This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

**Facts and data about this trust**

University Hospitals Coventry and Warwickshire NHS Trust provides acute and tertiary hospital services for over one million people. The trust has two main hospital sites: University Hospital Coventry and Hospital of St Cross, located in Rugby. University Hospital Coventry has 1,064 beds and 26 operating theatres. Hospital of St Cross has 110 beds and five operating theatres. The trust employs over 9,000 staff. The trust is a major trauma centre and specialist cancer centre. It provides fertility treatment, including invitro fertilisation (IVF), and carries out kidney transplants. The trust’s neurosciences unit is the sub-regional centre for treatment of epilepsy, multiple sclerosis, Parkinson's disease, head injuries, spinal disease, vascular disorders and tumours of the nervous system. In addition, the trust provides acute inpatient care and treatment for specialties including cardiology, cardiothoracic surgery, care of the elderly, dermatology, diabetes, ear nose and throat, gastroenterology, gynaecology, haematology, neonatal intensive care, nephrology, neurology, oncology, ophthalmology, plastic surgery, renal medicine, respiratory medicine, rheumatology, stroke, and urology.

(Source: Routine Provider Information Request (RPIR) – Context acute tab; trust website)

**Hospital sites at the trust**

Details of the trust’s hospital sites are below. Both hospitals cover the Coventry and Warwickshire area.

<table>
<thead>
<tr>
<th>Name of hospital site</th>
<th>Address</th>
<th>Details of any specialist services provided at the site</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Coventry</td>
<td>Clifford Bridge Road, Coventry, CV2 2DX</td>
<td>Acute hospital inpatient services and outpatient services.</td>
</tr>
<tr>
<td>Hospital of St Cross</td>
<td>Barby Road, Rugby, CV22 5PX</td>
<td>Acute hospital inpatient services and outpatient services.</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Sites tab)
The trust is registered to provide the following regulated activities:
• Assessment or medical treatment for persons detained under the Mental Health Act 1983
• Diagnostic and screening procedures.
• Management of supply of blood and blood derived products.
• Family planning.
• Maternity and Midwifery services.
• Surgical Procedures.
• Termination of pregnancies.
• Treatment of Disorder, Disease or Injury.

Activity:
• The trust has 1,107 acute beds, 70 critical care beds and 64 maternity beds.
• From March 2018 to February 2019, there were 151,028 inpatient admissions (+5% compared to previous year).
• There were 918,932 outpatient attendances (+6%).
• There were 236,626 accident and emergency department attendances (+24%).
• The trust employs 7,320 WTE staff.

Financial Position:
• The latest projected surplus for the trust was £27,704. The income earned was £630m which was 4% higher than the previous financial year.
• The trust is not in special financial measures. The NHS Improvement Oversight Framework provided targeted support when required.

Local Health population:
In terms of service used, Warwickshire sees a higher proportion of individuals aged 65 and over. Coventry had a population of 366,785. The majority of the population were white British. Coventry also had a notably higher percentage of black and minor ethnic population (BME) compared to the national average.

Coventry demographics 2019 (Arrows represent the comparison against the national rate)

<table>
<thead>
<tr>
<th>Population for Coventry</th>
<th>366,785 of which 51% are male and 49% are female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black and Minority Ethnic (BME)</td>
<td>33.4%</td>
</tr>
<tr>
<td>Children in poverty</td>
<td>21%</td>
</tr>
<tr>
<td>Disability</td>
<td>56,247 with a long term illness</td>
</tr>
<tr>
<td>Life expectancy female (82%)</td>
<td>↓</td>
</tr>
</tbody>
</table>

(Source: Local authority demographics)

Trust engagement:
We met with leads for the following services during the year prior to the inspection:
• Pharmacy services including the director of pharmacy, deputy director of pharmacy and associate director of operations.
• Outpatients service.
• Critical care service including the clinical director, clinical head of service, modern matron,
group manager and lead nurse for cardio-thoracic critical care.

- Urgent and Emergency care at University Hospital Coventry and Hospital St Cross, Rugby
- Learning and development leads.
- Neurosurgery including the clinical director and group director of operations.
- Held a variety of staff drop-in sessions and focus groups.
- Attended two University Hospitals of Coventry and Warwickshire improvement (UHCWi) events.
- Attended a trust board meeting.

What people who use the trust’s services say:

- The last CQC Inpatient survey was published on 20 June 2019. This survey looked at the experiences of 76,668 people who were discharged from an NHS acute hospital in July 2018. Between August 2018 and January 2019, a questionnaire was sent to 1,250 recent inpatients at each trust. Responses were received from 496 patients (40%) at University Hospitals Coventry and Warwickshire NHS Trust. The trust performed “about the same” in all eleven themes as most other trusts that took part in the survey.

Friends and Family Test:

- The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 81% and 97% from April and June 2019.

Friends and Family Test - Activity and Performance

<table>
<thead>
<tr>
<th>Location</th>
<th>April 2019</th>
<th>May 2019</th>
<th>June 2019</th>
<th>Internal trust target</th>
<th>KEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients/day case combined</td>
<td>91.26%</td>
<td>91.65%</td>
<td>92.57%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>A&amp;E (all areas)</td>
<td>79.46%</td>
<td>82.23%</td>
<td>81.29%</td>
<td>87%</td>
<td>T Target achieved</td>
</tr>
<tr>
<td>Outpatients all departments</td>
<td>90.12%</td>
<td>91.85%</td>
<td>92.12%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Antenatal (after 36 weeks)</td>
<td>89.47%</td>
<td>92.65%</td>
<td>96.00%</td>
<td>97%</td>
<td>Within 5% of target being achieved</td>
</tr>
<tr>
<td>Birth/Labour experience</td>
<td>87.69%</td>
<td>72.15%</td>
<td>93.68%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>Postnatal experience</td>
<td>89.19%</td>
<td>87.76%</td>
<td>93.91%</td>
<td>97%</td>
<td>Target not achieved by more than 5%</td>
</tr>
<tr>
<td>Postnatal (community)</td>
<td>98.57%</td>
<td>97.96%</td>
<td>97.56%</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>

(Evidence Source: Board papers September 2019)

Trust engagement with staff:

The trust’s 2018 scores for the following themes were significantly higher (better) when compared to the 2017 survey:

- Quality of care.
- Safety culture.
- Staff engagement.

There were no themes where the trust’s scores were significantly lower (worse) when compared to the 2017 staff survey.
Previous CQC inspection:

- Date of inspections: 23 April to 1 June 2018 (23 and 27 April University Hospital Coventry, 1 and 2 May 2018 (Hospital St Cross, Rugby), 10 to 18 May (Unannounced inspection and 29 May to 1 June 2018 (well-led inspection). Report published 31 August 2018. Overall the trust was rated as requires improvement as set out below.

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Coventry</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good Aug 2018</td>
<td>Requires Improvement</td>
<td>Good Aug 2018</td>
<td>Requires Improvement Aug 2018</td>
</tr>
<tr>
<td>Overall trust</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good Aug 2018</td>
<td>Requires Improvement</td>
<td>Good Aug 2018</td>
<td>Requires Improvement Aug 2018</td>
</tr>
</tbody>
</table>

Post inspection requirement notice and action plan:

- The trust sent us a detailed action plan in respect of the breaches of regulation 17 and provided regular updates on the progress to return to compliance.

Core Service Inspection 2019:

- We inspected three acute core services at University Hospital Coventry: urgent and emergency care, maternity and medical care from 08 to 10 October 2019 and an unannounced inspection for urgent and emergency care on 04 November 2019.
- We inspected the additional service neurosurgery from 8 to 10 October 2019 together with an unannounced inspection on 04 November 2019.
- We inspected one service at Hospital St Cross, Rugby: outpatients from 08 to 10 October 2019.

Well-led review: 05 and 06 November 2019:

To assess if the organisation was well-led, we interviewed the members of the board, the executive team and held a focus group with non-executive directors and a range of staff across the hospital. This included clinical and non-clinical staff and specialty directors. We met and talked with a wide range of staff to ask their views on the leadership and governance of the trust. We attended a trust board meeting. We looked at a range of performance and quality reports, audits and action plans, board meeting minutes and papers to the board, investigations and feedback from patients, local people and stakeholders. The well-led review team comprised of a head of hospital inspection, inspection manager, inspector, pharmacy specialist, an executive reviewer from another NHS trust and two special clinical advisors with significant experience of governance and NHS trust boards.

Is this organisation well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There had been changes to board membership since our last inspection. We heard from a refreshed, energetic and cohesive leadership team, ensuring positive professional challenge and scrutiny. Board changes since our last inspection included the chair (October 2019), chief medical officer and chief operating officer (July 2019), two non-executive directors (April and October 2019) and...
an associate non-executive director (January 2019) We heard there was a high degree of confidence in the newly appointed chair to focus strategic ambitions and further board's approach to remain dynamic and meaningful as a system leader. Since our 2018 inspection, trust had focused on continuing its improvement journey, through strengthened clinical leadership, and a focus on key aspects of performance. Examples of improvement included, improving referral to treatment time performance and a reduction in patients waiting for procedures, against a national deterioration.

Trust governance and performance management process was managed via group triumvirates. These triumvirates had been newly formed from 12 to seven during 2018. The reorganisation of clinical groups helped the trust to provide focus and introduce a revised management structure comprising a clinical director (CD), a group director of operations and a group director of nursing and allied health professionals (AHPs) for each group. This triumvirate oversaw the activity of the group and were held accountable for the performance of the group. Staff we spoke with said that the re-structure to seven clinical groups had increased strength of scrutiny, risk management and business focus at sub board member level. Senior staff and non-executive directors said that the changes had brought new ideas and respectful challenge to the leadership team. Group leaders attended monthly accountability meetings with corporate directors and quarterly performance reviews (QPRs) with chief officers. Groups held monthly boards and were supported by governance meetings covering sub-sets of their groups to oversee performance and make key operational decisions. We found these arrangements worked well and meant strong executive members were supported through capable deputies and groups.

Our interviews with the executive team demonstrated they recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. Senior leaders we spoke with confirmed that this was an effective process which allowed the team to develop the relationships that would see them become a collective leadership team and deliver the strategic objectives. We observed that the trust leadership team had a comprehensive knowledge of current priorities and challenges and acted to address them.

Trust leadership had a detailed understanding of the current priorities and challenges to quality and sustainability and had action plans in place to address these. Where some issues had been raised during the core service inspection, the trust took immediate action to address these and put in place robust action plans to sustain and embed learning. Leaders were highly visible and approachable. Many staff from different seniority and roles commented to the inspection team about the positive impact the restructure of the clinical groups had made. Many staff talked positively about the executive team describing them as both visible and approachable.

There were six non-executive directors (NEDs) with a variety of backgrounds and expertise. The NEDs had joined the trust at a variety of dates from 2013 onwards. We held a focus group and met with three NEDs. From our conversation with them, we were assured of their significant skills and experience. It was possible to see their influence and respectful challenge as part of the overall effective leadership team of the trust.

We observed a public trust board meeting (held in September 2019) and noted that the NEDs offered respectful and robust challenge to the information received by the board and suggested actions accordingly. We were assured by the level of challenge and noted that the chair conducted the board meeting effectively and ensured that discussion and challenge was maintained with respect. We observed the board meeting commenced with a presentation from clinical teams who either presented a patient story, a staff story or highlighted a clinical pathway to improve patient safety or experience. The presentations reflected a good or less positive
experience which enabled the board to gain an insight into an issue from a patient or staff’s perspective and offered triangulation about issues rather than simply reading meeting papers.

The trust had a guardian for safe working hours, and we saw highlights of the February to May 2019 report. There had been 36 exception reports (ERs) during this period. An exception report is a type of summary report that identifies any events that are outside the scope of what is considered a normal range. The main reason given for these reports were: staying late due to increased workloads and the inability to hand over. Only three ERs were reviewed within the seven-day target which meant the closure of ERs remained slow with only 53% of reports closed. There continued to be no fines of disbursements levied against the trust.

Leaders in all areas expressed the trust’s commitment to provide the best possible patient care. They stated services had a good safety culture which were demonstrated though local monthly scorecard returns and outcomes measures for example, mortality figures. Data seen showed that the trust’s Hospitality Standardised Mortality Ratio (HSMR) measurement for mortality remained within limits with a value of 103.2 (May 2019) against a national average of 100. The Summary Hospital-level Mortality Indicator (SHMI) value was at 1.10 against a national average of 1.00 and was within the expected range. HSMR is an overall quality indicator and measurement too that compares a hospital’s mortality rate with the overall average rate. SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die.

