery model to support patients with their goal planning and recovery. They said they updated patients' records with their achievements. However, we did not find achievements identified in the patient' records we read. The therapists said they did not measure the outcomes of patient's achieving their goals.
- The records read had generic care plans that were not person centred. The records did not identify the patients' or their carers/relatives' involvement with the care plans. None of the care plans read had been signed by the patient or their carer/relative.
- We saw a patient's best interest plan of care which required mild restraint. However, we did not find a care plan to support staff if they needed to use restraint. This meant that staff were unaware of how to support patients if they required restraint.

Pain relief

- Patients were asked before their operations for their preference regarding pain relief.
- The Vital PAC records showed that patients' pain relief had been risk assessed using the pain scale found within the early warning score system.
- Patients told us they were given pain relief when they needed it and nursing staff always checked if it had been effective.
- Staff could access support from the pain management team when required.
- The ward had access to the Macmillan team for pain management support when required

Medical care (including older people's care)

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration when applicable. We observed that fluid balance charts were used to monitor patients' hydration status. However, the records seen for both wards did not include the totals for ease of information to staff reviewing the MUST tool. We found one patient on Hoskyn Ward who had a MUST assessment completed with an outcome to refer to a dietician. We found no evidence within 8 days after the assessment that a referral had been made.
- Patients had access to drinks by their bedside. Care support staff checked that regular drinks were taken when required.
- The patients said they were given choices for food and snacks. However, they gave mixed views regarding the quality of the food available.
- Staff said they monitored patients' nutritional state and when required would make a referral to the dietician. We saw evidence of a referral to the dietician in the records we read.
- The wards we visited had an at a glance board that provided an overview of the patients. Areas identified included support with feeding and if the patient was diabetic.
- The wards had introduced protected time when visiting was not allowed. This was during meal times. However, during our inspection we observed visitors on wards during these times. When we spoke to visitors, they told us they came during lunch time to support their relative to eat. The visitors told us that they were concerned about how much assistance was provided for patients to drink and reported that they often visited their relative and saw that hot drinks left on the bedside table had turned cold.
- Cold snacks were available for patients outside of meal times.
- A catering assistant said they used a "cook chill" system and that patients were able to choose their lunch and evening meals the previous day. They were able to access texture-modified food and meals suitable for different cultures such as Halal food.
- There were 'red trays' to identify patients who needed support with eating. We observed one patient with a red tray being supported by staff. When we asked two members of staff on the ward what the red tray system meant, they were able to tell us.

Patient outcomes

- Patients receiving stroke rehabilitation at St Cross Hospital were not being included in the Sentinel Stroke National Audit Programme (SNNAP) audit at the time of inspection. The trust told us they plan to do this from March 2015
- We saw the risk of readmission for the Hospital of St Cross hospital was within expected range and compared favourably with the England average, except for general medicine and gastroenterology. It was deemed a risk when over 100 patients had been readmitted. We saw general surgery figures at 173 and 131 for gastroenterology.

Competent staff

- Staff told us they did not receive formal supervision but felt that handovers, ward rounds and board rounds provided them with learning opportunities.
- The records for 2014 showed that 89% of staff had received their annual appraisal. This was slightly higher than the England average of 85%.
- The ward manager said staff had access to a Parkinson's nurse when required and had identified Parkinson training for the ward staff to ensure appropriate support for patients with a diagnosis of Parkinson disease.
- Care of the elderly had regular input from a dementia specialist nurse. Most staff on the wards had attended dementia training. A number of staff on the medical wards we visited were trained to be dementia champions. We saw the trust had extended the dementia training programme to June 2015.
- New members of staff told us that they had been well supported since joining the hospital. They had completed a trust-wide induction programme. The nursing staff had also been supernumerary on the ward for a couple of weeks, giving them an opportunity to understand processes and procedures.

Multidisciplinary working

Medical care (including older people's care)

- We observed a multidisciplinary team approach in the ward areas we visited. During our visit to Hoskyn Ward we observed a good working relationship with the diabetic nurse, speech and language therapist and chiropodist who were visiting the ward.
- Doctors and nursing staff told us nurses and doctors worked well together within the medical speciality. We saw evidence of this on the wards we visited.
- Speech and language therapists attended the wards as required and patients were also referred to clinical psychologists if necessary. We saw evidence of this in the records we read.
- Patients' records across medical services showed patients were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.
- There was dedicated pharmacy support on all the wards we visited.
- On the medical wards we visited, patients with dementia were assessed and reviewed by dementia specialist nurses and a dementia care pathway was used for treatment.

Seven-day services

- On all the wards we visited, consultant ward rounds took place daily. Over the weekend, all new and deteriorating patients were seen by the duty doctor.
- Staff had access to on-call pharmacists to dispense urgent medications at weekends and out of hours.
- The medical services had access to a consultant over the weekend if required.

Access to information

- Staff told us they had good access to patient related information and records whenever required. Agency and locum staff also had access to the information in care records to enable them to care for patients appropriately.
- Nursing staff told us that when patients were transferred between wards, staff teams received a handover of the patient's medical condition. We saw that ongoing care information was shared appropriately in a timely way.
- Discharge summaries were provided to GPs to inform them of the patient's medical condition and the treatment they had received before discharge.
- The trust used the Vital PAC system to record the vital signs of patients and monitor early warning score recognition. We saw this in use by the nursing staff. This was seen as vital to ensuring patient safety on the wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with had awareness of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). This meant the trust had ensured that decisions about the care and treatment arrangements of a person without capacity did not amount to a deprivation of their liberty. The ward manager on Mulberry Ward confirmed the trust was rolling out training in relation to the MCA and DoLS.
- Patients were asked for their consent to procedures appropriately and correctly. We saw examples of patients who did not have capacity to consent and the MCA was adhered to appropriately with documented capacity assessments.
- The records, when applicable, showed clear evidence of informed consent that identified the possible risks and benefits of care.
- When patients did not have capacity to consent, staff said they would apply for best interest decisions in deciding the treatment and care patients required.
- Ward staff were clear about their roles and responsibilities regarding the MCA.

Are medical care services caring?

Good

Staff were caring and compassionate to patients needs and treated patients with dignity and respect. Patients told us that staff treated them in a caring way, and were flexible in their support to enable patients to access services.

Patients said they were kept informed and felt involved in the treatment they received. Emotional support for patients was exceptional according to relatives. For example, the trauma and orthopaedic ward had met the needs of a patient by allowing their family member to stay overnight.

Medical care (including older people's care)

Staff were focused on the needs of patients and improving services for patients. Patients and relatives we spoke with said they felt involved in care and treatment and were full of praise for the staff.

Compassionate care

- We observed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- We observed many examples of caring and compassionate care that was provided even when staff were under pressure. There was a culture of caring.
- The patients and relatives we spoke with were pleased with the care provided. They told us doctors, nurses and healthcare assistants were caring, compassionate, and responded quickly to their needs.
- We observed doctors doing ward rounds and saw that doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- Results of the NHS Friends and Family Test were displayed on every ward, and posters encouraged patients to give feedback so that the care provided could be improved. Overall these results showed satisfaction with the service provided. Between April 2013 and July 2014, 74% of patients on Hoskyn Ward and 86% on Mulberry Ward were 'extremely likely' to recommend the trust to family and friends.

Understanding and involvement of patients and those close to them

- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns in regards to the way they had been spoken to. All were very complimentary about the way in which they had been treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients about the care and treatment options.
- Generic care plans were in place. These were not person-centred and there was no documented record of patients and/or their relatives/carers participation and involvement with their care plans.

Emotional support

- During our inspection we observed that staff were responsive to patients' needs, and we saw episodes of kindness from motivated staff towards patients and their relatives.
- The hospital chaplaincy was available within the hospital and was happy to meet people to offer them support.

Are medical care services responsive?

Good

The responsiveness of medical services was good.

The ward managers said that timely discharge planning was sometimes an area of concern across the hospital. They said the aim was to discharge patients within 14 days. The white board identified that most patients' date of discharge had been estimated and was within the 14 days.

The acute care and clinical staff were investigating delays in discharge and the actions needed to promote appropriate discharge. The average length of stay at the Hospital of St Cross had improved, and we saw the speciality groupings were consistently meeting their length of stay targets.

Staff said they were able to support vulnerable people when required. This included people with dementia and mental health problems. During our visit we observed three patients with a diagnosis of dementia being supported by family members. Relatives said they appreciated the flexibility of visiting hours, which could "fit around their work".

Information leaflets were on display outside the ward areas. Staff said leaflets could be requested in different languages or formats. Patients reported that they were satisfied with how complaints were dealt with.

Service planning and delivery to meet the needs of local people

- The wards at the Hospital of St. Cross received their patients from the University Hospital, Coventry and GP direct admissions.

- The wards had processes in place for escorting patients, for example, x-ray. Patients were supported by the porter service, a health care assistant and a qualified nurse if required. Staff said arrangements were made to cover the ward in the absence of a qualified nurse.
- The ward managers said that timely discharge planning was sometimes an area of concern across the hospital. They said the aim was to discharge patients within 14 days. The white board identified that most patients' 'date of discharge had been estimated' and was within the 14 days.
- The clinical staff were assisting acute care by looking at delays in discharge and the actions needed to facilitate discharge. We saw this was identified in the quality strategy report.
- We were informed that discharge planning started soon after admission. However, it was difficult to identify the start of a patient's discharge planning inside the records we read because they were incorporated within several records. We found no reference to the discharge planning within the records' index.
- Discharge was sometimes delayed because of a lack of suitable accommodation for people to move on to or funding for specialist placements.
- The trust had introduced ward boards to identify the estimated date of discharge of patients. We saw this in use and observed a board meeting to discuss patients and their estimated date of discharge. The ward board also identified if a Section 2 (request for assessment) had been made to the social services team.
- The wards visited accommodated dementia patients. We did not observe dementia-friendly designs within the wards, such as, pictorial signage. However, they did have dementia clocks in all bays and there was pictorial signage available within all toilets.

Access and flow

- The risk assessments and documentation for medical patients were transferred and reviewed on the wards in a timely manner. Staff tried not to transfer these patients to a different ward unless clinically indicated.
- Bed pressures were compounded by high numbers of delayed transfers of care. Delayed transfer of care is when patients are in hospital and are fit to be discharged but are unable to leave the hospital because of external factors. The data provided by the trust demonstrated that between March 2013 and November 2014, there were an increasing number of delayed transfers of care. On our visit to the Hospital of St Cross we saw two patients who had been on the ward for 27 and 32 days respectively. Staff said the patients were waiting for a package of care, for example, placement within a residential care home or alterations to their home. This was confirmed in the records we read.
- We saw the average length of stay at the Hospital of St Cross hospital was, in the majority of areas, equal to or better than the England average. The exception was general medicine which showed a significant variance to the England average of over 32 days.

Meeting people's individual needs

- There was an arrangement with the local NHS mental health services to provide a liaison psychiatry service for people with learning disabilities and mental health disorders. Staff were able to access support and advice from a learning disability nurse for individual patients and there was relevant information and tools on the trust's intranet system.
- The trust had introduced a 'This is me' booklet for patients with dementia, which had been developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. We saw that there was inconsistency in its use on the wards we visited. In the records we read only one patient of the five patients with a diagnosis of dementia had the booklet completed. A 'forget-me-not' symbol and a blue pillowcase was used to identify people living with dementia on all the medical wards.
- Outside Hoskyn Ward there was a bluebell lounge which was designed for use by patients with dementia. The lounge had a radio, table and chairs and games for patients to enjoy. However, the lounge was located off the ward and a nurse told us that it was rarely used because there were not enough staff to care for patients in the room and the main ward.
- A wide range of patient literature was displayed in clinical areas covering disease and procedure specific information, health advice and general information relating to health and social care, and services available locally. Patient information leaflets were not displayed in languages other than English.
- Patients' diverse needs such as religion and ethnicity were recorded and we saw these were being met, for example through meals suitable for religious needs and access to religious services.

- There was adaptive cutlery to help patients with dexterity problems.
- There was a relative's room where people could stay overnight to be close to their loved ones. Nursing staff told us the room was rarely used.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Staff directed patients to Patient Advice and Liaison Services (PALS) services if they were unable to deal with their concerns directly and advised them to make a formal complaint. The Hospital of St Cross had no PALS office so people with complaints were given a Freephone number for this service.
- Literature and posters were displayed advising patients and their families how they could raise a concern or complaint, formally or informally.
- When patient experiences were identified as poor, action was taken to improve their experiences. For example, staff caring for the elderly explained how they had responded to a higher than expected number of patient falls. Risk assessments were in place and these identified the actions to be taken to minimise the high risk of falls.
- Staff told us that the ward sisters investigated complaints and gave them feedback about complaints in which they were involved.
- Patients felt they would know how to complain to the hospital if they needed to.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement because:

There were no processes and procedures in place to ensure equipment was regularly checked which included resuscitation equipment.

We found that senior nursing staff had poor awareness and knowledge of what was on the risk register.

During our unannounced inspection we found the temperature levels in the areas where medicines were stored, on Hoskyn, Mulberry and Oak Wards was above the acceptable levels. This resulted in the on-call pharmacist deciding to quarantine the treatment areas by restricting the use of these rooms.

The service held monthly clinical governance meeting where quality issues such as complaints, incidents and audits were discussed. These audits had not identified the concerns with equipment and treatment room checking.

Although staff and ward managers were aware of the trusts visions and values they were unaware of the strategies relating to the Hospital of St Cross.

Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service. Staff said they felt there was effective team working across professional groups in the community service.

Innovation was encouraged from all staff members across all disciplines. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

Vision and strategy for this service

- Staff at St Cross were aware of the trust's vision to become an organisation that is a national and international leader in healthcare and could direct us to the posters on display.
- Staff could say how they were able to achieve and deliver the best care for patients through staff education and training, and innovation through research and learning.
- Staff were unaware of trusts aims to achieve this vision with a ten-year clinical strategy to be a regional, national and international leader in world-class healthcare for the local populations of Coventry and Warwickshire.

Governance, risk management and quality measurement

- The wards held regular team meetings at which performance issues, concerns and complaints were discussed. When staff were unable to attend ward meetings, steps were taken to communicate key messages to them through e-mails and team meetings.
- Medical services had a quality dashboard for each service and this was available on the trust's intranet site. It showed how the services performed against quality and performance targets. The ward areas had visible information about the quality dashboard. Staff said they were aware of the quality dashboards but had not discussed the outcomes at team meetings.

- We found there was no system in place to monitor the checking of equipment for example; resuscitation trolleys and out of date needles.
- Medical services did not have systems and processes in place to ensure that the temperature in the clinical rooms was recorded to ensure the safe storage of medicines.
- Medical services had a robust governance structure. The service had quarterly clinical governance meetings where the results from clinical audit, incidents complaints and patient feedback were shared with staff. Minutes of clinical governance meetings showed patient experience data were reviewed and monitored.
- The service had a local risk register which had site specific risks in relation to the specialties working out of St Cross Hospital. The management of St Cross held monthly quality improvement and patient safety meetings where risks were discussed. However, we found that senior nurses had poor knowledge and awareness of what was on the risk register.

Leadership of service

- Regular team meetings took place and staff told us that they felt supported by colleagues and managers. Daily clinical leads' meetings were held in the morning to review any ongoing issues.
- Staff spoke highly of the leadership within their teams. They said that senior managers and clinicians were visible and approachable to front line staff and patients.
- Staff told us they felt that managers listened and acted on any issues raised and they could discuss any concerns with them.
- Managers said that they felt supported and enabled to manage poor staff performance and/or competencies.
- Managers said there were low levels of sickness in the service and that staff could be referred to occupational health services if necessary. The manager on Mulberry Ward said they had one staff member on long-term sickness while the manager on Hoskyn Ward said they didn't have any staff on long-term sickness.
- While there were challenges with recruitment and retention of staff for the services, we saw that the trust was taking steps to pro-actively recruit and retain staff. This included reviewing the reward package for experienced registered nurses.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.

Culture within the service

- Staff spoke positively about the high-quality care and services they provided for patients and were proud to work for the trust. They described the trust as a good place to work and as having an open culture.
- Individual feedback was variable regarding the effective reporting of incidents. Some staff told us they were happy to report incidents and raise concerns while others were less confident.
- Staff survey results from the 2014 NHS staff survey showed the trust's score of 3.77 was above (better than) average when compared with trusts of similar type. Examples of the top scores included staff agreeing that their role makes a difference to patients and work pressure felt by staff. Examples of the bottom scores were; staff feeling pressure in last 3 months to attend work when feeling unwell and staff experiencing physical violence from patients, relatives or the public in the last 12 months.

Public and staff engagement

- Clinical governance meetings showed patient experience data were reviewed and monitored.
- The trust held monthly care group engagement sessions for all staff. These sessions had a different focus every month, such as updates on human resources policies and training updates.
- The medical divisional leads also held monthly listening clinics for all the staff where staff could raise any concern or share an experience.
- The junior doctors told us they were able to raise concerns and the trust conducted junior doctor forums where they could express their views and share new ideas.
- Staff were updated on the work the trust had conducted in the In Touch plus magazine. This included the results of the 2014 NHS Friends and Family test and the trusts' values and behaviours framework.

Innovation, improvement and sustainability

- Senior professionals told us the trust followed the National Dementia Strategy that had been launched by the Department of Health. The aims of the strategy are to transform services for people with dementia and their carers. Staff were committed to providing the best service available for people with dementia.

Medical care (including older people's care)

- A framework for improvement had been laid out. Key performance indicators were discussed at the service's monthly clinical governance meeting, such as safeguarding, incidents and complaints
- Periodic service reviews had taken place to monitor the quality of the service, with actions identified as relevant.

Surgery

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

Information about the service

University Hospitals Coventry and Warwickshire NHS Trust (UHCW) provides both elective and emergency surgery to the population of Coventry and Warwickshire with a wider catchment for specialist services.

The trust provides surgical services on sites at University Hospitals, Coventry and Hospital of St Cross, Rugby. The two sites share common administrative and governance structures.

National audit data and reports are gathered and reported at trust level and therefore refer appear in our reports for both locations.

Different surgical specialities were managed by different departments of the hospital and had different executive leads. This provided clear management structures for the specialities but did not always provide an integrated approach to patient care.

Services at the Rugby hospital are part of the wider service provided by the trust, with senior managers generally based at the Coventry site.

The trust has six theatres at the Rugby site including one Vanguard mobile theatre. There are 41 surgical inpatient beds and 22 day surgery beds at Rugby. Surgical services have around 670 staff.

The surgery inspection team for the trust consisted of seven staff who inspected surgical services over 3 days. At Rugby, we visited Cedar Ward and the surgical day unit, and we observed practice in operating theatres.

We spoke with 25 staff including nurses, doctors, therapists and support staff. We spoke with 14 patients or family members. We held trust-wide focus groups to capture the experience of staff in different disciplines and at different levels within the organisation. We held listening events in Coventry and Rugby to capture information and experiences of patients current and past.

Surgery

Summary of findings

Overall, this core service was rated as good. We found that patients received safe, compassionate care and treatment. Services provided were effective, caring, responsive and well led.

Patients told us that staff were kind, friendly and "could not do enough" for them. Patient safety was ensured through the completion of risk assessments on the wards and in theatres. Learning from incidents and listening to complaints were seen as opportunities for improvements to services.

We saw that patients had received care and treatment that had been based on nationally recognised care pathways and guidance.

Patients told us they were pleased with the care they had received; the hospital had a calm, friendly atmosphere.

Staff were knowledgeable and supported in their work by managers and systems that encouraged learning and openness.

Equipment was maintained and safe to use, although there were issues with storage and we found some equipment left in corridors.

Wards theatres and public areas were all kept clean and staff followed good infection prevention and control procedures.

Patients were assessed in respect of their dietary needs and appropriate meals and fluids were provided. Staff on the surgical day-case unit told us that patients were unable to have hot meals at weekends because there were no catering facilities, cold snack boxes were provided.

Senior management was provided remotely from the trust's sister site at Coventry; however, staff reported that senior managers visited on a regular basis, as did executive officers and board members.

Concerns were raised before the inspection by some members of the public who reported the loss, over time, of services at the Rugby hospital. They feared that the trust was looking to close the hospital. We were told by the trust that surgical services were set to be increased at Rugby.

Surgery

Are surgery services safe?

Good

Surgery services at Hospital of St Cross, Rugby, were found to be safe.

The trust had policies and procedures that were designed to keep patients safe. We saw that staff followed these procedures most of the time, although in one theatre staff had prepared medicines for three patients who were due to have operations. Best practice is to prepare medicines individually so that it is not possible to confuse which medication is meant for which patient.

Incidents were reported, and learning from them was shared among teams.

Recognised tools were used to monitor performance and to assess patients.

Staffing levels and skill mix were calculated to meet the acuity of patients. Staff were knowledgeable and supported to learn and develop. Training gave staff the resources to support vulnerable patients and uphold their rights.

Infection prevention and control policies were followed in line with best practice. However, we were told of one instance when staff were unable to contact members of the infection control team at Coventry for advice.

Incidents

- Staff reported incidents and 'near misses' through a centralised web-based reporting system (Datix). The Datix system automatically escalates incidents according to the type of incident and clinical area affected. All surgical incidents would be reviewed by a senior nurse or consultant within the surgical department. A large proportion of incidents reported within surgery services were minor incidents that caused no harm.
- We were told that the Datix system generated an email reply providing feedback when an investigation had been completed.
- The trust had a Quality Improvement and Patient Safety (QIPS) group within each specialist department. Serious incidents were reported to the trust's significant incident group, which met weekly.
- The hospital had not reported any 'never events' during 2014/15. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been put in place. However, we found that staff at Rugby were aware of events that had occurred at Coventry, which showed that learning had been shared between the sites.
- We saw that the trust completed comprehensive root cause analyses of all never events and produced action plans.
- The trust attitude to reporting incidents was one of learning. Staff were encouraged to report incidents in the hope that lessons could be learned and further incidents prevented. This led to a high volume of incidents being recorded.
- Information provided by the trust for the 4 months preceding the inspection indicated that across both sites 1,041 serious incidents were reported in the surgical department; 72% of these were classed as negligible or no harm, 20% related to skin or tissue injuries such as pressure sores. There were 40 moderate harm incidents and 5 severe harm. Two incidents had been recorded as resulting in death.