The trust ran two leadership programmes:

- Lean for Leaders which is a five-day course teaching staff the University Hospitals of Coventry and Warwickshire improvement (UHCWi) methodology and the tools and techniques used for process improvement.
- Leading Together a leadership development programme aimed at all leaders, from frontline to chief officers.

Over 900 staff had been through or were currently on Leading Together (263 in 2018/19) and nearly 200 staff had completed the Lean for Leaders training.

UHCWi is a system of tools based on lean principles, designed to help deliver continuous improvement and learning through the development of self-awareness, confidence and capability while ensuring that all leaders were equipped with the tools to deliver their leadership roles. Both programmes complemented each other by developing standards and management of work through the creation of visual displays, the organising of daily staff huddles and engagement with staff teams to promote and generate ideas using the plan/do/study/act method.

Mandatory training showed compliance across the trust. The training figure trust staff and bank staff as at August 2019 was 96% which was above the trust target of 95%. Continued support and challenge were provided to clinical groups through monthly accountability meetings to maintain focus on increasing/maintaining their compliance rates. Topics which had not achieved the trust target were monitored through the training, education and learning committee.

Staff had the opportunity to discuss their learning and career development needs at appraisal and showed compliance across the trust. All medical staff had an annual appraisal that covered the doctor’s whole practice, which took account of all relevant information relating to their fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For example, medical appraisals were above 90% with 10% being reviewed quarterly and discussed at the bi-monthly revalidation team meeting. The appraisal system was subject to a quality assurance process and the findings reported to the board and/or
governance group.

The trust had a system in place to ensure the appropriate pre-employment background checks were undertaken to confirm all doctors, including locum and short-term doctors, had the necessary qualifications and were suitably skilled and knowledgeable to undertake their professional duties.

In conjunction with the trust’s sustainability and transformation partners (STP), black, asian minority ethnic (BAME) leaders were supported to partake in the national “Stepping Up” programme. Stepping up is a leadership programme for BAME colleagues who work within the NHS.

**Board Members**

Of the executive board members at the trust, one (12.5%) was Black and minority ethnic (BME) and five (62.5%) were female. Of the non-executive board members one (12.5%) was BME and two (25.0%) were female.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>12.5%</td>
<td>62.5%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>12.5%</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>All board members</strong></td>
<td><strong>12.5%</strong></td>
<td><strong>43.8%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board members tab)

Trusts are required to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 19 of the Health and Social Care act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are of good character and have the right qualifications and experience to carry out this important role. We carried out checks to determine whether appropriate steps had been taken to complete employment checks for executive and non-executive directors, in line with the FPPR requirement. We checked two sets of directors’ personnel records and found that all the employment files were compliant with the FPPR requirement. NHS Improvement is the appointing body for NEDs, with the trust undertaking the appropriate pre-employment checks. The trust processed NED recruitment in the same way as all directors, following both the NHS Employment Check Standards and Fit and Proper Persons Requirements; including processing a Disclosure and Barring Service check and by checking the director/insolvency registers.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy to meet the needs of the local community. Leaders and staff understood and knew how to apply them and monitor progress. A five-year business plan was in place with objectives to deliver this which were revised each year. Trust’s strategic objectives and direction were clear and supported by well monitored enabling plans.

Trust strategy, vision and values underpinned a patient centred culture. Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team.

The trust had a clear vision, mission and set of values with quality and sustainability as the top priorities. The trust’s vision was to be a national and international leader in healthcare by ensuring that all patients received the very best care possible while their mission was to focus on providing...
and improving quality of care which included patient experience, safety and outcomes. The trust's values had been developed with staff and reflected what was important. Areas covered included:

- **Compassion** - treating everyone with courtesy and compassion
- **Partnership** - working in partnership to deliver and improve the services provided to patients.
- **Respect** - treat everyone with respect and dignity.
- **Improve** - open to change and seek to innovate to improve what we do.
- **Learn** - education, research and learning as central to improvement.
- **Openness** – to act with openness, honesty and integrity.
- **Pride** - take pride in all we do and aspire to do.

The introduction of the trust’s organisational strategy in 2018 had been rolled out across the trust during 2018/19 and was illustrated by a triangle which was visible throughout the trust. It was included in all meeting papers and acted as a reminder in meeting rooms for staff to live the trust’s values in everything they did. We saw posters of the strategy triangle, (vision, mission and values and objectives) throughout the hospitals which enabled staff to talk about the five-year strategy during our inspection.

(Source: Public website)

The trust organisational strategy was approved by the trust board in 2018 with a vision that aimed to ensure that patients receive the very best care possible. The strategy was underpinned by six strategies.

(Source: Public website)
The organisational strategy included the following objectives to help assess progress in its delivery. These were to:

- Deliver the safest care and excellence in patient experience.
- Be a model employer.
- Be a leader in operational performance.
- Lead the integration of care pathways for the populations we serve.
- Be a front runner in research, innovation and education.
- Achieve financial sustainability.

The quality strategy outlined the priorities for the trust in addressing the three dimensions of quality: patient safety, clinical effectiveness and patient experience. The strategy focused on providing care in line with national and local evidence-based guidance and identified areas for improvement through a continuous programme of audit. For example, the trust’s mortality indicators had reduced to be within the “as expected” range. To ensure the quality strategy underpinned the processes of the organisational strategy the trust told us they were in the process of refreshing this to ensure that it remained relevant and appropriate.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans. The delivery of the strategy was reviewed annually and each year a set of annual goals were agreed which were related to achieving the strategic objectives. The goals were included in the clinical group operational delivery plans and the personal development review documentation. This ensured that the goals were built in, as appropriate, to the annual objectives for every member of staff.

The trust informed us that the dementia strategy was currently in development with the first draft version due October 2019. The dementia strategy group met monthly and followed a set agenda which included: education, standards and clinical practice issues. There was a clear governance process in place with quarterly updates to the patient experience and engagement committee (PEEC) and annual reports submitted to nursing and midwifery committee (NMC). Membership of the group had been reviewed to include representation from all organisational groups and the trust’s patient partners. Activity of the dementia strategy group initially focused on the development of an educational strategy.

The medicine optimisation committee received expert advice and direction on the safe and secure handling and the management of medicines within the trust. Areas covered included:

- The ratification of medicine related policies for approval.
- To review the medicines management risk register.
- Receive reports and monitor action plans from reporting committees regarding safe and effective use of medicines including controlled drugs.
- Receive assurance that the annual audit programme is effective including high level feedback on actions and trends.

The drugs and therapeutics committee promoted efficiency and cost effectiveness throughout the trust and health economy. Areas covered included:

- Reviewing all requests for new medicinal products and deciding whether the requests could be justified on therapeutic grounds.
- Maintaining a trust formulary of therapeutic agents that are available for use within the trust and subject to any restrictions on use.
- Reviewing prescribing within the trust to ascertain compliance and prevention of adverse drug reactions.
• Approve the National Institute for Health and Care Excellence (NICE) technological appraisal (TAs). Technology appraisals are recommendations on the use of new and existing medicines and treatments within the NHS.

The medical education strategy 2019-2021 was for all staff and patients using the trust’s services. The aim of the medical strategy was to ensure that the workforce had the skills and motivation to work as effective team players and had access to world class training facilities that would allow them to maximise their potential and continue to hone and adapt their skills in line with new innovations and challenges throughout their careers. The strategy was defined into five key objectives namely:

- Learning environment and culture.
- Educational governance and leadership.
- Supporting learners.
- Supporting educators.
- Developing and implementing prospectuses and assessments.

There was an acute liaison service which supported patients with learning disabilities admitted to the trust. Staff worked alongside a partnership agreement with another trust. The safeguarding team worked closely with the liaison service and were invited to the trust’s safeguarding committee. An annual report was submitted to the NMC which provided an overview of activity and recommendations.

The trust had recognised the need to develop a seven-day service and had created the Seven-Day Services Strategy UHCW 2019 to 2022. The aim of the strategy was to:

- To meet the clinical standards prescribed by NHS England for seven-day services.
- To involve staff, patients and other stakeholders in decision making.
- To consistently deliver safe, effective care to all patients that results in a positive patient experience.

Following a baseline assessment and gap analysis, the group directors determined priority areas for implementation/further development of seven-day services. Clinical groups supported their clinical services to identify potential solutions to ensure they met the clinical standards identified which were:

- Standard 2: Time to initial consultant review.
- Standard 5: Access to diagnostics.
- Standard 8: Ongoing daily consultant-directed review.
- Standard 9: Transfer to community, primary and social care.

Each speciality had individual performance metrics which included areas such as discharges, mortality, length of stay and readmissions. *(Source: P82)*

Performance against all set objectives were monitored through the performance framework. Key performance indicators aligned with key priorities and strategic goals were produced each month and monitored through trust scorecards. These metrics were reviewed annually to ensure they affiliated to both external and local strategic priorities. Performance against these were discussed and challenged through monthly and quarterly group performance reviews with corporate directors and chief officers as well as committee meetings feeding into the board.

**Culture**
Staff mostly felt respected, supported and valued and focused on the needs of patients receiving care. The trust promoted equality and diversity in daily work and provided opportunities for career development. The trust had a very open and transparent culture where patients, their families and staff could raise concerns without fear. All staff were fully committed and passionate about achieving the best possible outcomes for the patients in their care.

The trust’s strategy, vision and values underpinned an open, transparent and respectful culture which was patient centred. The leadership team informed us they worked hard to promote an open culture where patients, their families and staff could raise concerns without fear. Managers addressed poor staff performance with compassion and effectiveness where needed. The trust took appropriate learning and urgent action when concerns were raised. Feedback received during the inspection found that some staff felt that equality and diversity were not actively promoted in their day to day work and when looking at opportunities for career progression.

We held a series of staff drop-in sessions, focus groups and CQC presentations to provide information about the CQC inspection process and to take questions. These sessions were well attended by nurses of all grades, allied health professionals, some doctors, administration and support staff. Staff feedback were mainly positive and confirmed they were happy working at the trust and many commended on the open-door policy operated by the chief executive officer. Almost all staff recommended the trust as a good place to work and felt well supported and respected by their managers.

We saw the trust had created an equality and diversity action plan 2019/21 which recognised that BME staff were not proportionately progressing within the NHS into senior and leadership roles. The intended outcome was to ensure that BME staff had the opportunity to develop their leadership abilities and be involved in creating a transformational change in equality and diversity across the healthcare sector. Every employee undertook equality and diversity training as part of their induction. This assisted staffs understanding of equality and diversity and associated policy/legislation. Current compliance rate was at 99.29%. Additional training included unconscious bias which was delivered monthly as part of the leadership programme. Bespoke “dignity at work” and “transgender” training was available to departments and teams on request.

Volunteers played a key role at the trust and they were included in equality and diversity training sessions which included the understanding between direct/indirect discrimination and bullying and harassment. Deaf awareness training had been delivered on request and external contracted staff were given the opportunity to participate in a 10-week British Sign Language course. (Source: P81)

The trust had an organisational development, workforce and Innovation strategy 2018/2021 which was aligned to the trust’s vision, values and goals by optimising their potential and putting patients first. The aim of the strategy was to transform culture to make the trust a great place to work. The strategy was divided into three areas which included:

- Organisational Development - supporting a culture where the trust could contribute to improvements and decision making whilst demonstrating behaviours aligned to our values.
- Workforce - supporting a culture where staff happy, healthy and motivated at work.
- Innovation – supporting a culture where staff are empowered and encouraged to share and develop ideas.

The trust had a collaborative quality strategy that described and drove the improvements required to enhance its safety culture. The trust had improved its incident reporting by over 36% specific to those indicators relating to safety culture within the staff survey. The trust had a culture of continuous improvement and continued to strive for further excellence in its delivery of being a
safe organisation. (Source: PIR submitted by the trust). We looked at five serious incidents and found the reporting to be informative and well laid out. We observed that where appropriate the duty of candour had been applied appropriately. The trust had held a duty of candour event which identified several changes including renaming duty of candour as “saying sorry.” (Source: Board meeting minutes May 2019)

Staff Diversity
The trust provided the following breakdowns of medical and dental staff, qualified nursing and health visiting staff, and qualified allied health professionals by ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Medical and dental staff (%)</th>
<th>Qualified nursing and health visiting staff (%)</th>
<th>Qualified allied health professionals (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>34.8%</td>
<td>61.9%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Black and minority ethnic</td>
<td>36.6%</td>
<td>27.9%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Unknown / not stated</td>
<td>28.5%</td>
<td>10.2%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

NHS Staff Survey 2018 results – summary scores:
The trust had several ways in which they listened to staff to seek feedback and generate ideas for improvements. These included a quarterly staff friends and family test (FFT), first and last impressions (a survey of starters and leavers within the trust), listening events, involvement in the trust’s UHCWi programme, safety huddles, chief officer roadshows, the job evaluation survey tool (JEST) (a new tool to evaluate postgraduate training posts) and junior doctor forums. The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten. A higher score indicates a better result.

The trust’s staff survey 2018 scores for the following themes were significantly higher (better)
when compared to the 2017 survey:

- Quality of care.
- Safety culture.
- Staff engagement.

There were no themes where the trust’s scores were significantly lower (worse) when compared to the 2017 staff survey.

(Source: NHS Staff Survey 2018)

The trust’s staff survey scores were higher than the national average for eight of the ten themes. The trust had made improvements across six of these themes. Staff feedback on the themes of safety culture, quality of care and staff engagement showed significant improvements. For example:

- Safety culture: (a) The belief that staff who are involved in error or incident are treated fairly; and (b) Providing feedback in response to reported errors emerged as a clear strength indicating the level of empowerment and fairness experienced by staff.
- Staff engagement and morale: (a) Staff reported that they looked forward to going to work, this was an indicator of overall engagement and an area where the trust had seen consistent improvements; and (b) The belief that staff could make improvements to their area of work also improved. Senior staff said that this improvement had been through various areas of work including the implementation of UHCWi (the lean management approach).

Areas for improvement included:

- Health and Wellbeing: Being unwell due to work related stress was an area of concern and a series of actions were being undertaken by occupational health and the health and wellbeing team. Progress was being monitored by the strategic workforce committee. (Source: PIR121).
- Bullying and harassment was an area of concern and the trust recognised the need to have sharp focus to improve staff feedback on this. As part of national anti-bullying week, the trust ran an internal bullying and harassment survey and subsequently they have an action plan in place. Progress was monitored by the strategic workforce committee. (Source: PIR 121, 104).

Our interview with the senior leadership team including the chief information and workforce officer and Freedom to Speak Up Guardian (FTSUG) demonstrated that the trust was committed to tackling instances of bullying and harassment. During the inspection we heard examples of mixed staff dissatisfaction, including hot spot areas of cultural and Equality Diversity and Human Rights (EDHR) concerns. Whilst the FTSUG arrangements were well resourced and accessible, we heard of staff feeling frightened to speak up. However, most staff said they felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the FSUG.

For the period June 2018 to December 2018, there were 21 cases identified which were attributed from the appointment of the FTSUG in September 2018. Workplace relationship 19% (four) was the highest area of concern followed by bullying, harassment and aggressive behaviour 14% (three). Source P103

As part of the strategic objective to be a model employer the trust was committed to creating an environment where everyone could be their best. The trust undertook a specific campaign called “Break the HABIT” (Harassment and Bullying is not tolerated)). This campaign was overseen by a multi professional task and finish group incorporating staff side, workforce, engagement, head of diversity, external company’s human resources manager and the FTSUG.
The results for the HABIT campaign (January 2019) showed that 67% (543) stated they had been bullied and/or harassed in the last two years and 64% (354) respondents said this was still happening. The type of bullying/harassment was:

- humiliation 24% (320).
- shouting/threatening/intimidation 23% (314).
- being ignored 19% (260).
- set unreasonable workloads/targets 18% (239).
- Excessively monitoring of work 15% (207).
- Physical abuse 1% (14).

We saw the action overview resulting from themes identified in the HABIT campaign which included an agreed monthly focus. Bullying and harassment was also identified as a feature within the trust’s “This Week @ UHCW” (April 2019). *(Source: P104)* This meant the trust had taken the appropriate learning and action resulting from concerns raised.

**Duty of Candour**

From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. The trust had embraced the duty of candour regulation and had effective processes in place. There was a duty of candour policy in place and was clear, appropriate and reflected the requirements of the regulation; it included a section on surgical consent and candour with hyperlinks to the consent to treatment policy. Incidents submitted as part of the provider information request provided evidence of duty of candour had been appropriately applied. Staff knew the triggers (moderate harm above) and awareness of the regulation was well-embedded in areas visited. All patients who had suffered harm (moderate or severe harm) received an apology within 10 days of the incident being reported. For minimal harm, duty of candour according to the regulation does not apply but there was an expectation at a local level of being open and honest: staff must still give an apology. Duty of candour was followed in all cases of a never event even when no harm had occurred. The senior clinician involved at the time of the incident was responsible for duty of candour: all patient or relative contact would be at consultant or modern matron level at a minimum.

**Workforce race equality standard**

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts must show progress against nine measures of equality in the workforce. The scores presented below are indicators relating to the comparative experiences of White and Black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard. The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- The questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
• The presence of a statistically significant difference between the experiences of BME and white staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts’ circumstances.

### WRES Indicators from ESR (HR data) ⊛

<table>
<thead>
<tr>
<th>WRES Indicators from ESR (HR data) ⊛</th>
<th>BME Staff</th>
<th>White Staff</th>
<th>Are there statistically significant difference between BME and White staff?</th>
<th>Last year and this year? (BME staff)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8+</td>
<td>2.2%</td>
<td>5.3%</td>
<td>✗</td>
<td>0.1%</td>
</tr>
<tr>
<td>1b. Proportion of non-clinical staff in senior roles, band 8+</td>
<td>10.4%</td>
<td>11.5%</td>
<td>✗</td>
<td>1.3%</td>
</tr>
<tr>
<td>2. Proportion of shortlisted candidates being appointed to positions</td>
<td>5.8%</td>
<td>7.6%</td>
<td>✗</td>
<td>-61.8%</td>
</tr>
<tr>
<td>3. Proportion of staff entering formal disciplinary processes</td>
<td>0.6%</td>
<td>0.6%</td>
<td>✗</td>
<td>0.3%</td>
</tr>
<tr>
<td>4. Proportion of staff accessing non-mandatory training and CPD</td>
<td>93.5%</td>
<td>94.7%</td>
<td>Not assessed</td>
<td></td>
</tr>
</tbody>
</table>

### WRES Indicators from the NHS staff survey (*)

<table>
<thead>
<tr>
<th>WRES Indicators from the NHS staff survey (*)</th>
<th>Proportion of respondents answering “Yes”</th>
<th>Are there statistically significant difference between...</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td>
<td>Trust: 22.1%</td>
<td>Peer group: 28.9%</td>
</tr>
<tr>
<td>6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months</td>
<td>Trust: 26.8%</td>
<td>Peer group: 30.1%</td>
</tr>
<tr>
<td>7. Staff believing that the trust provides equal opportunities for career progression or promotion</td>
<td>Trust: 76.3%</td>
<td>Peer group: 69.8%</td>
</tr>
<tr>
<td>8. Staff experiencing discrimination at work from a manager / team leader or other colleague?</td>
<td>Trust: 12.0%</td>
<td>Peer group: 15.9%</td>
</tr>
</tbody>
</table>

### Trust staffing numbers ⊛

<table>
<thead>
<tr>
<th>9. (BME) Voting Board Members and Board compared to overall staff demographic</th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>[1]</td>
<td>✗</td>
<td>[1]</td>
</tr>
</tbody>
</table>

**Key**

- ✗ Statistically significant or negative finding
- ✗ Not statistically significant
- ✗ Positive finding
- ✗ Statistical analysis not undertaken as less than 30 BME staff responded
- ✗ Statistically significant improvement
- ✗ No statistically significant change
- ✗ Statistically significant deterioration

As of March 2018, two of the ESR staffing indicators shown above (indicators 1a to 4) showed a statistically significant difference in score between White and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (2.2% of BME staff compared to 5.3% of White staff). This remained similar to the previous year, 2017.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (5.8% of BME staff compared to 7.6% of White staff). This was a significant decrease compared to the previous year, 2017. However, it should be noted that the very significant drop from 67.6% in 2017 to 5.8% in 2018 (a 61.8% drop) mainly resulted from the trust changing to a different reporting system in 2018. The trust noted that this system is more accurate than that used in 2017. The proportion of white staff appointed from shortlisting also fell considerably, albeit by a smaller proportion, from 53.9% to 7.6% (46.3%). See the trust’s WRES report 2018, page 3).

Of the four indicators from the NHS staff survey 2018 shown above (indicators 5 to 8), three showed a statistically significant difference in score between white and BME staff:

5. 22.1% of BME staff experienced harassment, bullying or abuse from patients, relatives and
the public in the past year which was significantly lower when compared to 28.2% of White staff. This remained similar to the previous year, 2017.

7. Aor promotion which was significantly lower when compared to 86.5% of White staff. This remained similar to the previous year, 2017.

8. 12.0% of BME staff experienced discrimination from a colleague or manager in the past year which was significantly higher when compared to 5.7% of White staff. This remained similar to the previous year, 2017.

There was one BME voting board member at the trust. This was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

NHS England developed an equality delivery system (EDS) that helped NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. A refreshed EDS known as EDS2 was made available in November 2013. An open event was held with 30 to 35 individual stakeholders to co-develop the EDS2 action plan. This included community providers and other service areas within the trust to identify actions to address issues impacting on individuals.

We saw that the action plan (2019-2021) met both the trust’s strategic objectives as well as the EDS2 outcomes. Examples of areas covered included: knowledge update, patient experience, black and minority ethnicity (BME) staff progression and supporting disabled staff. (Source: P100.2). The EDS2 was signed off by trust board and the independent advisory group (IAG). The IAG was made up of trust staff (clinical and non-clinical) as well as members from local community groups and the local authority. The IAG monitored the EDS2 action plan bi-monthly and monitored staff and patient issues in relation to equality and inclusion.

Friends and Family test
The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 90.0% and 93.1% from July 2017 to June 2019.

University Hospitals Coventry and Warwickshire NHS Trust – Friends and Family Test scores July 2017 and June 2019
The response rate chart below is included to give context as the trust’s Friends and Family test scores showed statistically significant findings. The response rates for the relevant months, November 2017 to August 2018, were quite similar to the overall response rate for the whole 24-month period.

University Hospitals Coventry and Warwickshire NHS Trust – response rate May 2017 and April 2019

(Obtained from NHS England Friends and Family Test)

Compassion and respect were two of the seven trust values. The trust informed us that patient care and feedback was invaluable in ensuring staff were treating patients with kindness. Putting the patient first was a core principle of the UHCWi methodology embedded across the organisation. The trust aimed to achieve the following by:

- putting patients first.
- empowering all staff.
- delivering safe care.

The trust’s internal system allowed all verbatim comments provided through the friends and family test (FFT) and patient survey to be regularly reviewed with action logs created to highlight relevant improvements where needed. The trust's performance for FFT was shared through its governance process with key areas identified in regular “We Care” reports.

The trust's patient advice and liaison service (PALS) provided support and information for patients and carers seven days a week. Since the 2018 inspection the trust had introduced values based FFT, linking feedback to the trust values. Patient experience had been improved with the introduction of specific rooms for difficult conversations and toolkits to support patients with complex needs to communicate with staff.

Sickness absence rates
The trust’s sickness absence levels from April 2018 to March 2019 were consistently similar to the England average.
The trust was aware of the need to reduce staff sickness and constantly monitored sickness figures. The overall trust sickness absence rate in August 2019 had increased by 0.07% to 4.76%, which was above the trust target of 4%.

Sickness rate April to August 2019

National guidance from NHSI changed in September 2018 and safe staffing was now measured using Care Hours per Patient Day (CHPPD) rather than fill rate. The trust had embedded safe staffing meetings to ensure that the right staff were in the right place at the right time both day and night. Senior staff monitored staffing levels which were reported through the nursery and midwifery committee. The trust undertook an annual nursing and midwifery workforce budget and planning review of all in-patient areas. We saw that for quarter four (January to March 2019), the registered midwives/nurses staffing rate for in-patient areas were compliant at 95%. A total of 320 nurses and midwives had been recruited against a 2018/19 target of 310. To safeguard patients there were daily oversight at specialty huddles which ensured staff were reallocated according to service demands. Recruitment plans continued with trajectory monitored locally. During the same period the staffing rate for health care support workers was compliant.