Safety thermometer

- The trust used the nationally recognised NHS Safety Thermometer as one of its improvement tools for measuring, monitoring and analysing care. Performance was measured for all specialties within the trust, including surgery, against four possible harms: falls, pressure ulcers, venous thromboembolism (VTE) and catheter-associated urinary tract infections (UTIs).
- The safety thermometer was used to determine the likelihood of patients experiencing harm-free care while at the hospital. Harm-free care means that patients should be protected against avoidable harms such as falls, pressure ulcers and catheter-associated UTIs. National targets say that at least 95% of patients should experience harm-free care. General surgery within the trust achieved 99%.
- The trust year to date result for VTE risk assessment was over 96% against a target of 95%. The trust used an electronic recording system to monitor VTE assessment. The results indicated that the trust had performed better than national targets.

- We saw that the safety thermometer was displayed on the wall charts inside the ward areas, together with details of 'harm-free days', which indicated how long it had been since particular types of incident had occurred in that area.
- The trust provided information regarding its trust-wide Houdini project, which was designed to reduce the already low incidents of catheter-associated UTIs. While this had yet to be evaluated, it indicated how staff were keen to improve services even when they were already performing to the required level.
- Patient safety boards, with information on performance, were displayed on the wards or at their entrances.

WHO Safety Checklist

- The World Health Organization (WHO) had produced guidance to increase safety for patients undergoing surgical procedures. The guidance set out five steps that should be undertaken during every procedure to help prevent errors.
- The guidance formed a basis from which organisations were able to adopt and adapt practices to reflect the specific needs of their service.
- The trust had developed a surgical safety checklist from this guidance.

Surgical and theatre staff we spoke with were all familiar with this checklist.

- Staff were able to describe the processes required for compliance with the guidance and we observed aspects of the system being used in theatre.
- We observed theatre practice and saw how the different aspects of the safety checklist were carried out in line with the guidance.

Cleanliness, Infection Control and Hygiene

- The hospital appeared clean and bright. Housekeeping staff were observed completing various tasks throughout the course of our inspection. Patients told us they had always found the hospital clean.
- We saw many instances of staff observing infection control measures by washing their hands and using protective gloves and aprons when providing care or coming into physical contact with patients.
- The trust maintained theatre discipline, such as using appropriate theatre wear and minimising movement of people in and out of the operating area.
- The trust highlighted that the infection, prevention and control team (IPCT) had won the Infection Prevention Society Team of the Year in 2013, and that the team had a successful Twitter account with almost 2,000 followers.
- The trust had IPC healthcare assistants whose role was to be a roving educator for all staff. All the trust areas were covered over a 2-week period providing education and reminders to staff about cleaning, decontamination and IPC practices. A monthly report was fed into the 'Saving Lives' and operational cleaning meetings. Staff we spoke with were aware of infection control procedures and were able to describe the training and guidance they had received.
- We saw documentation that showed that compliance with Clostridium difficile (C. difficile) and MRSA management was monitored and analysed monthly.
- Theatre equipment was transported to Coventry to be decontaminated and sterilised after use. Staff confirmed that this had not caused issues with supplies because sufficient equipment was always available on the Rugby site to meet their needs.
- The infection control matron attended the surgical department in Rugby about once every 2 weeks, and the team was available for advice by telephone. However, we were told of one incident when a patient who was suspected to have tuberculosis was admitted. Staff wanted advice on how to proceed but they were unable to contact any of the team.

Environment and equipment

- Major pieces of equipment in the hospital were provided under contract to the trust and were repaired or replaced as part of the contract. This included replacement of equipment with the latest version when appropriate. This meant that staff had state-of-the-art equipment available and maintained ready for use.
- Smaller items were maintained by the hospital's technicians. Staff told us that they did not experience difficulties in obtaining repairs or replacements for faulty equipment.
- Equipment that might be required for short periods was available through the trust's equipment library, and included such items as syringe drivers and specialist mattresses. Staff told us that storage was an issue at the Rugby hospital, which often resulted in equipment such as trolleys and beds being stored in corridors. During our inspection, we found the corridors were unobstructed.

- We saw that resuscitation trolleys were available and log books completed; these indicated that the trolleys had been regularly checked by staff.

Medicines

- The trust had systems in place to ensure the safe storage and administration of drugs.
- Each surgical ward and department was covered on weekdays by a pharmacist, who assisted nursing staff by reviewing medication charts, counselling patients and reviewing any medication that they had brought in with them. This ensured that patients received medication appropriate to any existing medical conditions in addition to any medication relating to their hospital stay.
- There was an emergency medicines cupboard on site and an on-call system to contact pharmacy at weekends.
- Quarterly antibiotic and controlled drug audits were completed.
- We saw that medication in one theatre had been drawn up for all patients on that day's list. The drugs for the three patients had been placed out in the anaesthetic room in separate piles corresponding to the patients on the list. This meant that there was opportunity for incorrect medication to be given. Good practice would be to draw medication for each patient individually, thereby reducing the possibility of error.

Records

- Patients' notes and records were maintained to a high standard. We checked four sets of notes and saw that entries were legible, concise, timed and signed. Risk assessments had been completed when required to inform staff of any ongoing risks and to keep patients safe.
- We saw that care plans were based on individuals' needs and reflected the care pathways relative to their condition.
- Every patient was assessed on admission for a range of potential risks, including malnutrition, mobility, pressure sores and falls. We saw that, when risks were identified, appropriate interventions had been recorded and implemented.

Safeguarding

- Safeguarding training formed part of the trust's mandatory training. Staff we spoke with were fully aware of their responsibilities to identify and report safeguarding issues. Nursing staff received safeguarding training at either level 2 or level 3, depending on their role. Healthcare workers were able to describe the different types of abuse people might be subject to, and how they would escalate any concerns.
- The trust had a safeguarding team; staff were aware of the team and knew who to approach if they needed advice or guidance on safeguarding issues.
- Across the trust, level 3 training for children's safeguarding was currently at 93% compliance. Level 2 was at 88% against a target of 85%.
- Safeguarding training was available as both an online package and a face-to-face session. Joint adults and children training sessions had been co-delivered by the safeguarding team and the clinical commissioning group. The events included learning from recent serious case reviews.

Mandatory Training

- Training was available through various media including online learning, classroom-based sessions and individual support.
- Staff were responsible for their own training and compliance was monitored both locally and at trust level.
- A clinical education lead had recently been appointed to support both the monitoring and delivery of mandatory and specialist training.
- Mandatory training attendance rates at St Cross, Rugby, was 91% across all staff groups.

Assessing and responding to patient risk

- We saw that National Institute for Health and Care Excellence (NICE) guidance was used to monitor and respond to deteriorating patients.
- The national early warning score (NEWS) had been introduced by the trust and integrated into the existing electronic monitoring system. This enabled early recognition and intervention in the management of the deteriorating patient on the ward. The system alerts and advises staff on what actions are required.
- Staff told us that they were supported by the outreach team who responded with specialist care advice and support when patients needed more intensive nursing.

Surgery

- Medical input was visible in all areas. Formal ward rounds were completed and medical staff were available throughout the day and evening to assist nursing staff.
- Out of hours, the 'hospital at night' model of care had been adopted. This ensured that medical services could be contacted at all times on an on-call basis.

Nursing staffing

- The trust used the nationally recognised Safer Nursing Care Tool (SNCT) along with NICE guidance to assess required nursing staff levels. This included surgical areas and ensured that experience and skill mix were considered.
- Staff turnover and sickness were audited monthly. Daily checks were completed across all areas to check staffing requirements and availability against gaps in the rota. Vacant shifts were offered first to bank and then to agency staff. Trust data showed that the surgery group had experienced a high level of vacancies during the past 12 months. The current shortfall was 13% of trained nurses. If agency staff were new to the department, they underwent an induction process to familiarise them with the environment and local policies and procedures.
- Nursing handovers occurred at the change of shifts and were based on an electronic e-handover that enabled the process to be monitored. The trust's theatres, including those at Rugby, had invested in a staff development in-house programme that included advanced training post (ATP) training, theatre nurse accreditation, and a theatre practitioner recruitment and retention plan. This had resulted in a significant increase in recruitment of theatre and anaesthetic practitioners.

Medical staffing

- Doctors within the surgical department had a broad range of experience. The skill mix was similar to the England average and consisted of 40% consultants, 12% middle-career doctors, 38% registrars and 10% junior doctors.
- Medical rotas were managed by specialties and planned in advance. Each sub-specialty within the surgery group had a consultant on-call rota covering 24 hours, 7 days a week.
- Middle-grade rotas were overseen by the trust's rota team; gaps were identified and filled by temporary staffing services, either by internal bank staff or by locums.
- Out of hours (overnight and weekends), there were extra middle-grade staff to deal with outlier patients and provide specialty cover. The 'hospital at night' team provided support to the middle-grade team, with all unstable patients handed over from the day to the night team.
- An e-handover system had been implemented to ensure that tasks were carried forward from out-of-hours to day teams.

Major incident awareness and training

- The trust had a major incident policy. The response plan specified clear actions to be taken in the event of a major incident. Action cards were available for specific areas of the hospital.
- Staff were aware of how to access the policy online and understood that they would be given specific tasks to complete in the event of an emergency.
- Protocols for deferring elective activity to prioritise unscheduled emergency procedures were in place.

Are surgery services effective?

Good

Surgery services at Hospital of St Cross, Rugby, were found to be effective.

Patients we spoke with were extremely positive about their experiences of care and treatment.

The trust-wide surgical services engaged with national audits and completed local audits, which helped to monitor compliance with guidance and effectiveness of treatment.

Nationally recognised care pathways were based on National Institute for Health and Care Excellence (NICE) guidance, and recommendations from national registration bodies and societies.

Standardised re-admission rates at Rugby were close to, or considerably better than, national averages for each discipline.

Evidence-based care and treatment

- Trust policies and procedures were available on the trust intranet and staff reported that they could access them easily. We saw that the policies were reviewed and updated at regular intervals and were based on NICE and Royal College guidelines.
- We saw examples of staff delivering care in line with NICE guidelines (for example, NICE Clinical Guideline 3 (2003) 'Preoperative tests', used in preoperative assessment clinics to ensure that patients were safe for surgery, and NICE Quality Standard 49 (2013) relating to surgical site infection).
- We saw how pathways of care were based on NICE guidance and recommendations from national registration bodies and societies.
- Standardised re-admission rates for the top three specialties provided at Rugby were close to or better than the national averages. Rates were set against a target baseline of 100 cases; anything below 100 was positive. For the previous 12 months, the trauma and orthopaedics score was 101, and ophthalmology 104. Across all disciplines at Rugby, the average was 84.
- Clinical audits were completed within each surgical specialty at trust level supported by a clinical audit facilitator. Results of audits were reviewed at surgical quality improvement and patient safety (QIPS) meetings. Examples of audits provided by the trust included the following:
  - Ophthalmology – audit of the NICE interventional procedure guidance for corneal endothelial transplantation (NICE IPG304, 2009), which resulted in unifying the follow-up procedure for patients.
  - Patient outcomes for the three bariatric surgery procedures performed, which included gastric bypass, vertical sleeve gastrectomy and gastric banding, were reported as part of the National Bariatric Surgery Registry. The surgical outcomes for patients having bariatric surgery at the trust were within the expected range nationally for all these procedures.
  - The National Joint Registry (NJR) identified the trust as an 'outlier' (falling outside expected results) having a high number of revision knee operations. The trust investigated the findings and found that the NJR statistics were analysed separately for the Coventry and Rugby sites. Because most of these operations were carried out at the Rugby site, the statistics appeared very high. When taken as a trust, the figures were in line with national figures and the trust was not seen be an outlier. The NJR was notified and asked to consider future data at trust level.

Pain relief

- We saw that patients were given pre-operative assessment for post-operative pain relief. Most patients told us that they had been kept pain free.
- The trust had a dedicated acute pain management service, which was nurse led with consultant input.
- Daily ward rounds are undertaken by the surgical clinical teams, with education and support given to nursing staff with direct intervention by the pain management team when needed.
- Referrals could be made to the team from nurses, doctors or therapists.
- The team used an acute pain software package, which could be accessed from portable devices to manage all activity in relation to pain management patients.
- The acute pain service currently did not operate at weekends, although we were told that weekend working and consultant dedicated hours were being reviewed.

Nutrition and hydration

- Patients received a malnutrition universal screening tool (MUST) assessment on admission, and those with complex dietary needs was referred to and seen by dieticians. We saw evidence of the MUST assessments and dieticians' advice in the patients' notes we examined.
- We saw that on weekdays people were able to make choices regarding their meals and drinks, and to select from a range of hot and cold items. Staff on the surgical day-case unit told us that at weekends, there were no on-site catering facilities and patients were provided with snack boxes. This meant that only cold meals were available. Staff and visitors had to use vending machines. We were told that the provision of catering services at weekends was being reviewed. The trust have since advised us that hot meals are now available seven days per week at Rugby St Cross.
- Drinks rounds were completed in between meal times and we saw that patients could ask for extra drinks if they wanted them.
- We saw that cultural needs were catered for: menu sheets took account of cultural and dietary requirements.

- Patients who needed assistance with eating were identified during the admission process and red tray liners were used to help staff identify those requiring support. Help with meals was provided by relatives, healthcare workers or nurses.

Competent staff

- Nursing and clinical staff we spoke with were knowledgeable and understood their role within the organisation. Nurses and healthcare workers described the induction process and support they had received when they first started at the trust.
- Staff told us they had been supported to undertake extra training that complemented their role.
- The trust was host to the West Midlands Surgical Training Centre (WMSTC) based at Coventry; however, surgeons worked across both sites meaning that the learning gained at the centre was equally important to patients who underwent operations at Rugby. Surgeons from all specialties learned to perform operations in a safe environment, either as trainees learning basic principles or expert consultants learning new techniques,
- Specialist nurse training was supported among, for example, orthopaedic clinical nurse specialists, pain nurses and urology nurses. Advanced nurse practitioners undertook extra duties, such as prescribing medications and blood products.
- Theatres had recently introduced education facilitators and a series of video-based training products to support staff and encourage development.
- As well as mandatory training, some surgery group staff received additional competencies in order to perform their roles effectively. These included epidural training, total parenteral nutrition (TPN) training, central line management and nasogastric (NG) tube placement and management.
- Ophthalmology had led nationally in training optometrists in enhanced roles, such as eye casualty, and in corneal, vitreo retinal (VR) and medical retina clinics. Paediatric ophthalmology had trained orthoptists in advanced roles.
- Revalidation of medics was monitored and completed as required.
- Band 6 physiotherapists had undertaken up-skilling sessions.

Multidisciplinary Team (MDT) Working

- We saw how different therapists were used to provide a multidisciplinary approach to patient care. Therapy services including physiotherapy, occupational therapy and other specialist support, such as dieticians, could all be referred to by nursing or clinical staff.
- MDT meetings were an embedded feature of patient management with weekly meetings to agree patient management and to plan treatment.
- We observed ward rounds and saw how people's care was discussed between clinicians, nursing staff and the patient.
- Surgery staff were involved in a number of MDT meetings. Most covered cancer care (breast, colorectal, head and neck, upper gastrointestinal, hepatobiliary and pancreatic, and urology), but there were also others, such as bariatric, vascular and inflammatory bowel disease MDTs, at which non-cancer patients' care was discussed.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- The trust had a consent to treatment policy and an information sharing policy. These policies included the process for obtaining consent. Staff we spoke with understood the importance of ensuring that patients gave their consent, and they were aware of how to support people who could not make informed decisions for themselves.
- Advice to staff on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) was contained within the trust's safeguarding vulnerable adults policy. The trust had implemented an internal training programme for the MCA, DoLS and mental health. The programme included the government-led 'PREVENT' terrorism awareness, which highlights how to recognise vulnerable people who may be targeted by extremist organisations.
- We saw from patient records that patients had signed to show their consent. We observed many instances of patients being spoken with and their consent checked before they were anaesthetised or given specific care.
- Staff we spoke with were aware of their obligations to ensure that patients gave their consent to all aspects of their care and treatment. We saw how staff explained processes to patients and waited for them to respond before giving care.

- The trust used pale blue pillows on the beds of patients with dementia. These helped staff to recognise patients who might need more support when dealing with aspects of consent and understanding.

Seven-day services

- A 7-day services steering group had been established to coordinate a trust-wide approach to developing 7-day services. A gap analysis was currently being undertaken to establish a work plan for delivery.
- On-call consultant rotas covered 24 hours, 7 days a week.
- The trust planned to recruit an extra thoracic surgeon during 2015/2016 to support extended cover arrangements for trauma on call, ward based services as well as patient review across a 7 day period.

Access to Information

- The trust used electronic patient records, which meant that information was accessible.
- Theatre list were prepared in advance and provided information regarding number of cases, type of procedure and identified potential complications or considerations such as allergies.
- Theatres and recovery areas used monitoring equipment during and where appropriate following procedures which provided visual and audible information which assisted staff to monitor patients.
- Trust intranet and email systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides to policies and procedures to assist in their own role.
- Audit information was shared during meetings and copies were available in manager's offices if staff wished to review them.

Are surgery services caring?

Good

Surgery services at Hospital of St Cross, Rugby, were found to be caring.

All areas of the surgery services portrayed a calm and relaxed atmosphere.

We observed how staff interacted with patients throughout their care pathway. All staff were caring and attentive to patients' needs and to the needs of their families or carers.

Patients spoke highly of the nursing staff and also of the support and guidance they had received from support staff, therapists and doctors.

Staff told us they were happy working at St Cross and this was reflected in their dedication.

Compassionate care

- It was noted that staff maintained a calm and professional atmosphere throughout all areas of the surgery services.
- Interactions between nursing staff and patients appeared pleasant and unhurried; patients appeared to enjoy the company of staff.
- We saw that staff responded promptly to patients' requests. Patients confirmed that staff were always attentive and not being so simply because of our presence.
- We observed how patients who were less well were treated with compassion and tenderness.
- Patients' privacy was considered when care or discussions about care and treatment took place. We saw that bed curtains were drawn and staff spoke quietly to reduce the chance of being overheard. Staff explained that if sensitive or potentially difficult conversations were needed, patients were offered the facility of being spoken to in a side ward or family rooms where there was a higher level of privacy.
- The Rugby surgical day unit had used the NHS Friends and Family Test since October 2014. Patients were able to respond electronically or by completing a paper questionnaire. While there had only been a 20% response rate, 94% of those who had responded said they would recommend the service.
- We saw that Friends and Family Test results were displayed on the noticeboards on the wards.

Patient Understanding and involvement

- Patients told us they understood the treatment they were receiving. Both doctors and nurses had explained what procedures were required and how these would affect their condition. Patients and their family members all told us that they felt fully informed and engaged in their care.

Surgery

- We saw there was a wide selection of information available to patients and visitors on the wards and in waiting rooms. To help staff communicate with patients who had difficulty with speech or understanding, staff had access to a commercially produced communications tool that was presented in a book format with over 100 bespoke illustrations. Staff and patients were able to point at the illustrations to help understand each other.
- We saw how the trust had developed a system to enable patients and visitors to identify the nurse in charge of their area. Yellow epaulettes were worn for ease of identification. We also saw that bedside tables had mats with pictures of the different staff uniforms to help patients identify who the various staff members were and what their role was.

Emotional support

- We saw how patients were treated with compassion by nursing staff. When patients were upset or unwell, staff would close the bed curtains and spend time to explain and reassure them.
- Quiet rooms and family rooms were used to discuss sensitive issues.
- Patients and family members were signposted to external organisations when appropriate so that they could access further information or support.
- The trust had a chaplaincy service that included all major Christian religions and representatives from the Muslim, Sikh and Hindu faiths. Fifty lay visitors across the trust assisted the trained staff to provide pastoral, spiritual and religious support.
- St Cross had a traditional Christian chapel and a multi-faith room available to patients, family members and staff.
- Religious services were held on Sundays and Tuesdays.
- Staff told us they were supported by their local managers and also supported each other during difficult emotional situations.

Are surgery services responsive?

Good

Surgery services at Hospital of St Cross, Rugby, were responsive to the needs of both the local community and individual patients.

Theatres operated an 8am to 8pm service 7 days a week, although not all theatre capacity at the site was used. The trust had plans to increase services at Rugby both to relieve pressure at Coventry and to provide increased access to some specialties for people in the area.

While trust-wide there were high numbers of cancelled operations due to the increased volume of emergency patients and medical outliers occupying surgical beds, Rugby did not face the same pressures and most planned operations went ahead.

Day surgery had unused capacity that could assist the trust to reduce any overall backlog.

Physiotherapy services at Rugby were proactive.

Interpreter services were available and used.

Service planning and delivery to meet the needs of local people

- Rugby had five conventional theatres and also a Vanguard theatre on site. Vanguard was a private company that provided mobile theatre services. The trust used the Vanguard theatre to increase capacity and help meet referral to treatment times. At the time of our inspection, the Vanguard theatre was not staffed by trust employees; however, we saw that there was an excellent relationship between the trust and Vanguard staff, which ensured that patients received a seamless service.
- Staff we spoke with described that the day surgery unit had been running under capacity since September 2014. They were not aware of any specific reason for this and found it strange, given the high workload and over-capacity of theatres at the sister site at Coventry.
- When we spoke with senior managers at Coventry who also managed the Rugby site, they told us that extra theatre lists had been diverted to Rugby and there were plans to increase the surgical activity at the Rugby site. Recruitment was continuing in order to facilitate this. The main recruitment drive had been in respect of emergency provision at Coventry.
- Managers also explained that a further consideration for surgery at Rugby was the lack of a blood bank on site. Procedures needed to be risk assessed so that potential draws on large volumes of blood products were avoided.