To support the trust’s recruitment drive, they were working with an external organisation which allowed them to advertise and promote their medical and dental vacancies via their website. Open days for recruitment had been held at both Hospital St Cross and the University Hospital Coventry. Dependency versus staffing levels was assessed using the safety nursing care tool, monthly fill rate and the CHPPD report provided to the trust board bi-annually together with a monthly exception CHPPD report. The associate director of nursing led a twice daily safe staffing meeting where actions were recorded and agreed to mitigate safety and staffing risks. There was a monthly nurse agency reduction group which supported the planned reduction in the reliance of agency and the development of bank supply staff. This worked alongside the nurse recruitment plan.
plan which included: overseas recruitment and the development of new roles.

General Medical Council – National Training Scheme Survey
In the 2019 General Medical Council Survey, the trust performed as expected for all 18 indicators.
(Source: General Medical Council National Training Scheme Survey)

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, we could not be assured that there were appropriate governance arrangements in place in relation to Mental Health Act administration and compliance.

World Patient Safety Day took place on 17 September 2019 and is an annual event initiated by the World Health Organisation. The Trust took an active part starting with stand up in the morning highlighting the fantastic work the trust had undertaken in improving patient safety over the past three years. All staff were encouraged to wear orange for the day signalling their commitment to ‘speak up’ for safety

Governance arrangements were clear with information and decisions flowing through tiers well. Papers for board meetings and other committees were of a reasonable standard and contained appropriate information, the board had recognised where developments would enhance current arrangements. The trust’s governance and performance management process which included group triumvirates attending monthly accountability meetings with corporate directors and quarterly performance reviews (QPRs) with chief officers. The board monitored trust-wide performance against key performance indicators within the integrated quality, performance and finance report (IQPR).

Outcomes of the QIPS meetings were submitted to the group management board to provide assurance that actions arising were being undertaken in a timely way. The clinical group was accountable to chief officers for the delivery of performance through quarterly performance reviews. Performance metrics were reported at all levels of the organisation. For example, the safer staffing reports and the quality, effectiveness and safety trigger tool (QUESTT) was reviewed from ward through to trust board. QUESTT is a self-assessment tool that enables senior staff to review and monitor key information to understand and support the management of pressure that may affect the quality and safety of care being delivered.

Non-executive directors (NEDs) and executive directors were clear about their areas of responsibility and participated in the carrying out of board walk-rounds and visited ward areas and met with staff. Not all meetings were recorded as some were done on an “ad hoc” basis or in relation to normal operations (such as executive rounding). Examples of recorded walk-round included:

- Visits to wards, attendance at safety huddles and “genba” walks. Genba is a term from the trust’s lean programme and means “the place where the work is done.” For example, data seen showed visits to wards 22a (vascular), ward 41 (stroke medicine) and ward 31 (respiratory and infectious diseases). (Source P90.2)
- Question and answer sessions for staff on “leading together”. Leading together is the trust’s management development programme.
- ‘Day in the life sessions’, where chief officers spent half a day alongside a key team, so they could understand the issues affecting that team. These visits were written up on the
trust’s weekly communication ‘This Week’.

Wards and departments reviewed quality through daily safety huddles, department meetings and ward level quality data. Each speciality and clinical group held monthly multidisciplinary quality improvement patient safety (QIPS) meeting. Managers used these meetings to review patient safety, clinical effectiveness and patient experience in line with the trust strategy. There was a clear framework which set out the structure of wards/service teams, departments and senior trust meetings. The re-structure to seven clinical groups has increased strength of scrutiny, risk management and business focus at sub board member level. Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

Another trust provided a mental health liaison service. The governance framework did not always address the needs or meet people’s physical health care and we were not assured that there were appropriate arrangements in place in relation to Mental Health Act administration and compliance within the emergency department.

Following the inspection, the trust informed us that they recognised historic underfunding of mental health provision and the added pressure that this placed on the trust. The trust was pursuing improved mental health provision with partners in both adult, and child and adolescent mental health services. The trust were leaders in the STP Mental Health and Emotional Wellbeing Programme and was an active member of the acute and crisis care workstream.

The trust aimed to create a joined up and integrated urgent care pathway to support individuals with acute mental health distress. This was to include:

- An enhanced and improved Crisis Resolution and Home Treatment Teams (CRHTT) treatment and response times. This was a phased implementation which was due to commence in January 2020 with the introduction of Fast Response Hubs to be followed by an enhanced Home Treatment Team.
- The enhanced Acute Mental Health Assessment Team (AMHAT) to meet its “Core 24” service standard in January 2020 to make mental health liaison services available 24/7 for acute hospitals in Coventry and Warwickshire.

Board Assurance Framework

The trust had developed its Board Assurance Framework (BAF) over the last two years to include re-aligning it to the revised strategy. The trust provided us with their Board Assurance Framework as of March 2019. This detailed six strategic objectives and accompanying risks within each. A summary of these are below.

- To deliver the safest care and excellence in patient experience.
- To be a leader in operational performance.
- To be a model employer.
- To achieve financial sustainability.
- To be a frontrunner in research, innovation and education.
- To lead the integration of care pathways for the population we serve.

(Source: Trust board assurance framework)

Our observations during the inspection and review of documentation demonstrated that there was a clear process to provide the trust board with assurances. Assurances were provided to the board through committees, sub-committees and reports. There were three main committees which reported directly to the board. These were the quality governance committee, finance and performance committee and audit committee. Feeding into these three committees were several
sub-committees including medicines optimisation, mortality review, and risk committee. However, during the inspection we found that the links between the board assurance framework and corporate risk register required strengthening. The board were aware of the need to review approaches and a development day had been planned later in the year. The trust informed us that the planned further developments would include greater visibility of the links between corporate risks and the BAF and how controls and assurances would be reviewed.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

We found robust arrangements in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their “worry list”.

The non-executive directors spoken with said that they had sight of the most significant risks and found that mitigating actions were clear. They demonstrated good knowledge of the risks attributed to the trust.

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts. Outstanding actions relating to serious incidents had reduced overall for the last two years. The trust strived to achieve 100% compliance with the management of incidents in line with its policy. Incidents were regularly reviewed, and assurances were given to the trust board that these continued to be reviewed and looked at by the governance team with accountability to quarterly performance meetings.

There were plans in place for emergencies and other unexpected or expected events such as adverse weather, a flu outbreak or a disruption to business continuity. The trust had put processes in place for frontline staff to be vaccinated. Data seen showed that 78% of staff had taken advantage of having the flu vaccine which supported the safety of patients attending the hospitals.

Leaders were satisfied that clinical and internal audits provided assurances. Teams acted on results where needed. The trust has participated in 100% of the national audit activity identified within the 2018/2019 audit programme enabling the monitoring of key standards of care and the implementation of quality improvements based on patient outcomes. A total number of 372 actions had been fully implemented relating to clinical audit activity with the trust performance reported as being the fifth highest nationally regarding their participation in the national chronic obstructive pulmonary disease audit.

The trust’s learning from deaths and review outcomes and mortality data enabled the trust to benchmark and compare outcomes with other organisations such as other major trauma centres and regional peers. Review of outcomes data such as mortality rates had allowed the trust to monitor, identify and investigate risk areas in a timely manner and respond to outlier status reports as part of a robust process.

The trust was participating in Getting It Right First-Time (GIRFT) reviews and had clinical lead support enabling them to move forward with its implementation plans. GIRFT is a national programme, led by clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice.

Finances Overview
The deficit reported in 2018/19 was more than two times the deficit for 2017/18. The trust projected small surpluses for 2019/20 and 2020/21.
(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

Currently there was no reported variance either with the year to date or forecast to the financial plan. The high level of risk was reported through the BAF. The drivers for this risk was described in the integrated finance report and discussed monthly in the Finance and Performance Committee.

The March 2019 year to date position showed a £31.8m deficit against £15.9m planned deficit, which was a £15.9m adverse variance to plan which meant the year to date financial control total has not been met. The forecast position as at March 2019 showed a £33.6m deficit, against £9.7m planned deficit, which was a £23.9m adverse variance to plan which meant the forecast financial control total had not been met. However, this forecast was in line with the revised forecast submitted to NHSi in January 2019. (Source: Finance and Efficiency Report March 2019 - P114.6)

The trust’s financial position was forecast to be in line with the financial plan as at 31st March 2020 except for:
- A significant variance in property plant and equipment balances due to the downward revision of expected capital spend. This was due to the limited loan funding available and the further slippage of finance lease schemes. This was offset by a reduction in the amount of capital loan and finance lease borrowing required.
- A favourable movement in retained earnings due to the final 2018/19 provider sustainability fund (PSF) allocation and shortfall in return on equity (ROE) pay award funding.
- An increase in the revaluation reserve because of the 2018/19 revaluation exercise.
- Movements in receivables and payables which offset the above improvements in reserves.

Trust corporate risk register
The trust provided their corporate risk register, which details current risks and how they are being managed. This included 109 risks with a risk score of “high” as of June 2019. Of these five had a current consequence score of “catastrophic”, while 58 had a current consequence score of “major”. The five risks with a current risk score of “high” and current consequence score of “catastrophic” are shown in the table below.

<table>
<thead>
<tr>
<th>Date risk opened</th>
<th>ID</th>
<th>Description</th>
<th>Risk score (current)</th>
<th>Risk level (target)</th>
<th>Next review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2016</td>
<td>2472</td>
<td>A hybrid operating theatre is an operating theatre which has a fixed image intensifier and equipment for</td>
<td>High</td>
<td>Low</td>
<td>30/08/2019</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year (2017/18)</td>
<td>Last Financial Year (2018/19)</td>
</tr>
<tr>
<td>Income</td>
<td>£630.7m</td>
<td>£668.2m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£14.8m)</td>
<td>(£30.1m)</td>
</tr>
<tr>
<td>Full costs</td>
<td>£645.5m</td>
<td>£698.3m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£0.3m)</td>
<td>(£9.7m)</td>
</tr>
</tbody>
</table>
performing vascular surgery. Modern vascular surgery requires good quality imaging and stock of equipment kept in theatre to perform modern surgical techniques. These cannot be carried out using the current facilities in both elective or acute settings. Hence patients are being offered ‘older’ techniques which have a higher morbidity and mortality rather than modern techniques.

In addition, staff are being exposed to higher levels of radiation than would occur if we had a fixed system for imaging. A hybrid operating theatre is recommended by the MHRA for the above reasons on safety grounds.

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident Number</th>
<th>Description</th>
<th>Risk Level</th>
<th>Control Level</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2017</td>
<td>2590</td>
<td>There have been three incidents of transfusion associated circulatory overload (TACO). [Patient data from original risk register removed. In two of these cases the patient died. WEB numbers 55080, 75320 and 79216.] All above patients were either over transfused or transfused too quickly. Added to risk register in view of trend.</td>
<td>High</td>
<td>Low</td>
<td>02/08/2019</td>
</tr>
<tr>
<td>April 2017</td>
<td>2540</td>
<td>If the trust does not deliver the fire compartmentation remediation plan and maintain our current high levels of control and risk mitigation then the risk of a fire incident developing might increase. Resulting in potential patient harm and/or consequent risks to the trust’s ability to deliver effective and safe services</td>
<td>High</td>
<td>Mod</td>
<td>01/10/2019</td>
</tr>
<tr>
<td>May 2018</td>
<td>3086</td>
<td>There have been multiple events where public, including patients, have accessed the roof above the Arden Centre in a threatened attempt at suicide/self-harm. They have been rescued by security but due to the height of the roof if they had been successful the result of a successful attempt would be serious injury and potentially death.</td>
<td>High</td>
<td>Low</td>
<td>02/09/2019</td>
</tr>
<tr>
<td>March 2019</td>
<td>3309</td>
<td>Patients sustaining falls in the emergency department due to environmental and equipment constraints, causing harm to</td>
<td>High</td>
<td>Low</td>
<td>28/06/2019</td>
</tr>
</tbody>
</table>
patients.  
(Source: Trust corporate risk register, June 2019)

The Integrated Quality, Performance and Finance Report covered the trust’s reported performance. Data seen showed that for August 2019, the trust achieved 16 of the 35 indicators reported within the trust’s performance scorecard. The scorecard aligned with the objectives outlined in the 2018-2021 Organisational Strategy. Key indicators in breach against the trust’s performance were:

- 18 weeks referral to treatment.
- Cancer 62-day screening.
- Emergency care four hour waits.