Access and flow

Surgery

- We found that there were three medical outliers on the surgical ward at Rugby. These were patients who had been transferred from Coventry. Two female patients were accommodated on the 27-bed female side of the ward and one male patient on the 14-bed male side. The patients had been moved to Rugby because they were local to the area, which meant that their relatives could visit more easily. They had been accommodated on the surgical ward because of lack of space on the medical wards.
- Average stay after surgery was good with patients returning home earlier than national averages.
- We were told that this figure may have been skewed by one patient who had remained in the hospital for an extended period of several months, although much of their stay had been unrelated to the operation. Trauma and orthopaedics stays were 2.8 days against an average of 3.5, and neurosurgery stays were 1.8 against an average of 4.1.
- Physiotherapy teams supported inpatient management and helped to assess whether patients were fit for early discharge.

- Operations at Rugby ran between 8am and 8pm on weekdays, although not all theatre capacity was used at the site. Similar operating times applied at weekends but were dependent on the availability of theatre staff who volunteered to do overtime.
- Staff told us that operations were not cancelled for a lack of beds because they did not face the capacity issues at Rugby.
- Operations were cancelled if theatres ran over but we were told this was a rare occurrence.
- Recall rates after cancellation were within the 28-day government target.

Meeting people's individual needs

- The trust had learning disability champions who undertook extra training and supported staff on the wards.
- Interpretation services were available for patients whose first language was not English. There were posters in several languages advertising this service.
- The trust website offered users the facility to view content in any one of 91 different languages.
- Staff had received dementia training and trialled the forget-me-not challenge which covered patients with multiple needs, not just a diagnosis of dementia. The trust had comprehensive information for dementia patients and their carers on its website.
- The trauma and orthopaedic department had employed a healthcare worker as a dedicated activities coordinator to provide therapeutic activities in small and large groups and to visit patients' bedsides for one-to-one interactions.
- The trust was implementing a personalised knee improvement programme (PKIP). This was an alternative to arthroscopy. Surgeons would refer directly from their clinic. It was evidenced based, with a focus on exercise and weight loss using a multidisciplinary team (MDT) of physiotherapists, dieticians and orthopaedic surgeons. The programme had been approved and the implementation date set as 1 June 2015.
- Discharge planning started when patients were first admitted to the wards. Assessments were completed which enabled staff to understand how much support was available to people after discharge and what additional interventions may be required.

Learning from complaints and concerns

- The trust had a complaints policy. Complaints were handled by the Patient Advice and Liaison Service (PALS). Staff we spoke with understood how to support people to make complaints, and the trust website had information about how to complain.
- Staff told us that they tried to address concerns for patients or their families as they arose, and thereby prevent the issue escalating into a complaint.
- Information was sent directly from the complaints department to senior leadership on a monthly basis, informing them of the complaints received and giving brief descriptions of the concerns with a 'due date' for response to each. Complaints information was also included on Quality Improvement and Patient Safety (QIPS) dashboards for information and discussion.
- Evidence of learning from complaints and concerns included:
  - Ensuring that the box of referrals to physiotherapy services was checked daily for discharge patients, after a complaint that follow-up visits had not been made.
  - Reviewing weekend catering facilities.

Surgery

Are surgery services well-led?

Good

Surgery services at Hospital of St Cross, Rugby, were found to be well led.

We saw that clinical leads, senior nursing staff and managers were all enthusiastic about the breadth and depth of services provided. They were justly proud of the staff they worked with.

Senior staff were liked and respected by the teams.

The trust had identified 100 risks relating to surgical issues. These were being monitored and investigated, indicating a culture of raising and addressing issues. However the volume of incidents meant that management of risks was not as effective as it should be.

The local leadership had a clear vision for the service and many innovative practices had been or were being introduced.

Management teams were based at Coventry, but staff reported good visibility of senior managers and staff at board level.

Vision and strategy for this service

- The staff we spoke with were familiar with and engaged with the trust vision, 'Together towards World Class'. The service had strong leadership with an open culture and robust management of quality. Key issues and lessons learned from investigation of incidents were discussed at quality improvement and patient safety(QIPS) meetings and circulated across the units via email.
- At trust level, surgery services were struggling to cope with capacity issues while trying to expand and provide world-class services. We saw how plans were in place to increase capacity at Rugby to free capacity at Coventry. At the time of our inspection, these proposals had not been implemented.
- The trust had a clinical strategy with a clear vision to be a national and international leader in health care, which was underpinned by a mission to provide care that was patient centred; to achieve quality and efficiency; and to innovate through clinically led research. There were five objectives and a delivery plan based on a hub and spoke model.
- Strategies of the surgical specialties supported the corporate strategy to develop the trust as the hub for specialist and non-elective services, with 'spokes' elsewhere for elective and less complex services. For example, the general surgery strategy included the development of an integrated network for emergency surgery. The theatres strategy had made provision for a second emergency theatre that is supported through the reconfiguration and expansion at St Cross.

Governance, risk management and quality measurement

- Surgical team meetings took place weekly when group managers, matrons, human resources and business managers came together to discuss issues.
- There was a clear structure for the escalation and investigation of never events and serious incidents.
- An information governance manager had recently been appointed to support staff in the surgical department; they had introduced a surgical newsletter to highlight the good work of the department and to raise awareness of issues among the 670 staff.
- Surgery risks were identified through a variety of sources, such as risk assessment, service changes and incident trends, and logged on the trust's risk register, which was held centrally on the web-based software system. There were 100 items listed by the trust which related to surgical issues at the time of our inspection. Risks were managed by the appropriate manager within teams and most risks were either low or moderate. Specialities discussed risks at QIPS meetings. The list identified when risks had been reduced and the interventions that had been made.
- The trust-wide mortality review process applied to all inpatients aged 18 years or more who died at the trust. The primary review forms were completed by the consultants responsible for caring for the patient at the time of death.

Leadership of service

- The surgery specialty groups were led by a senior management team, comprising a clinical director, modern matron and group manager. Each surgical specialty had a consultant clinical lead who reported operationally to the specialty group management team

and professionally to the clinical director. The groups were supported by specialist corporate functions, such as finance and performance, human resources and quality.
- Professional accountability was via the relevant clinical or professional leads. That is: medical staff were accountable to the chief medical officer, and nursing staff to the chief nursing officer.
- Nursing staff in general had confidence in their managers. They were frustrated by issues such as medical outliers and high workloads, but believed their managers had done and were doing all they could to raise the issues and help them cope. Nursing staff within theatres were extremely complimentary about the leadership they received from their matron. They felt they were given the direction and support they needed to provide a high-quality service.

Culture within the service

- Hospital of St Cross was small community-style hospital with a homely atmosphere. This was reflected in the way patients reacted with staff; there was a family feeling about the service.
- Relationships between clinical and nursing staff were good. Each felt respected and supported by the other.
- Senior managers were enthusiastic about the work of the department and the staff they supported. This enthusiasm was not always reflected in the actions of some staff. The culture of clinicians arriving late for theatre had been escalated and some improvement seen, but only for a short period. We did not see any sustained effort to identify and deal with the issues.

Public and Staff Engagement

- Over a period of time, a number of services had been reduced or cut at Rugby. This had caused a great deal of public unrest. Some members of the public who attended the listening event showed a clear distrust of the trust's objectives and believed that the board intended to close the Rugby site.
- People who had used the hospital, or who had relatives who had done so, were extremely complimentary about its services.
- We spoke with a representative of the Friends of the Hospital of St Cross Charity, who detailed a number of initiatives that the local community had supported. He was proud to explain how the relatively small population had contributed so much to the charity.
- The trust website provided information to the public with comprehensive guidance for patients and visitors. The website had the facility to be viewed in any one of 91 different languages.
- The Patient Advice and Liaison Service (PALS) provided information and guidance to patients and visitors.
- Performance information, details of staffing levels and other useful information were posted on noticeboards on the wards.
- The trust had a patient engagement and experience committee.
- Staff had access to the trust intranet where newsletters and general information were disseminated. Some support staff such as housekeepers and porters said that they did not know if they could access the intranet and their roles did not give them access to computers. They told us they received information about the trust from their line managers and noticeboards.
- All nursing and clinical staff had access to the trust email system, which was used to distribute information and for general messaging.

Innovation, improvement and sustainability

- Within the surgery group, there were some notable innovations, including:
  - Development of KingMark, a radiographic scale marker that had been commercially developed and marketed globally since 2013 by an international medical innovation company.
  - Collaboration with the University of Warwick including providing a chair in surgery for a number of projects:
    - Development of removable bone cement.
    - A cervical collar designed specifically for use on intensive care patients.
    - Development of graphical methods to display trainee surgeon performance data (currently under discussion with the Royal College of Surgeons for potential integration into national trainee portfolios).
  - A proposed clinical trial of 3D-printed orthotics.
  - Use of iPads to access clinical systems at a patient's bedside.
  - Trialling wifi tracking systems to allow localisation of critical equipment.
  - Purchase and use of a Da Vinci robot, which enabled minimally invasive robotic surgery.

  - Imminent implementation of a secure clinical photography app to enable safe capture of images on mobile phones.
  - Development of a novel 'non-surgical' treatment package for patients with moderate knee arthritis.
  - Procurement of an innovative 'patient outcomes' software tool.
  - Introduction of collagen crosslinking in ophthalmology; this is a new procedure that uses riboflavin and UV-A light to enable new bonds to form between collagen strands.
- A large UK Orthopaedic Trauma Research Unit. The trust hosted four out of seven of the National Institute for Health Research (NIHR) programmes, Health Technology Assessment (HTA)-funded multicentre clinical trials in orthopaedic trauma and contributed to all other major UK clinical trials in orthopaedic trauma. It had the largest NIHR clinical academic training programme in the country.
- Transformation of the vascular line service, reducing referral to treatment time from 7 to 3 days.
- The trust's theatres had a reputation for being innovative. Examples of the initiatives were as follows:
  - A reference site for GE Healthcare theatre systems – hosting a number of UK and internal hospitals each year, showcasing the real-time patient tracking and materials management capabilities at UHCW.
  - Video-training packages that complemented policies and procedures.
  - Information portal for theatre statistics.
  - Electronic surgical safety checklist documentation monitoring.
  - Clinical education facilitators.
  - Introduction of an electronic stock management system.

Outpatients and diagnostic imaging

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

Information about the service

The Hospital of St Cross is a general hospital providing services for the people of Rugby within the University Hospitals Coventry and Warwickshire NHS Trust. It is situated in Rugby about 12 miles from the larger University Hospital, Coventry site. It is made up of a number of buildings, some old and some more modern, on a wooded site. The outpatient and endoscopy departments are situated in an older part of the hospital, while radiology, although nearby, is housed in a newer building. Around 8,400 patients are seen in the outpatient department every month, and this number is growing year on year.

Blood test services are provided within the hospital. There is also a pre-admission service for patients to be prepared for planned surgery.

The radiology department offers plain imaging, ultrasound and computerised tomography (CT) scans, and magnetic resonance imaging (MRI). No invasive procedures are carried out. Patients needing advanced imaging are sent to the University Hospital, Coventry. The department holds outpatient clinics as well as supporting inpatients and emergency patients referred from the minor injuries unit.

As well as main outpatients we also visited the outpatient physiotherapy department, the dialysis unit and the endoscopy suite, which is a member of the Joint Advisory Group on gastrointestinal endoscopy.

During our inspection, we spoke with nine patients and some of their relatives. We also spoke with 12 staff, including managers, cleaning staff, nurses of all grades, radiographers, healthcare assistants, clerical staff and doctors.

We observed care. We received comments from our listening events and from patients and the public directly. We also reviewed performance information about the department and the trust.

Outpatients and diagnostic imaging

Summary of findings

All the patients we spoke with told us they had been treated with dignity and their privacy protected. They preferred to be seen at St Cross, rather than the larger University Hospital, because they felt they received more individual attention and had no problems parking. They spoke highly of the staff in outpatients, radiology and endoscopy. They found staff polite and caring.

Although a reporting restructure was underway in radiology, there was a disorganised and confusing reporting structure across this department, particularly because some people were managed from the main hospital in Coventry.

Staff reported incidents via the trust's electronic reporting system. These were discussed at the clinical governance meetings within the directorates. Some learning was evident from incidents and complaints via staff meetings in outpatients and endoscopy. In radiology, it was not formalised within the department.

The outpatient department's environment was poor. The walls were scuffed and the furniture was old and chipped. We noticed that some areas were not very clean and the carpets were stained. The radiology and endoscopy departments were clean but, again, dated. The dialysis unit appeared more modern and was clean and bright.

The departments held their own training records, which were up to date with regards to mandatory training.

Staff showed a commitment to patient-centred care. We found many examples of such care, and of attention to patients' conditions and preferences.

The trust had met its national targets and consistently performed higher than the national average with regard to radiology waiting times. Images were reported within 28 days, a national standard, even though this was done remotely from University Hospital, Coventry.

Are outpatient and diagnostic imaging services safe?

Good

Staff reported incidents in line with the trust's policies, and showed knowledge and understanding of the system. Some said they did not always receive feedback from incidents they reported. In outpatients, there was a daily team brief in which any incidents, complaints feedback and learning were shared. This meeting also enabled general communication between staff.

There were systems to reduce the risk and spread of infection. However, the environment in outpatients, with regard to décor, was dated and not very clean, the lighting appeared to be inadequate and the carpets were stained.

The endoscopy department was clean, well-organised and had an excellent system for cleaning and decontaminating endoscopes. This complied with national best practice. There was one endoscopy room.

The radiology department was clean, but the environment was poor. Corridor lighting was insufficient.

Mandatory training was managed and monitored within the outpatient, physiotherapy, radiology and endoscopy departments and medicines were stored, checked and administered safely.

Incidents

- The trust used an electronic incident reporting system to record accidents, incidents and 'near misses'. Training was provided in using the system, and staff we spoke with showed knowledge and understanding of it. They knew what incidents to report, and had indeed done so.
- Nursing and clerical staff in outpatients gave us examples of incident reporting. These concerned a lack of patients' records and delayed transport.
- Staff in outpatients told us that learning from incidents was discussed at the daily team brief and regular departmental meetings. We saw various examples of minutes that showed learning being discussed at meetings. Not all staff who reported incidents felt that they received feedback after investigation.

- Complaints and incidents were also discussed at monthly clinical governance meetings. However, these were held in Coventry. Only senior staff attended.

Radiology

- Regular staff meetings were not held in radiology. We saw minutes of the last meeting dated November 2014, which was mainly to deal with a change in the on-call system. The manager and staff told us that, if there was a problem, then a meeting was called; however, there was no evidence of this. Staff told us that the department was small and any areas of concern (for example, incidents) were discussed informally; other staff, though, said that essential information was not communicated to them, other than in gossip.
- We were told that, in November 2014, there was a backlog of 3,500 images for both the Coventry and St Cross sites that had been unreported for more than 28 days because of staff vacancies. However, the clinical directors in radiology had ensured that this backlog was reduced to almost zero by March 2015. This had been done without any extra resources or outsourcing. This was a significant improvement with regard to safety because it meant that images were reported on in a reasonable time frame, so that any clinical problems could be identified quickly.
- The radiology department had specific patient information and event report forms for identified risks in some procedures, such as extravasation of x-ray contrast media and contrast reaction incidents. Staff showed awareness of the importance of reporting any incidents.
- The clinical directors told us that they held a monthly clinical adverse event meeting, which was attended by the radiologists (x-ray doctors) only. This included incidents at St Cross. They gave us some examples of adverse incidents and the learning that had arisen from them. For example, a computerised tomography (CT) scan list was cancelled because the radiographer was diverted to undertake another task. The patients were not notified and arrived at the hospital. There was some learning from this with regard to improving communication between the radiology departments at St Cross and the University Hospital.

Cleanliness, infection control and hygiene

- Patients we spoke with felt that the areas were always clean. However, one said, “It looks clean, it’s just old. It looks drab.” We saw that, although the consulting rooms had hard floors, the carpets in the corridors were stained and worn in some places. We moved a portable computer table and found accumulated dust underneath it, because it had not been moved when the department was cleaned. We saw ground-in dirt on the edges of some of the desks and on the doors where they were pushed open. The bathrooms we saw were all clean, as were the utility areas. We saw trailing wires from electrical equipment (for example, when computers were not situated close enough to an electricity supply). No wires represented a trip hazard, but they were difficult to clean thoroughly. The department was cleaned by an external contractor. Senior staff told us that, if they found any areas that had not been cleaned properly, the contractor was very responsive.
- We observed that all staff complied with the trust policy of ‘bare below the elbow’ and were wearing minimal jewellery.
- Hand gel was available in all clinical areas. Notices were displayed about hand washing and infection control.
- Mandatory training records showed that all staff had received recent infection prevention and control training. Staff we spoke with showed knowledge and understanding of cleanliness and control of infection.
- The outpatient and radiology departments made regular infection control reports. We asked to see these but they were not made available to us. Regular physical audits were also undertaken. Trolleys and clinical areas were cleaned by staff daily.
- We saw that single-use equipment was used when available, (for example, vaginal speculums).
- There was a pre-admission service within the department and MRSA screens were undertaken for patients being admitted for planned surgery.
- Hand hygiene audits were carried out in the department. The results, which were held within the department, showed over 90% compliance. A hand-washing ‘champion’ completed these and took responsibility for training staff.
- If there was awareness that an inpatient, who required imaging, had an infection, they were scanned or x-rayed at the end of the list to allow all unnecessary equipment to be moved out of the room. None of the staff we spoke with could remember the last time a patient with an infection had attended the department.

Outpatients and diagnostic imaging

Environment and equipment

- All areas of outpatients and radiology that we visited were shabby and dated. The lighting was poor. Furniture was old and in some cases stained. Curtains were old; the linings in some had deteriorated. Some of the blinds had deteriorated too, and did not work properly. It was unclear whether the blinds or curtains had been cleaned. There was no system to ensure that this was done regularly.
- The outpatient clinics were divided into separate waiting areas, according to which suite the patient was attending. Each suite was divided into a consulting room with two adjacent examination rooms. The corridors were carpeted, but the carpets were worn and stained. Some areas had portable electric convection heaters. All had portable appliance test (PAT) stickers on their plugs.
- We saw radios outside every consulting suite. The staff told us they were often left on quietly so that conversations, taking place in the consulting room, could not be heard in the adjacent waiting area.
- The reception was well and clearly signposted.
- We saw evidence of daily performance checks of equipment.
- All equipment we looked at was visibly clean and stored appropriately.
- Emergency resuscitation equipment had been checked appropriately in all areas we visited.
- The trust's electrical maintenance engineering department was responsible for annual PAT.
- The radiology department provided a full range of diagnostic imaging services, but no advanced imaging techniques such as vertebroplasties. Any advanced imaging required was done at the University Hospital in Coventry.
- There was a large x-ray room in the centre of the outpatient department. This had been used for plain films. However, although the equipment did not look outdated, we were told it had been decommissioned 2 years ago. The room was used occasionally for visiting engineers to service portable imaging equipment such as C-Arms. A senior member of outpatient staff agreed that the room would be useful for expanding the pre-admission service, which was currently operating from a small space in the outpatient department.

Medicines

- There was a pharmacy on site. Its staff checked and replenished stock medicines in all departments and provided an outpatient dispensing service.
- In outpatients, radiology and endoscopy, medicines were stored in locked cupboards in the departments. Lockable medicine fridges were in place, and daily temperature checks made.
- In all three departments, most medicines were prescribed and administered by doctors and recorded in the patients' records.
- FP10 prescription pads were stored securely.
- Emergency trolleys were checked every day.
- Outpatients and radiology had no controlled drugs. These are medicines that are subject to strict controls in order to minimise their abuse. We checked a sample in endoscopy and found that they had been ordered, reconciled and recorded in line with national guidelines and the law.

Records

- Written and electronic records were available for patients in the outpatient department.
- Radiology was fully equipped with digital equipment in all areas. Reports on examinations were recorded on the radiology information system and images were recorded on the electronic picture archiving and communication system.
- We were told that sometimes patients' records were not available for their outpatient appointments, particularly if patients with complex conditions were visiting both hospital sites within a short time. Clerical staff created a temporary set of notes, and the electronic patient records system meant that the referral letter and any previous clinic letters and blood test and x-ray results were available.

Safeguarding

- The trust's safeguarding team consisted of a trust lead for safeguarding, which incorporated the role of a named nurse for safeguarding children. There was also a named nurse for safeguarding vulnerable adults and a named doctor for safeguarding children as well as the lead clinician for safeguarding adults. There was full-time administrative support. Staff showed knowledge and understanding of safeguarding and of the trust's process for reporting concerns. They understood their role in protecting children and vulnerable adults. All staff had been trained in

safeguarding adults to at least level 1. In outpatients, all staff had completed level 2 and three had completed level 3. A patient told us, "They all seem well trained here. I'm in safe hands."

Mandatory training

- Mandatory training was done on both a face-to-face basis and via e-learning packages. There was 99% compliance.