Key indicators achieving the target included:

- Diagnostics waiters – six weeks and over.
- Mandatory training compliance.
- Last minute non-clinical cancelled operations elective.

Emergency four-hour wait
Emergency four-hour wait was at 85% for August 2019. This was below the latest available benchmarked position for England but was above for the Midlands area. Ambulance handover items for 30 (96.8%) and 60 (99.8%) minutes both remained below target.

<table>
<thead>
<tr>
<th>Stream</th>
<th>Last Month</th>
<th>Current Month</th>
<th>Last Year</th>
<th>This Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1 Minors</td>
<td>88.06%</td>
<td>91.13%</td>
<td>93.83%</td>
<td>92.55%</td>
</tr>
<tr>
<td>Type 1 Majors</td>
<td>61.81%</td>
<td>62.66%</td>
<td>64.82%</td>
<td>64.34%</td>
</tr>
<tr>
<td>Type 1 Resus</td>
<td>60.39%</td>
<td>54.21%</td>
<td>59.63%</td>
<td>58.36%</td>
</tr>
<tr>
<td>Type 1 Paediatrics</td>
<td>97.80%</td>
<td>92.89%</td>
<td>93.27%</td>
<td>93.38%</td>
</tr>
<tr>
<td>Local Health Economy</td>
<td>85.19%</td>
<td>85.29%</td>
<td>86.92%</td>
<td>86.41%</td>
</tr>
</tbody>
</table>

(Source: Integrated Quality, Performance and Finance Reporting Framework)

Referral to Treatment
Staff had access to the risk register either at a team or departmental level and were able to effectively escalate concerns as needed. Staff spoken with during the inspection matched concerns found on the risk register which included: referral to treatment (RTT) performance, delays to mental health units for patients and the failure to assess patients in 15 minutes within the walk-in centre.

The trust’s RTT incomplete position remained below the national target of 92% and stood at 85% (July 2019). The focus on 40-week waits had improved and the trust continued to maintain its zero 52-week breaches.

The trust’s cancer targets were achieved except for the cancer 62-day screening target. Senior leaders stated that they had a target of achieving this target by April or May 2020. (Source: September board meeting minutes 2019). Ambulance turnover rates had improved with 100% being achieved within 60 minutes. The rapid assessment area had improved this process with patients being transferred from trolleys immediately when appropriate. NHS Improvement had acknowledged that this trajectory was being achieved by the Trust.

Patient Flow
• The national Long Length of Stay (LLOS) workbook and coding system was introduced into the trust (5th July 2019). To embed this, the trust introduced ‘Discharge Wednesday’ where matrons met with multidisciplinary team colleagues to review all patient discharge progress and record this on a central database. This meeting formed the basis for continuing work across the week with a bi-weekly “huddle” with chief officers and lead directors. The trust had been identified as being in the lower quartile regionally for their LLOS and intensive actions were being operationalised by the chief operating officer (COO) in partnership with the chief medical officer (CMO) and chief nursing officer (CNO).

• A second Community Hub event (11 September 2019) had been held with system partners to develop an overview of capacity for escalation and processes for when additional capacity required authorisation (with timescales for response/action). The integrated delivery team lead was co-IDT co-ordinating this work to link with winter planning.

• A simple discharge waste reduction scheme was on track for delivery. All wards (nine) took part and had discharge production boards in place and were currently doing focused work on “to take out” (TTOs) and blood requests. There was a weekly board round where improvements were shared and “ward of the week” identified and voted for by peers.

The BAF had been reviewed by both the risk committee and audit committee to discuss the risks contained therein. The audit committee had undertaken a deep dive into the assurances of two BAF risks for safety metrics and financial sustainability. This allowed the committee to ascertain whether the overview and levels of control were effective. We saw the trust board had requested that the BAF risk score identify any improvement or deterioration. (Source: Board meeting minutes September 2019).

Safeguarding
The trust safeguarding team had a robust governance system that ensured safeguarding was paramount and embedded throughout the organisation. The safeguarding team shared with the board that three of the five safeguarding training compliances were above the trust target of 95% and all five had achieved the clinical commissioning group target of 90%. There had been 19 safeguarding concerns raised by the trust of which 13 were raised by trust staff indicating the trust’s values of openness and knowledge of the Care Act 2014.

The trust had seen its training figures achieve 95% for PREVENT awareness. PREVENT is about safeguarding and supporting those vulnerable to radicalisation. Training compliance for clinical band 7’s and above in relation to the Mental Capacity Act (MCA) was at 91%. The trust trajectory was to reach 95% by the end of quarter two (July to September 2019).

Infection prevention and control
The trust continued to perform well against Department of Health (DH) targets. Compared to 35 teaching NHS Trusts, the combined unweighted rank for the hospital was second for the outbreaks of MRSA, MSSA (Meticillin Sensitive Staphylococcus Aureus, a type of bacteria (germ) which lives harmlessly on the skin) and Clostridium difficile (C.difficile) (bacterium that’s found in people’s intestines). This reflected the trust’s excellent performance in infection prevention and control across the hospitals.

Infection prevention and control annual report 2018-19

<table>
<thead>
<tr>
<th>MRSA rate per 100,000</th>
<th>MSSA rate per 100,000</th>
<th>C.difficile rate per 100,000</th>
<th>E.Coli rate per 100,000</th>
<th>MRSA rank</th>
<th>MSSA rank</th>
<th>C.difficile rank</th>
<th>E.coli rank</th>
<th>Summed rank</th>
</tr>
</thead>
</table>
Infection control training for 2018/19 was at 94% which was just below the trust target of 95%. Hand hygiene remained a key indicator of quality for the trust and compliance rates across the trust were 95% for 2018/19 which was equal with the trust target.

<table>
<thead>
<tr>
<th>Training</th>
<th>2017-2018</th>
<th>2018-2019</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand hygiene</td>
<td>89.9%</td>
<td>95%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Mandatory infection prevention</td>
<td>85%</td>
<td>93.9%</td>
<td>8.9%</td>
</tr>
<tr>
<td>and control</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: September Board meeting minutes 2019)

Cleanliness

Cleaning at the trust was undertaken by external providers. National cleaning standards (NCS) 2004 provided the contractual obligation against which the external company was audited and managed. In addition, the matrons and the infection prevention and control team utilised the infection control nurses’ association audit environmental audit (ICNA) tool. Cleaning issues and environmental audit score were recorded on the infection prevention and control scorecard. The results and any concerns were raised at the monthly infection prevention and control quality meeting. This was managed at weekly meeting between the estates team and the external contractor.

Sepsis

Over 2018-19, the sepsis team saw many changes and improvements across the trust. This resulted in the reduction of mortality attributed to sepsis in patients. The trust had been placed in the ‘expected’ category for relative risk in national comparison with other acute trusts. In June 2018 the sepsis introduced sepsis trolleys into five areas within the trust. The trolleys contained everything required for timely treatment. The introduction of a sepsis trolley coincided with the introduction of the Sepsis Outcome Response Team (SORT). This team was made up of emergency department (ED) staff who attended all patients with potential sepsis to deliver prompt initial treatment. At the end of March 2019, ED were screening 92% and treating 86% of patients within an hour and 76% of inpatients were being screened appropriately with 64% being treated promptly.

The sepsis team worked alongside the UK Sepsis Trust to facilitate a local post sepsis support group for patients and their families to attend. The support group provided insight into how sepsis and its treatment could affect patients leading to the sharing of post sepsis information with local GPs and communities’ teams. Sepsis information leaflets and discharge packs were available across the trust which ensured that patient and their family were empowered.

Information management

The trust collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The trust was aware of its performance using key performance indicators and other metrics. This data fed into a board assurance framework to ensure the board had information on service quality and sustainability. The board reviewed performance reports that included data about the services
which departmental groups could challenge. The board and senior staff expressed confidence in the quality of the data and welcomed challenge.

The trust collected, analysed, managed and used information well to support activities. Data for internal and external reporting went through robust data quality checking processes. Leaders used meeting agendas to address quality across the trust. Staff said they had access to all necessary information which was in an accessible format, timely, accurate and identified areas for improvement. Staff also said they were encouraged to challenge the reliability of data where appropriate.

Information governance systems were in place including confidentiality of patient records. The trust had upgraded its hardware and software programmes to enable a document interface with the GPs system. For example: a GP “Pathology copy to” interface had been developed that provided GPs with an electronic copy of the hospital’s results directly into their system.

The trust had a Caldicott Guardian, and information governance manager and a Senior Information Risk Owner (SIRO). The role of the SIRO is to take ownership of the organisation’s information risk policy, act as an advocate for information risk on the board and provide written advice on the content of the annual governance statement regarding information risk. The chief medical officer was the Caldicott Guardian and was responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing.

The information and communication technology (ICT) team had retained their cyber essentials accreditation. They had also been successful in retaining both International organisation for Standardisation (ISO) 9001 (quality management system) and ISO 27001 (information security standard) accreditation.

A trust wide automated medication dispensing system was being implemented across the trust. An automated medicine dispensing system is a computerised drug storage cabinet which allowed medicines to be stored and dispensed near the point of care while controlling and tracking drug distribution. The roll-out of the medicine dispensing system was being undertaken gradually to ensure staff were fully compliant in its use. The aim of the system was to improve medicine management and patient safety.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations. The wards/service teams and departments had access to feedback from patients, carers and staff and were using this to make improvements. The trust had an employee engagement officer who was dedicated in improving engagement with staff. In addition, there was a group of 136 change makers who worked with the employee engagement officer to support engagement activities in the local area. Some of the works carried out included:

- Developing “proud” displays to encourage staff to shout about all their achievements.
- Encouraging staff to complete the staff Friends and Family Tests.
- Developing plans to support the completion of the 2019 staff survey through a series of one-stop clinics across both sites. The 2019 focus was on health and wellbeing which coincided with a national campaign.
The trust participated in joint working with partners through the Sustainability Transformation Plan (STP). Coventry and Warwickshire Healthcare Partnership was the name of Coventry and Warwickshire’s STP. The programme was a way for the NHS and social care in Coventry and Warwickshire to develop its own local proposals to improve health and care for local people. Coventry and Warwickshire Healthcare Partnership partner organisations include four provider trusts, three clinical commissioning groups, and two local authorities. The joint STP vision was to “work together to deliver high-quality care which supports the communities to live well, stay independent and enjoy life.” Areas for consideration included: improving quality and developing new models of care; improving health and wellbeing; and improving efficiency of services. The trust informed us that the better health, better care, better value board had agreed that arrangements should reflect local requirements and be a standalone Joint Strategic Needs Assessment (JSNA). This would form the basis of the five-year STP which was being developed. A dedicated programme team was in place to oversee the delivery of Coventry and Warwickshire Healthcare Partnership and progress was monitored via the STP board and quarterly meetings with NHS England.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they had. This quarterly Patient Experience (We Care) report brought together information on compliments, complaints, patient feedback, patient involvement, board walk rounds and information from the Involvement Hub.

The board received an equality and diversity report each year for assurance that the trust was meeting its statutory duties under the Equality and Human Rights Act 2010. In addition, the report provided information and equality and diversity activities and actions in relation to staff, patients, visitors and carers. The report also contained the trust’s workforce race equality standard (WRES) action plan and progress against its delivery.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Staff were being supported to have a good understanding of quality improvement methods and developing the skills to use them. Leaders encouraged innovation and participation in research.

The UHCWi management and improvement system has been developed through a five-year collaboration between NHS Improvement and a hospital in the United States of America. This would be achieved through:

(Source: trust public website)

UHCWi was based on lean principles, designed to help deliver continuous improvement. A team of staff trained in the UHCWi methodology taught and coached staff in the use of the management system. Training was aimed at senior leaders in the organisation initially and was now open to all members of staff in a leadership role, both clinical and non-clinical.

This was achieved through a range of training sessions which included for example:

- UHCWi Improvement Passport - five bite-sized sessions covering the UHCWi methodology. These sessions had seen 1,700 staff participate since inception.
• Lean for Leaders – five-day long sessions which looked at the following:
  o Background of the method and understanding staff’s role as a leader for change and how to create a sense of urgency.
  o Understanding processes from a patient’s perspective and to focus the teams’ improvement ideas.
  o Understanding the burden of work on staff.
  o Learning the tools of the improvement method to apply to the knowledge
  o Staff to develop standard work, production and improvement boards where the work happened.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. To promote a culture of openness and learning, all chief officers extended an open invitation to any other member of staff to attend “stand up” Tuesday in the hospitals main public entrance at Coventry and in the main outpatient department at hospital St Cross, Rugby. Stand up Tuesday offered staff the opportunity to discuss areas of learning.

Research
The trust had a dedicated research and development team of professionals committed to developing research. Each year nearly 5,000 people took part in research studies at the trust and the trust had around 400 studies running at any one time. Patient and public involvement was defined by “INVOLVE”. INVOLVE is a national advisory group, funded by the Department of Health, that promotes public involvement in health and social care research. The trust’s patient and public involvement and engagement team held quarterly patient and public research advisory group meetings where researchers could present their project to members of the group, who were either patient’s carers or members of the public. (Source: public website)

Complaints process overview
The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months (May 2018 to April 2019).

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>Three working days</td>
<td>89%</td>
</tr>
<tr>
<td>What is your target for completing a complaint?</td>
<td>25 working days</td>
<td>70%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>Not provided</td>
<td>Not provided</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>3,455 (May 2018 to April 2019)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab; trust complaints policy)

Number of complaints made to the trust
From May 2018 to April 2019, the trust received 682 complaints. Medical care received the most complaints with 24.9% of the complaints received by the trust. This was followed by surgery (22.4% of complaints) and outpatients (14.7%). Four core services accounted for 75.5% of complaints made to the trust: medical care, surgery, outpatients and urgent and emergency care. In addition, 6.2% of complaints could not be mapped to a specific core service.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>170</td>
<td>24.9%</td>
</tr>
</tbody>
</table>
The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. The trust received over 682 complaints for the year 2018/19. A complaint satisfaction survey was sent to all complainants to gain feedback about whether the process was user friendly by gaining insight and learning from the user experience. During the year 72 responses were received which showed mostly positive results.

Senior staff spoken with said that the focus of the team was to improve the turnaround of complaints to progress the quality of the responses. The Patient Advice and Liaison Service (PALS) had managed 2,523 enquiries over the same period of which 3% went on to be a formal complaint. Staff spoken with confirmed they aimed to support the complainant through open dialogue and conversation. We saw that the complaints team were being supported by one of the non-executive directors who had the responsibility for complaints. They held regular meetings with the head of patient relations.

A Kaizen event took place at the end of August focussing on improving the complaints process and the way that complaints were allocated for response when the trust first received a complaint. Kaizen is a concept referring to business activities that continuously improve all functions and involves all staff. This was part of a continuing drive to tackle the underlying problems in managing complaints within the trust’s 25-day target. The performance had been discussed at the quality governance committee and chief officers’ group with a set of actions to address the backlog and develop options to enable a consistent achievement. Areas identified included:

- Improvement of the backlog.
- Increase the resilience of the team.
- Move towards a more engaged model with the clinical group.
- Develop a wider trust understanding of the complaints issuing process.

We spoke with the complaints’ team during the inspection who informed that many changes had been implemented including the recruitment of staff into the complaints team. They said they had begun to see improvement and were currently meeting 49% of complaints being responded to within 25 working days. A trajectory of achieving 90% by May 2020 had been set for the complaints team.

### Complaints activity and performance

<table>
<thead>
<tr>
<th>Quarter one</th>
<th>April 2019</th>
<th>May 2019</th>
<th>June 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of formal complaints received for further local resolution.</td>
<td>54</td>
<td>54</td>
<td>58</td>
</tr>
<tr>
<td>% of complaints acknowledged within three days</td>
<td>44 (83%)</td>
<td>41 (82%)</td>
<td>28 (52%)</td>
</tr>
<tr>
<td>% of complaints responded to in 25 working days</td>
<td>30 (56%)</td>
<td>20 (39%)</td>
<td>15 (33%)</td>
</tr>
<tr>
<td>% of complaints responded to or still within agreed</td>
<td>29 (54%)</td>
<td>24 (44%)</td>
<td>27 (47%)</td>
</tr>
</tbody>
</table>
The top five complaint subjects were:
- Communications – with patients (12), relatives (4), carers (2).
- Appointments – cancellations (8), delays (3) and errors (2).
- Clinical treatment (emergency department – delay or failure to diagnose (8), lack of clinical assessment (3) and delay or failure in treatment for infection (1).
- Patient care including nutrition and hydration – care needs not adequately met (4), communication with relatives/carers (2), patient care (2).
- Clinical treatment (general medicine group) – delay or failure in treatment or procedure (2), incorrect treatment (2) and delay or failure in observations (1).

(Evidence Source: Patient Experience Report (Quarter one) 2019-2020)

Compliments
From May 2018 to April 2019, the trust received a total of 1,592 compliments. The highest number of compliments were for medical care, with 26.1% of total compliments, followed by critical care (14.8% of compliments) and surgery (12.9%). A breakdown by core service can be seen in the table below:

<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical care</td>
<td>415</td>
<td>26.1%</td>
</tr>
<tr>
<td>Critical care</td>
<td>235</td>
<td>14.8%</td>
</tr>
<tr>
<td>Surgery</td>
<td>206</td>
<td>12.9%</td>
</tr>
<tr>
<td>Maternity</td>
<td>156</td>
<td>9.8%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>148</td>
<td>9.3%</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>130</td>
<td>8.2%</td>
</tr>
<tr>
<td>Services for children and young people</td>
<td>108</td>
<td>6.8%</td>
</tr>
<tr>
<td>Other</td>
<td>78</td>
<td>4.9%</td>
</tr>
<tr>
<td>Diagnostic imaging</td>
<td>70</td>
<td>4.4%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>33</td>
<td>2.1%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>8</td>
<td>0.5%</td>
</tr>
<tr>
<td>End of life care</td>
<td>5</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,592</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations
NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited. The table below shows which of the trust’s services had been awarded an accreditation as of July 2019.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Services accredited and dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy departments at both sites, August 2017 for five years</td>
</tr>
<tr>
<td>Medical laboratory accreditation</td>
<td>Cellular pathology and mortuary, December 2017</td>
</tr>
<tr>
<td></td>
<td>Clinical biochemistry and immunology, December 2016</td>
</tr>
<tr>
<td></td>
<td>Haematology, blood transfusion and phlebotomy, March</td>
</tr>
</tbody>
</table>
Work Experience
The trust had been awarded Fair Train’s Gold Quality Standard in recognition of the quality of its work experience programmes. The standard related to the full range of opportunities offered including clinical and non-clinical work placements; career taster days; healthcare taster weeks; internships and apprenticeships. These programmes combined with career events ensured that the trust was actively promoting careers in healthcare to the local community and potential future employees.

Apprenticeships
During September, 21 individuals had started a two-year MSc or MBA leadership programme and a further seven staff have commenced the four-year Chartered Managers degree programme delivered through Coventry University. These development programmes were part of the trust’s leadership development programme.

Health and Wellbeing
A new self-referral physiotherapy service for staff experiencing musculoskeletal (MSK) problems had been launched to staff working with clinical support services and medicine groups. In addition to the existing physiotherapy service, the new service was open to all staff and was aimed at both supporting to maintain their attendance at work and return to work more quickly following a period of absence.

The Hospital of St Cross at Rugby
The trust had successfully gained urgent treatment centre (UTC) status for Hospital St Cross, Rugby. The trust had strengthened its management and oversight by allocating a dedicated matron to the UTC. In addition, a new role of site manager for St Cross has been implemented to bring together the disparate service provided from that site.

Innovation
The trust had created an innovation hub located in their clinical science block. The hub was a defined space for innovation and transformation activity. The innovation hub had been carefully created and offered a flexible space to suit the needs of anybody who was after an area where they could formulate ideas and watch them grow to improve the quality of care the hospital offered. The innovation hub was divided into four areas:

- The red space – “A space to Dream” (a space designed for promotional based activities).
- The blue space – “A space to Think” (a space designed for thinking and small discussion activities).
- The green space – “A space to Create” (a space designed for group-based activities).
- The yellow space – “A space to Influence” (a space designed for classroom-based activities). (Source: Trust website)
The trust had secured a free trial of Dr. VR, a virtual reality distraction therapy solution to improve the patient experience. This was being trialled in the maternity services.

The trust had developed an innovative new ‘seasonality’ forecasting tool for predicting demand for outpatient appointments. This was based on comparisons of capacity of demand over the previous year. It had been implemented prior to the inspection and was demonstrating a proactive way for the trust in predicting future capacity and demand in the outpatients service.

All serious incidents and never events were emailed to the patient safety response team. A member of this team would go to the area to check on four main issues:

- How is the patient?
- How are the staff?
- Has duty of candour been enacted?
- Has an investigation been started?

A lead investigator was appointed on the same day from another speciality; they would contact the patient/family at the beginning of the investigation. The patient safety team had a safety huddle every morning at 8am (Monday to Friday) to look at all incidents received in the previous 24 hours (72 hours on a Monday). We observed one meeting and found it was very focused on patient safety and experience. Clear processes were in place to immediately provide support for the local team where the incident had occurred. Immediate lessons and learning were identified as soon after the incident as possible and this learning was cascaded effectively thought out relevant clinical areas via safety huddles. In order to break down barriers between staff groups, the patient safety team wore polo shirts with their team name embroidered so they were clearly identifiable to staff and they felt this made them more approachable.

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**Acute services**

**University Hospital Coventry**

University Hospital,  
Coventry,  
Clifford Bridge Road,  
Walsgrave,  
Coventry, CV2 2DX  
Tel: (024) 7696 4000

Date of inspection visit:  
8 to 10 October and 4 November 2019

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**Facts and data about this hospital**

University Hospitals Coventry and Warwickshire NHS Trust has approximately 1,175 inpatient beds and 116 day case beds located across two acute locations: University Hospital which is located in Coventry and Hospital of St Cross which is located in Rugby. These two hospitals serve a combined population of over one million people. The trust is a major trauma centre and the specialist cancer centre for the region. In addition, it specialises in cardiology, neurosurgery, stroke, joint replacements, invitro fertilisation (IVF) and maternal health, diabetes and kidney transplants. The number of staff employed by the trust as of January 2018 was 8,136. The trust’s services are commissioned by Coventry and Rugby Clinical Commissioning Group.
Services provided at this hospital include:
- Critical care.
- Diagnostics.
- End of life care.
- Gynaecology.
- Maternity.
- Medical care.
- Outpatients.
- Surgery.
- Services for children and young people.
- Urgent and emergency care.
- Neurosurgery.

### Urgent and emergency care

#### Facts and data about this service

Details of emergency departments and other urgent and emergency care services
- University Hospital Coventry emergency department.
- Hospital of St Cross urgent care centre.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Total number of urgent and emergency care attendances at University Hospital Coventry and Warwickshire NHS Trust compared to all acute trusts in England, March 2018 to February 2019

From March 2018 to February 2019 there were 236,620 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission reduced in 2018/19 compared to 2017/18. In both years the trust proportion was higher than the England
average.  
(Source: NHS England)

Urgent and emergency care attendances by disposal method, from March 2018 to February 2019

<table>
<thead>
<tr>
<th>Disposal Method</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted to hospital</td>
<td>55,813</td>
</tr>
<tr>
<td>Discharged*</td>
<td>106,306</td>
</tr>
<tr>
<td>Referred*</td>
<td>41,781</td>
</tr>
<tr>
<td>Transferred to other provider</td>
<td>2,152</td>
</tr>
<tr>
<td>Died in department</td>
<td>149</td>
</tr>
<tr>
<td>Left department</td>
<td>6,997</td>
</tr>
<tr>
<td>Other</td>
<td>1,577</td>
</tr>
<tr>
<td>Not known</td>
<td>21,845</td>
</tr>
</tbody>
</table>

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other outpatients, other professional
# Left department includes: left before treatment or having refused treatment
(Source: Hospital Episode Statistics)

Is the service safe

Mandatory training

The service provided mandatory training in key skills to all staff and most staff had completed it.

The mandatory training was comprehensive and met the needs of patients and staff.

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training. Nursing staff received and kept up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses as of April 2019 at trust level for qualified nursing staff in urgent and emergency care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSA obtaining venous blood</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric life support update</td>
<td>12</td>
<td>12</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>134</td>
<td>134</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>In-hospital resuscitation</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>125</td>
<td>126</td>
<td>99.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>132</td>
<td>134</td>
<td>98.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>129</td>
<td>132</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NPSA collection and transportation of blood and blood products</td>
<td>86</td>
<td>91</td>
<td>94.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>125</td>
<td>133</td>
<td>94.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>124</td>
<td>132</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NPSA preparing and administering a transfusion of blood or blood products</td>
<td>114</td>
<td>123</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>107</td>
<td>116</td>
<td>92.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In urgent and emergency care at University Hospital Coventry the 95% target was met for eight of the 20 mandatory training modules for which qualified nursing staff were eligible.