Assessing and responding to patient risk

- Patients we spoke with told us they felt safe.
- Staff we spoke with showed knowledge and understanding of patient risk, particularly for elderly or frail patients with more than one medical condition.
- Adult resuscitation equipment was stored within the department. We saw evidence that this was checked regularly, and that staff signed to show that the equipment had been checked and was within its expiry date.
- There were processes within all the departments to manage patients who deteriorated or became unwell. There was an emergency response team that could be summoned rapidly. The patient would have first-line treatment and then be transferred to University Hospital, Coventry, via 999 ambulance for further treatment. If patients attending a department showed signs of rapid deterioration, a call was made to the emergency response team and they would come to the department, assess the risk to the patient and decide on the actions to be taken.

Nursing staffing

- There was one matron who was responsible for the outpatient department, the rehabilitation wards and day surgery. There were no nursing staff in the radiology department because no invasive procedures were undertaken.
- Nursing staff told us that, although they were busy, they felt they provided good and safe patient care. The outpatient nurses felt that staffing was generally sufficient; use of bank staff was extremely rare.
- We were told that turnover of nursing staff was low. There were two whole-time equivalent vacancies.
- A registered nurse in charge of each shift was clearly identified by yellow epaulettes.
- Agency staff were used in the radiology department. When extra staff were needed, this was covered by staff working overtime or by bank staff. We saw the induction procedures and the completed paperwork for agency staff.

Medical staffing

- The individual specialties arranged medical cover for their clinics. This was managed within the clinical directorates, where the structure of the clinics and patient numbers were agreed.
- Doctors we spoke with felt they had a good relationship with outpatient nursing and clerical staff. They said they could discuss issues with these staff and were well supported by them.
- In radiology, there were 26 doctors of varying grades; this included four locums and three agency locums. These were shared between the two hospitals. However, most of the reporting was carried out by the doctors at University Hospital.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

University Hospitals Coventry and Warwickshire NHS Trust is a teaching hospital and therefore the consultants and doctors using the department were actively engaged in research and implementing national guidance in treatment. Some junior doctors and medical students rotated to the site in Rugby as part of their training.

There was evidence that staff competency was checked and that staff received appraisals and opportunities for further training. We found examples of good multidisciplinary working both within and across teams.

Evidence-based care and treatment

- There were protocols for radiology examinations, such as cervical spine and orthopaedic x-rays.
- We saw protocols to ensure fast tracking where there were significant imaging findings for known or unknown cancer diagnoses, as well as severe abnormalities relating to benign or malignant growths. These findings

were reported to the referrer and passed immediately to the multidisciplinary team for review and action. Clerical and electronic system procedures were included in the protocol.

- Dissemination of clinical audit findings was done via presentations at each of the specialties' quality improvement and patient safety (QIPS) meetings. This allowed the audit results to be debated within the clinical teams, any lessons learned to be shared, and any improvements to practice identified and action agreed. Progress against audit action plans was reported at future QIPS meetings.
- The radiology department had one radiographer who was undertaking an advanced practitioners' course to enable them to read and report on some plain images. Patient Group Directives were used to administer routine medicines in imaging. Patent Group Directives are used so that professional staff who are not prescribers can administer a very limited range of medicines used for routine examinations, for example, contrast media.

Patient outcomes

- In endoscopy, all examinations were audited, using specific software for these examinations. The rate for caecal intubation during colonoscopy was over 90%. This meant that the patient had received a thorough examination of their whole large bowel in line with national standards.

Competent staff

- A trust education and learning programme for non-medical healthcare staff, nurses and radiographers had been developed and was delivered in-house by the practice development team. This programme included:
- Leadership development for band 5 staff: to give them the opportunity to explore the concept of leadership, and to show them how the principles of leadership can be applied in the practice setting.
- Preceptorship: to prepare the newly registered nurse in the transition from nursing student to professional practitioner.
- Medicines management workshops: to raise awareness of drug safety and security and the registered nurse's role and responsibilities.
- In radiology, we were told by a senior member of staff that most of the staff were mature and many were part time, had worked in the department for a long time and were not interested in further professional development. It was also difficult to release people for training because they were short-staffed. However, two members of staff we spoke with told us that they were interested in further development and that it caused some frustration when "It just didn't happen." Trust data showed that completed appraisal rates differed in each department. The rates were trust wide and included appraisal rates across both hospital sites:
- Outpatients 80%.
- Radiology 88%.
- Endoscopy 100%.
- Most staff told us that they had received an annual appraisal and that it was a useful process for identifying any training or development needs. However, many we spoke with told us that the appraisal was done as a 'tick box' exercise and not reviewed again until the next appraisal was due.
- An induction process was in place for new staff. We spoke with a new staff member who told us that they found both the trust-wide induction and their local induction useful. They said, "I couldn't have asked for more." An agency radiographer told us they felt their induction to the department had been good.
- The staff who applied plaster to fractured limbs had received no specific or certified training to undertake this role. They had learned the skills from a colleague. This meant that they may not have been following best practice with regard to treating fractured limbs.
- The trust is a teaching hospital, allied to Warwick University. Medical students were attached to different clinical specialities and rotated around these as part of their training.

Seven-day services

- We were told that, when the demand for appointments exceeded clinic availability, further clinics would be arranged. For example, there had been some Saturday and evening clinics to ensure that the referral to treatment waiting times were not breached. Endoscopy had developed ways to use the space made by cancelled procedures to minimise waiting times.
- The radiology department provided 7-day services via an on-call system that started at 5pm. The radiographer would usually stay in the hospital until about 9pm, then either go home, if they lived a short distance away, or

use the on-call room in the hospital. However, often operating lists had not been completed by 5pm. Many of them, particularly in orthopaedics, needed a radiographer in the operating theatre to provide peri-operative images. After 5pm and at weekends, this task was taken up by the on-call radiographer. However, there was some dissatisfaction among staff that their on-call service was being used for routine operating lists.

- At the weekends, there was a single radiographer on call from 5pm on Friday until 9am on Monday. If this radiographer was busy in the operating theatre, there was no radiographer available for the rest of the hospital. Furthermore, because of the shortage of radiographers, the on-call service at the weekend was often provided by staff from an agency. On occasions, these staff did not arrive for work. There was no second radiographer on call, or back-up plan. This had been an item on the trust's risk register since April 2014, rated as a moderate risk. However, there was no evidence that the register had been updated since then or controls put in place to mitigate the risk.

Access to information

- We found access to relevant patient information in all areas of the outpatient services that we visited.
- There was a helpdesk in the main waiting area in outpatients. This was run by volunteers to assist patients and visitors find their destination. There was a small tea bar, again run by volunteers who were able to provide information as needed.
- Information included a map of the hospital, general outpatient information, information about personal data confidentiality and coming into hospital, and details of infection prevention and control. There was also information on the Patient Advice and Liaison Service (PALS), based at the hospital in Coventry, and how to make a complaint.
- Patients we spoke with told us they felt well informed. The trust's patient survey we saw confirmed these findings.
- We saw some health promotion information in outpatients (for example, information on smoking cessation), and in the dermatology suite there was information about different types of skin conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw training records showing that all staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).
- Staff demonstrated knowledge and understanding of MCA and DoLS when we asked them to describe what they would do in different scenarios.
- Staff told us that doctors discussed treatment options during a consultation. When written consent was needed, this was often obtained in the outpatient clinic.
- In endoscopy, consent was obtained after admission but before the procedure. This was often done by the nursing staff who had received specific training in asking patients for consent. One nurse told us how they would explain to a patient the risks and benefits of an upper gastrointestinal examination.

Are outpatient and diagnostic imaging services caring?

Good

All the patients we spoke with in outpatients and endoscopy were complimentary about the way staff had treated them. We observed staff constantly checking on patients and updating them on waiting times. We observed the receptionist on radiology being polite and helpful.

Compassionate care

- We observed staff greeting patients in a friendly but appropriate manner. Patients we spoke with in outpatients praised the staff and told us they were "very caring". One said, "It's so much nicer here. It seems calm and the staff recognise me and remember my name."
- Patients were asked whether they wanted their family or friends to be present during their consultation and treatment.
- We saw that clerical staff in clinics dealt with patients promptly, and were friendly and efficient in busy clinics.
- Staff were trained to keep patients informed of waiting times and the reasons for delays, and they were expected to do so. We observed this happening in all outpatient areas during our inspection. One patient told us, "It is annoying when I have to wait, but they always say why and try and estimate how long I'll have to wait.

Outpatients and diagnostic imaging

- Staff in the physiotherapy department told us that patient consultations took place behind curtains. Other patients could overhear conversations between therapists and patients.
- We saw that the curtains in outpatients were old. In some rooms, the curtains were too small for the windows. This was particularly evident in the dermatology consulting suite. This meant that, if a patient was being examined, their privacy could be compromised.
- In endoscopy, patients were taken into individual rooms so that they could discuss their procedure in privacy. Because the unit was so small, there were no facilities to separate men and women into different recovery areas. Therefore, the department had arranged for separate lists for men's and women's examinations. Relatives were asked to wait in the reception area to ensure that the dignity and privacy of patients were maintained. All patients undergoing a lower gastrointestinal endoscopy were given disposable privacy pants. These enabled them to remain covered during their procedure.

Understanding and involvement of patients and those close to them

- Patients told us their relatives were included in discussions once their permission had been given.
- We spoke with two members of staff in radiology who told us how they would make a patient feel comfortable and at ease. One said, "Even when we're busy, we try not to communicate that to the patients, so they don't worry. We can't let relatives into the x-ray room routinely, but we will comfort the patient and their relative when they're anxious." We observed a member of staff giving a thorough explanation to a patient's relative about when the x-ray results would be sent to their GP.

Emotional support

- Patients told us that staff asked whether they were happy to have relatives present for consultations.
- The outpatient department appeared calm and well ordered.
- We saw staff constantly checking on patients and updating them on waiting times.

Are outpatient and diagnostic imaging services responsive?

Good

Waiting times for investigations in both endoscopy and radiology were better than the England average.

All departments were clearly signposted and there was easy access for people who were less mobile.

There was evidence of learning from complaints and concerns in both the endoscopy and outpatients departments.

We observed that staff in the clinics were responsive to patients' individual needs.

Some patients arriving for their appointments waited some time to be seen. However, the patients' perception was that the waiting time at St Cross was less than it was at University Hospital, Coventry.

Patients told us their appointments were often moved several times. We saw that when people tried to book into follow up clinics, they were often not available due to being overbooked. Data supplied to us by the trust demonstrated that for July, August and September 2014, 612 appointments were cancelled by the trust. This equated to less than 2% of all patient appointments for that period.

There was only one on call radiographer after 5pm. Often they were involved in late operating lists and could not respond to requests for imaging from the minor injuries unit or for inpatients who required urgent imaging.

Service planning and delivery to meet the needs of local people.

- The hospital only had one on call radiographer on duty after 5pm. They were often still involved in routine operating in the theatre. This meant that patients requiring imaging from the minor injuries unit or inpatients who required urgent imaging were obliged to wait for the operating list to finish.
- According to trust data, less than 1% of patients waited for longer than a few minutes for their appointment. However, the patients' perception was different. One told us, "I arrived in good time for my appointment with the dietician and booked in. I sat and waited for 50 minutes. The dietician walked past me twice. When I asked at the reception desk, they told me I hadn't arrived." Another patient said, "This appointment has

been rescheduled 4 times in the past 2 weeks. I asked why and they said it's because of consultants' annual leave. They try to squeeze people in." Audits of waiting times had been carried out and we were told that if, for example, clinics were always running late because the doctor could not get to the clinic to start on time, a discussion would be held with the doctor and the clinic time altered accordingly. Initiatives such as this had reduced waiting times.