The trust provided us with updated mandatory compliance data for the urgent and emergency care speciality. The nursing and midwifery staff overall training figure as of October 2019 was 92.68% which was just below the trust target of 95%. (Evidence source: DR17)

Medical staff received and kept up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses as of April 2019 for medical staff in urgent and emergency care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>56</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>54</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>53</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>53</td>
</tr>
<tr>
<td>Moving &amp; handling - medical and dental</td>
<td>50</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>47</td>
</tr>
<tr>
<td>Information governance</td>
<td>48</td>
</tr>
<tr>
<td>European paediatric advanced life support</td>
<td>23</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>45</td>
</tr>
<tr>
<td>Fire safety - annual</td>
<td>45</td>
</tr>
<tr>
<td>Advanced life support update</td>
<td>42</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>43</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>13</td>
</tr>
<tr>
<td>NPSA obtaining venous blood</td>
<td>11</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>0</td>
</tr>
</tbody>
</table>

In urgent and emergency care at University Hospital Coventry the 95% target was not met for any of the 15 mandatory training modules for which medical staff were eligible. (Source: Routine Provider Information Request (RPIR) – Training tab)

The trust provided us with updated mandatory compliance data for the urgent and emergency care speciality. The medical and dental staff overall training figure as of October 2019 was 91.24%. (Evidence source: DR17)

Mandatory training was delivered face to face or by e-learning. There was a mandatory training policy in place, this was in date and due for review in 2022. The purpose of the policy was to
reinforce the trust’s commitment to mandatory training, to ensure the legislative and local requirements were known to managers and employees and to ensure a systematic and planned approach to delivering mandatory education was maintained. The policy contained details such as booking on training, attendance at mandatory training and non-attendance. The policy was that non-attendance at mandatory training was recorded on each individuals’ learning history.

Staff in the children’s department could attend autism awareness training. There was a poster in the children’s emergency department to alert staff to autism awareness training which they could book onto via the child and adolescent mental health services (CAHMS).

Staff in the emergency department and the observation ward received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS). However, it was unclear what training staff received regarding the Mental Health Act (MHA) 2007. Staff we spoke with said they were reliant on a mental health information folder but had no knowledge of its contents. Staff referred to MHA training as MCA and DoLS. We reviewed the nursing and allied health professional’s trauma competencies which included complex communication assessment and the management of trauma patients. The competency asked staff to outline the key considerations in the care of a trauma patient with communication difficulties such as a patient with a learning disability.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us how they received mandatory training reminders from managers and how the training system was easy to access; staff said they were happy with the training provided. Trust policy was that it was the responsibility of managers to pursue matters of non-attendance at training with individual employees. Leaders reminded staff about training, for example in the children’s’ emergency department we saw meeting minutes for September 2019 where training was recorded as an agenda item. We saw leaders in the children’s emergency department had displayed staff training details and highlighted any noncompliance for staff to see.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We spoke with a staff member who was in the process of contacting a charity about referring a patient for support. The charity helped people facing severe disadvantage to find jobs, homes and the support they needed. The charity also raised awareness of the dangers of weapons and looked to equip vulnerable young people with the knowledge and skills to stay safe from the risk of knife crime.

Contact details of organisations who offered support were displayed in public areas, these included the youth violence intervention service and domestic violence and abuse helplines. There was also a poster displayed with advice. There was a safeguarding vulnerable adults’ policy in place and available for staff on the trust intranet. The policy was due for review in August 2019 which meant that it had not been evaluated to ensure the information contained within the policy was up to date and safe for staff to use. The policy was version controlled and contained information such as a flow chart on how to make a referral, how to add an alert and had the roles and responsibilities of staff. The child protection policy was also out of date as it was due for review in August 2019. This policy covered topics such as the roles of staff, referrals, duty to refer and referral pathways. There was additional links to relevant safeguarding information on the trust
intranet site for example, modern slavery guidance, female genital mutilation (FGM) policy, and a child protection pathway.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They explained how to find the safeguarding team contact numbers and policies on the intranet. Heath care assistants told us how they would escalate any safeguarding concerns to the nurse in charge and record them. We saw evidence from a patient record of how staff had made a safeguarding referral for a patient experiencing domestic violence. There were visible photographs of the safeguarding team with the names of staff and their role on display.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust set a target of 95% for completion of safeguarding training. The tables below includes preventing radicalisation training as a safeguarding course. This training module works to stop individuals from getting involved or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses as of April 2019 for qualified nursing staff in urgent and emergency care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5</td>
<td>Staff trained: 133, Eligible staff: 133, Completion rate: 100.0%, Trust target: 95%, Met: Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2</td>
<td>Staff trained: 133, Eligible staff: 134, Completion rate: 99.3%, Trust target: 95%, Met: Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>Staff trained: 129, Eligible staff: 134, Completion rate: 96.3%, Trust target: 95%, Met: Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>Staff trained: 18, Eligible staff: 19, Completion rate: 94.7%, Trust target: 95%, Met: No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>Staff trained: 104, Eligible staff: 117, Completion rate: 88.9%, Trust target: 95%, Met: No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>Staff trained: 14, Eligible staff: 16, Completion rate: 87.5%, Trust target: 95%, Met: No</td>
</tr>
</tbody>
</table>

At University Hospital Coventry the 95% target was met for three of the six safeguarding training modules for which qualified nursing staff were eligible.

The trust provided us with updated figures for their safeguarding training. Please see the updated data set out below:

**Safeguarding figures: September 2019**

<table>
<thead>
<tr>
<th>Nursing Staff</th>
<th>As of September 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>98.13%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 3 Years</td>
<td>91.67%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>Not Required</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>98.31%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 3 Years</td>
<td>8 staff members</td>
</tr>
<tr>
<td>Overall</td>
<td>93.62%</td>
</tr>
</tbody>
</table>

(Evidence Source: DR18)

Medical staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as of April 2019 for medical staff in urgent and emergency care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding children level 2</td>
<td>Staff trained: 2, Eligible staff: 2, Completion rate: 100.0%, Trust target: 95%, Met: Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>57</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>17</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>56</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>52</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>44</td>
</tr>
</tbody>
</table>

In urgent and emergency care at University Hospital Coventry the 95% target was met for one of the six safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust provided us with updated training figures as of September 2019 which are set out below:

**Safeguarding figures: September 2019**

<table>
<thead>
<tr>
<th>Medical staff</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults Level 1</td>
<td>95.83%</td>
</tr>
<tr>
<td>Safeguarding Adults Level 2 - 3 Years</td>
<td>96.00%</td>
</tr>
<tr>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>Not Required</td>
</tr>
<tr>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>100.00%</td>
</tr>
<tr>
<td>Safeguarding Children Level 3 - 3 Years</td>
<td>79.25%</td>
</tr>
<tr>
<td>Overall</td>
<td>91.12%</td>
</tr>
</tbody>
</table>

(Source: DR18)

We reviewed the safeguarding annual report 2018-19 and saw that the safeguarding training content included subjects such as female genital mutilation, domestic violence and abuse, child sexual exploitation, completion and appropriate use of child protection and early help referrals and parental behaviours such as substance misuse and mental health. PREVENT training formed part of the wider safeguarding agenda and training had been developed in accordance with the prevent training competencies framework 2015. Prevent is the name given to part of the government's strategy to prevent terrorism by reducing the possibility of radicalisation.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and mostly well-maintained. All areas were clean and tidy, hand gel was available for staff and patients. Staff were “arms” bare below the elbow and had long hair tied back. We observed staff carrying out various cleaning tasks in different areas such as the main emergency department waiting room and in the children’s emergency department; staff had access to an infection control link nurse. On the observation ward curtains were material and were not dated to see when they had last been cleaned. We spoke to the cleaner about this who informed us they would change the curtains if they noticed they were dirty: for example, if they had any marks or stains. Following the inspection, we were told that curtains were laundered by a service partner to EN14605 British standards laundering of healthcare textiles and the frequency of scheduled changes were in accordance to National
Cleaning Standards 2004. There were some chairs in the main reception area that were showing signs of wear.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff completed cleaning rotas to record the areas they had cleaned such as treatment rooms, showers, chairs, fridges and sluices. There were I am clean stickers on equipment to show it had been cleaned. The latest cleaning audit of the emergency department in October 2019 had a score of 83% scoring minimal compliance. The infection control nurses’ association audit (ICNA) was undertaken by the infection prevention and control team. This identified several issues which were raised with the cleaning provider. Leaders told us how all audit findings were discussed and emailed to the modern matron and ward manager. Poor results were fed back to the cleaning provider and discussed at a weekly group including the director of estates and the head of services and infection prevention and control.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore personal protective equipment such as aprons and gloves and these were readily available to staff throughout the department. We reviewed the minutes from the children’s emergency department and saw infection control was an agenda item in September 2019. There was information available to staff and patients on hand decontamination techniques and the five moments for hand hygiene. Matrons were responsible for completing any cleaning audits which included: infection prevention and hand hygiene. Audits used were five moments to educate when hand hygiene should take place and mandatory training with a light box to educate staff around hand decontamination techniques, this data was then inputted by the clinical groups and discussed at quarterly review. Additionally, matrons attended monthly infection prevention control quality meetings to discuss areas of concern and any actions being taken. We reviewed the emergency departments audit results around compliance with the five moments of hand hygiene from August 2019 to October 2019 and found that staff in the children’s emergency department scored 100% whilst staff in the emergency department scored 43%. We found no issues or concerns during the inspection and observed staff being compliant with hand hygiene procedures.

Environment and equipment

Some areas of the premises were unsuitable for emergency patients and patients with mental health needs. However, staff managed clinical waste well.

The resuscitation area was too small. At the last inspection we had identified the resuscitation room was cramped, there was not always enough space for all the equipment needed and there was very little circulating space for staff. This was still the case, however, since our last inspection capital funding had been secured to increase the size of the resuscitation room. Plans had also been agreed to expand capacity by two bays. The plan was for work to commence in April 2020. It was felt this would enable the service to continue to deliver enhanced care to the most unwell patients. This was on the departmental risk register.

The design of the environment was not always suitable for those with mental health needs. The emergency department environment posed challenges for patients with a mental health issue, including those with a learning disability or autism. The reception desk provided limited privacy for patients. This was important as patients with a mental health difficulty might find it difficult to discuss their reasons for attending the emergency department in the hearing of other patients.

The observation ward was locked with swipe access only with patients needing to make a request to staff to leave the ward. There was signage on one of the entrances stating it was a locked door.
and informing patients that if they needed access through the door they needed to call a member of staff. Staff did not routinely inform patients they were on a locked ward.

Mental health assessment rooms used by staff to assess patients presenting with mental health problems were ligature free. They had appropriate heavy furniture, strip alarms, two doors to the room and were fit for purpose. However, toilets in the emergency department had ligature points and doors were not anti-barricade; however, staff could unlock doors from the outside. Ligature points are fixtures to which people intent on self-harm might tie something to strangle them self. This was brought to the attention of senior staff. As a result, the ED safety plan included a ligature daily spot check to ensure the safety of patients.

When we returned to the department unannounced we found that the mental health room/area was being used by two patients. We brought this to the attention of staff who confirmed that this should not occur and immediately arranged for one patient to be moved to an empty room close by. We observed that while this was not considered best practice, staff had constant observation of the area and could instantly intervene where necessary.

Staff carried out daily safety checks of specialist equipment. Electrical equipment was tested for safety and had a sticker to show this. Staff also completed additional safety checklists to make sure equipment such as the oxygen, call bells and suction were working. Resuscitation trollies had equipment checklists in place which staff completed daily.

The service had enough suitable equipment to help them to safely care for patients. Staff told us they could order any equipment they needed through the equipment library which they told us they could access via the main hospital switchboard. A helipad was near to the emergency department to enable air ambulances to land.

Patients, in the corridor did not always have access to a call bell. Patients in bays had access to call bells, however, one patient told us staff had not explained how to use the call bell and we found it was on the floor. We also saw that patients in the corridor did not have access to a way to call for help. We spoke with one patient in the corridor on our unannounced visit on 4 November who told us they would not know who to ask if they needed help and one patient told us the nurse had said if they had any issues to shout or stop them.