- Trust data also demonstrated that less than 1% of patients were seen in outpatients without a full set of medical records. However, clinic letters were available electronically, so that the doctor knew why the patient was attending. This system also enabled the viewing of over 10 years of pathology and radiology results, within the outpatient consulting room. It provided endoscopy and theatre reports, cancer information, cardiac investigations/reports and a diagnostic request facility.

Access and flow

- Patients reported to us that clinic times were often changed or cancelled. Data supplied to us by the trust demonstrated that for July, August and September 2014, 612 appointments were cancelled by the trust. This equated to less than 2% of all patient appointments for that period.
- The percentage of people seen by a specialist within 2 weeks via urgent GP referral, the percentage of those waiting fewer than 31 days from diagnosis to first definitive treatment and the percentage of those waiting fewer than 62 days from urgent GP referral to first definitive treatment were all slightly better than the England average. This was the case for all cancers.
- In radiology, no patients were waiting more than 6 weeks to have their examination completed. This was better than the England average.
- The average wait for endoscopy was around 4 weeks. However, the service provided a direct access service for GPs who suspected that someone may have cancer. This meant the patient had their endoscopy within 2 weeks.
- In 2014, the 'did not attend' (DNA) rates, at 6% of all appointments, were slightly better than the England average of 7%.
- The outpatient department had introduced initiatives to reduce DNA rates, such as text messaging. This had had some impact because some patients who received a text message had called to cancel their appointment, which could then be offered to someone else.
- The pre-operative assessment service discussed all aspects of discharge arrangements before admission.
- Challenges in radiology included an increase in demand for magnetic resonance imaging (MRI), computerised tomography (CT) and ultrasound scans. There was an on-call service but routine requests were not accommodated out of hours.
- Some clinics continued into the evening, although this was not routine.

Meeting people's individual needs

- Outpatients, radiology and endoscopy were all on the ground floor. Access to outpatients was via a wheelchair-friendly door. The reception desks were easy to find because they were directly inside the door of each department.
- All departments were well signposted.
- Translation services were available on request and generally planned in advance of a clinic appointment.
- In the outpatients department, the reception desks were low so that people in wheelchairs could see the receptionist and be seen by them.
- We saw that the eye test area was situated in an area adjacent to a corridor and in sight of other waiting patients. This could be distracting to the patient having the examination, as well as a potential breach of confidentiality.

Learning from complaints and concerns

- Most complaints were about delays in clinics. The staff in outpatients discussed any complaints or concerns from patients at their daily briefing meeting. Most staff were therefore made aware of the issues and able to learn from them almost immediately. In endoscopy, this was done via monthly staff meetings. We saw the minutes of these (for example, a specimen not being adequately labelled) and evidence of learning. There was a discussion about the correct procedure, and staff were referred to the relevant policy.
- In the radiology department, there were no formal staff meetings. Discussions about complaints took place informally. There was therefore no evidence of learning from concerns or complaints.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services well-led?

Requires improvement

The reporting structure in radiology appeared to be confused and disorganised for both clinical and non-clinical staff. A recent reorganisation of clerical staff in radiology had caused some dissatisfaction.

There was good monitoring, audit and data collection regarding waiting times and delayed clinics, with staff proactively managing these as necessary. Some adjustments had been made, but we did not find evidence of improvement over the past 12 months.

The reporting structure in outpatients and endoscopy was clear. Staff knew who they reported to, and there were clear leaders. Senior staff were visible and supportive.

Vision and strategy for this service

- The outpatients departmental vision was displayed within department which was developed following a departmental away day.
- The Radiology Department at the University Hospital had a long term strategy to further utilise the department at Hospital of St. Cross to improve response to the demand for imaging across the whole of the area that the trust served.

Governance, risk management and quality measurement

- Patient Advice and Liaison Service (PALS) leaflets were available in the waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments. The PALS service was based at the University Hospital in Coventry.
- Incidents that occurred in outpatients, radiology and endoscopy were noted on the trust's electronic incident recording system, and investigated in line with the trust's policies.
- On the trust's risk register beginning April 2014, we saw that all risks were rated according their likelihood of happening and their risk to patients, business continuity or staff. There was an action plan and completion date for all risks. However, very few of them appeared to have regular updates of progress. This meant that the trust's board may not have had current oversight or assurance that the risks were being managed or minimised.
- Radiology reviewed their risks at their monthly multidisciplinary risk management group and at QIPS meetings, updating controls and risk ratings as appropriate. All quality and performance data was considered to ensure that risks were being managed. Local risks that could not be managed within the specialty groups were escalated to corporate level. The lead radiographer told us they did not attend those meetings.
- The matron for outpatients met monthly with all the senior nurses in the trust, and governance, quality, patient experience and learning were standard agenda items. The meetings were chaired by the trust's chief nurse.

Leadership of service

- The nursing staff told us that they felt well supported by their managers and that the managers were always available to assist if they had a concern, even if it was minor.
- Staff told us that the nursing managers were visible throughout (and beyond) the areas covered by their role.
- The matrons reported to the deputy chief nurse and met every week. They told us they felt well supported, even though the deputy chief nurse was based at the University Hospital in Coventry.
- The endoscopy staff worked across the two hospital sites. This was mainly to cover for illness and holidays. On a day-to-day basis, the unit was led by a band 6 nurse. Managerial support was given from the hospital in Coventry. Staff reported that the structure worked well and, even though senior management worked remotely, support was always available.
- The radiology department, although very small, was managed by four different people, three of whom worked at the hospital in Coventry:
- Radiographers who did plain x-rays were managed by a band 7 radiographer who worked in the department. This person told us they worked clinically most of the time because this was what they enjoyed.
- Radiographers who worked in other modalities (computerised tomography [CT], magnetic resonance

imaging [MRI], ultrasound and dual energy x-ray absorptiometry [DEXA] scanning) were managed from Coventry. For example, the CT radiographers were managed by the CT lead at the Coventry hospital and the MRI radiographers were managed by the MRI lead, again in Coventry.

- Administration and reception staff who, until recently, had been managed by the band 7 radiographer within the department at St Cross. However, there had been a recent reorganisation and the administration staff were now managed by the imaging administration leader in Coventry. Staff we spoke with told us, "It's not clear who is managing and they tell us different things. The staff have been reduced from three to one. There was no explanation for this."

Culture within the service

- Throughout the inspection, all staff were welcoming and willing to speak with us. They described their role and most showed obvious pride in their department. Most had worked at the hospital for some considerable time. They were warm and complimentary about their peers.
- The staff in outpatients and radiology were concerned that their departments were shabby and needed redecoration. A radiographer told us, "I would like this place to have a paint job."
- Staff we spoke with described good team working within the hospital and their departments. One told us, "Team work here is brilliant."

Public and staff engagement

- Some staff felt that trust executives did not visit their specific areas of work. However, others told us that the chief executive often held briefing meetings at St Cross.
- The radiology staff said they hardly ever saw their manager visit from Coventry. One said, "We are not encouraged to liaise with Coventry."
- There was an active group of volunteers who, as well as running the tea bar and a small shop to raise funds, organised other fund-raising activities to improve facilities for the patients who used the hospital. One of them said, "My wife and I have been patients here. It was terrific. It's nice to be able to put something back."

Outstanding practice and areas for improvement

Outstanding practice

- The University Hospital of Coventry and the Hospital of St Cross were working to improve the experience of older patients. Initiatives included blue pillow cases, screening all patients aged 75 and over for risk of dementia and the development of the care bundle.
- The trust was adopting the VERA technique as a means of communicating with a person with later stage dementia. VERA stand for: valuing what the person says, emotional which looks at the feelings behind the person's words, reassurance and an activity which is helpful for the person. Staff were rolling this technique across the trust.
- The trust was using the "M" technique as a means of holistic communication through a system of touch on hands and feet for older adults. This included the repetition of stroking and conventional massage through slow, constant and rhythmical pressures.
- The endoscopy department responded to the needs of its patients by having separate lists for men and woman so that each group had their dignity maintained.

Areas for improvement

Action the hospital MUST take to improve

The hospital MUST ensure that :

- Its systems to review equipment and audit compliance are effective so far as they relate to checking resuscitation equipment.
- Medicines are stored safely across the hospital.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure that nurse staffing levels comply with NICE's 'Safe staffing for nursing in adult inpatient wards in acute hospitals'.
- Consider improving GP support within the RUCC.
- Review the frequency of senior leader presence at the RUCC and assess its effectiveness in the monitoring of risk.
- Define its vision and strategy for the RUCC, and more effectively inform the local public about the limitations of the service.
- Ensure that all ENP staff at the RUCC undertake child safeguarding training at level three.
- Provide local people with a clear message about what the RUCC offered.
- Ensure that fluid scores are completed and recorded appropriately so that patients who are at risk of dehydration are correctly escalated.
- Provide information leaflets and signs in other languages and easy-read formats.
- Ensure that the access and flow of medical patients is improved and delayed patient discharges are managed appropriately, including robust processes in place to meet the estimated discharge dates.
- Ensure that they have robust arrangements in place to meet referral to treatment times.
- Ensure that learning from incidents is shared across all staff groups.
- Ensure that all patients accommodated over weekend periods have access to a choice of suitable and nutritious food and hydration. This should include the provision of hot meals where this is the patients preferred choice. This is something which is required as part of regulation 14(1)(a, b & c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Protecting patients from the risk of inadequate nutrition. However it was considered that it would not be proportionate for the finding to result in a judgement of a breach of the Regulation overall at the location
- Review the anomalous reporting structure within the radiology department, so that reporting lines are clear.
- Review the arrangements for communication within the radiology department to ensure that staff receive essential information in a more methodical and regular manner.

Outstanding practice and areas for improvement

- Review the radiography arrangements for regular late operating lists, so that the on-call radiographer is not restricted or delayed in undertaking urgent x-rays.
- Review and update the environment in both outpatients and radiology.
- Consider the use of wasted space in the outpatients department, currently containing obsolete x-ray equipment.
- Review the anomalous reporting structure within the radiology department, so that reporting lines are clear.
- Review the arrangements for communication within the radiology department to ensure that staff receive essential information in a more methodical and regular manner.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision [Now Regulation 17 including Regulation 17(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider did not operate effective systems to identify, assess or monitor risks relating to the health, safety and welfare of people who use services and staff. This included incident-reporting systems within the trust where we found actions plans, open, overdue and uncompleted; and risk management processes for the maintenance of equipment in the division of medicine.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control [Now Regulation 12 including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] People who use services and others were not protected against the risks associated with the unsafe management and storage of medicines within the division of medicine.