Staff disposed of clinical waste safely. Yellow sharps bins were in place, dated and not over full. Clinical waste bins with different coloured bags were readily available for staff to dispose of clinical waste throughout the department. There was a safe handling of sharps policy in place, this was available to staff on the trust intranet. There was a waste management policy in place, this was in date, version controlled and covered staff responsibilities.

Assessing and responding to patient risk

Staff mostly completed risk assessments for each patient swiftly. However, they did not always remove or minimise risks and update the assessments relating to mental health.

Staff identified and quickly acted upon patients at risk of deterioration.

Staff did not always complete risk assessments for each patient on admission / arrival. While there were mental health risk assessments, staff referred to the risk assessment checklist as their Mental Capacity Act risk assessment. At the time of the inspection there was eight patients at risk of self-harm with no details on how staff managed the risks while on the ward. Five of these patients were awaiting mental health beds within a mental health hospital. Following the inspection, we raised gaps in mental health documentation such as a patient who had taken an intentional overdose not having an enhanced observation risk assessment form in their notes. We
were told that the form was not required as the patient had capacity, and this was documented in the medical records. However, the patient had been waiting for a mental health bed and a risk assessment would be needed despite them having capacity. Leaders told us they would undertake a review with their mental health colleagues of the assessment process for patients with capacity that had a mental health risk. There was an enhanced observation risk assessment form which had check boxes such as if a side room was required or if an observable location was needed. However, we found in three instances these had not been completed or had not been completed in full. We found patients at risk of ligature did not have any ligature risk assessments in place.

The AMHAT team supported hospital staff with managing patients who were suspected as being mentally unwell. The service provided assessment and advice on the management of patients with mental health problems in urgent and emergency care and specialist assessment by mental health clinicians to support patients discharge to an appropriate service or to assist with a management plan triage. There was a clear pathway in place for patients presenting at the emergency department with mental health concerns. Staff completed a mental health screening tool once any mental health needs were identified and concerns were then escalated to the mental health team. The screening tool included the Australian mental health triage assessment. The tool considered details such as why the person was presenting, action plan and outcomes and a suicide risk screen. It also had an area for staff to record a description of the patient, including if they had any distinguishing features. Those with a triage score of red, orange or yellow would be seen by the AMHAT.

Ligature cutters were kept on the observation ward by the nurse’s station where there was a sign indicating where they were; however, we spoke with three staff (two nurses and a health care assistant) who did not know where they were kept. The wards sister knew where they were kept. When we returned to the department in November 2019 we saw processes in place to ensure staff knew the whereabouts of the ligature cutters.

During the unannounced inspection in November 2019, we saw that there were numerous ligature risks throughout the observation ward including shower fittings and support rails around the toilet. We found staff were managing the risk in a variety of ways such as use of family members to supervise patients, use of security to prevent patients leaving the ward and staff observations however in two cases we reviewed these had not been completed hourly. Due to our feedback given, the ED immediately introduced a safety plan which included a ligature daily spot check to ensure the safety of patients.

When patients were returned to the waiting area for example, if there was no capacity there was no clear process for their regular monitoring or continued observation recording while in the waiting area. We observed one patient returning to the reception desk to ask what was happening as they had been waiting an hour and had not been updated. The streaming nurse was able to bleep the manager of the day to ask for support in the waiting area. Due to our feedback, the department implemented an ED overcapacity safety plan which outlined additional intentional waiting room rounding by the streaming nurse to manage the safety/deterioration of patients.

We reviewed the children’s emergency department local audit results from May to September 2019 and found 100% of children and young people had a pain score completed and the target of 95% for the administration of analgesia. However, the audit also showed low compliance rates with children having repeat observations done if analgesia was given for pyrexia (raised body temperature) or pain. The compliance rate was low and scoring below 50% in all months and 23% in May 2019. We saw this was discussed in the children’s emergency department monthly meeting in September 2019 when staff were advised this continued to not be done and staff were asked for their ideas on how this could be improved. Leaders recognised this was an issue and told us they
had looked at the electronic system which they had in place and asked for an additional column to be added for the repeat pain scores, a meeting was due to take place in the near future to arrange the implementation of this.

The ED had processes and procedures which enabled those patients with a National Early Warning Score (NEWS2) of five and below to be cared for in the corridor. While not all patients could be observed when in the corridor, they had allocated staff to maintain patient safety. NEWS2 is a tool that was developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients. Patients who were unwell or who had dementia were placed close to the nurse’s station, so they were visible. Red or green clipboards showed at a glance which patients had been seen by a doctor and which patients had not.

Staff told us each area had an allocated nurse who was responsible for a set of patients. On our return visit to the department on 4 November 2019 there were 17 patents in the corridor. We looked at the central section in the major’s area and found it difficult to ascertain who the nurse was as they were not visible. We reviewed this with senior staff who informed us that they were looking at ways of clearly identifying the nurse allocated to specific areas. However, following the inspection, the trust informed us that the ED used a ‘Nursing Allocation’ form which was used daily for each of the ED’s three working shifts. The aim of the nursing allocation form was to clearly denote the nurses allocated which included for example, the nurse in charge, resuscitation and the RAT team. The trust had installed safety fencing around the approach to the first-floor emergency department to prevent patients with a mental health need jumping and injuring themselves or others. We were told this was in response to a number of incidents when patients had attempted to do this. Staff told us that there had been similar near misses at the entrance of the paediatric emergency department and no fencing had been installed. The trust’s health and safety lead had completed a risk assessment (risk 3086) which covered falls from height around the ED and the children’s ED. The risk had been discussed at the trust health and safety committee chaired by the chief nursing officer and attended by senior health and safety managers and staff. There were currently no plans to extend the fencing beyond what was currently installed, and the risk continued to be reviewed as part of a generic risk of falls.

We returned to the emergency department unannounced on the 4 November 2019 and found that all three sets of doors to the resuscitation area were left open. We also found the corridor to be very cold when outside doors used by ambulance staff were opened. This was highlighted to the nurse in charge who immediately arranged for patients being given additional blankets to combat the cold.

During the unannounced inspection the resuscitation area was at full capacity. Doctors spoken with said they often moved patients out into the corridor, so they could deal with more deteriorating patients. Two doctors spoken with confirmed this was a daily occurrence. Other doctors told us they did the best they could for patients under the circumstances but did not compromise patient safety. We found no issues or concerns with the management of patients within the resuscitation area with no evidence of patients coming to harm or staff compromising patient safety.

The sluice room outside the resuscitation area had the door propped open with no clear locking mechanism in place. Inside the sluice room we saw two full bottles of undiluted disinfectant spray and a large bottle of diluted cleaning fluid which were accessible to anyone. This was a concern as if a person had a condition such as dementia they may mistakenly drink the fluid which had the potential to cause them harm. This was raised with senior staff who immediately attended to our concern and stated that this would be included in the next staff huddle.
The layout of the emergency department meant there was limited areas for family members to sit down and it was unclear how patients would be moved quickly in an emergency. This was fed back to senior staff during the inspection who confirmed they had recognised and identified the need for improving the transit of patients through and out of the department. This resulted in the creation of a mobilisation team with a focus on operational agility within the emergency department. This was a three-month pilot beginning in October 2019 and was flexible across three roles, namely: domestic, portering and hostessing. During the unannounced we observed the mobilisation team were clearly visible and patients said they were very helpful. Senior spoken with said that the support of the mobilisation team was invaluable and helped with the flow and support of patients within the emergency department.

The department had a consultant attending model which meant all major patients were discussed with a senior doctor. Leaders told us how every patient in majors and resuscitation was discussed with a consultant and how it was felt this added to decision making. There was a top tray re-assessment tool in place. The purple form had details of the patient’s presenting complaint, details for the re assessment, any investigation results, any concerns and ongoing issues and plans for next review/escalation. The form was placed in the urgent to be seen tray. The next available doctor would then reassess the patient. We heard of examples which demonstrated this was working such as the identification of patients deteriorating within the department.

A falls prevention booklet was in place for staff to complete. The booklet included an individualised falls assessment, a falls care plan and a bed rail risk matrix tool. It also contained a post fall protocol with safety steps. Staff told us how they recognised patients living with dementia may be at increased risk of falls, so they would support them to walk around the ward if they wanted. Staff completed patient risk assessment booklets which included areas such as infection, pressure ulcers, moving and handling and bed rail assessments. We also saw a form was completed for the monitoring of patients with alcohol withdrawal symptoms such as tremors, orientation and headaches.

Staff from the rapid assessment team used the Rockwood clinical frailty scale to assess frailty augmented by specific facts about an individual’s life and level of dependency. The scale was numbered one to nine with one being categorised as very fit (people who were robust, active, energetic and motivated) to nine those patients that were terminally ill– (approaching the end of life).

Staff completed hourly safety checks on patients in the emergency department. The department checklist included tasks such as if a pressure area assessment had been completed, if a Rockwood frailty score had been completed, if refreshments were offered, when to escalate a NEWS score, complete sepsis screening and if medications had been administered as prescribed. The checklist needed to be signed and contained the time the patient was booked in.

In the children’s emergency department casualty assessments cards had an alert section where the reception staff could put either a green dot, or a red dot. A red dot advised others to an alert in which the professional reviewing the notes would need to look up further information. This could be a medical alert or to alert staff there had been safeguarding concerns about a child. Leaders aimed to ensure urgent cases following reporting on of scans were picked up quickly. Each day a consultant was allocated four hours a day to identify any urgent recalls of patients to the department. There was a head injury and renal colic pathway in place, these were available on the trust intranet site.

Staff used a nationally recognised tool to identify deteriorating patients and escalated concerns appropriately. Staff in the emergency department used the national early warning tool NEWS2.
We saw staff used an electronic recording device to input patient observations. This automatically calculated the patients NEWS2 score and prompted staff to take any further action, for example, to screen for sepsis if scores were not within the correct range. During our unannounced return visit in November 2019, we had a concern about the escalation process of a child with a high paediatric early warning score (PEWS). This was brought to the attention of the senior management team who investigated our concerns. The trust provided us with their review with a step by step guide of the management of the patient and the processes utilised to maintain patient safety.

Following a recent incident, the service had reviewed their processes and implemented an escalation procedure (25/10/2019). The procedure included an enhanced department overcapacity safety plan which included notifying the matron of increased safety concerns and additional doctor out of hours and at weekends. Areas which identified the need for the escalation procedure to be implemented included:

- Limiting the capacity of patients in the corridor to 18.
- Use of the emergency department minor’s area during overcapacity.
- Escalation doctors to be integrated to the daily rotas for ED.
- Nurse in charge to oversee daily audits, intentional rounding and board rounds.
- The streaming nurse to conduct intentional waiting room rounding.

We saw this was in place during our visit on 4 November 2019. We spoke with two doctors who were aware of the reason for the implementation of the overcapacity safety plan. Both felt it was sustainable at the time of the inspection but were not certain about long term.

The sepsis team performed a retrospective audit involving 50 sets of emergency department notes each month. Compliance with the audit was reported to the emergency medicine group leads and through quality improvement and patient safety groups which were chaired by the emergency department clinical lead. The emergency department also had representation on the sepsis steering committee. Results showed that in October 2019, 97% of patients in all of the emergency department were screened for sepsis, 92% were treated within one hour on suspicion of sepsis and 57% were treated within one hour of arrival at the department. Many actions had been put in place to improve sepsis screening and treatment compliance. These included a sepsis steering group held bi-monthly with regular representation from the emergency department, seventy-seven members of staff from the department had received sepsis awareness training, the department had five sepsis heroes. Grand rounds were held to discuss learning from a significant event relating to sepsis and pocket-sized card on sepsis had been developed. We saw a copy of a weekly safety message about sepsis which included a case study and action points. All staff were encouraged to attend a suspicion of sepsis study day in September 2019.

Staff in the children’s emergency department used the paediatric observation priority score (POPS). POPS is a bespoke emergency and urgent care checklist which quickly scores between 0-16 for acutely ill children on a combination of physiological behavioural and risk identifiers using easy to collect data. Leaders completed local audits around POPS scores and PEWS charts. The most recent audit dated May 2019 to September 2019 showed the target rate of 95% was met in all months for PEWS chart in observations and 100% compliance was achieved for PEWS charts being completed with POPS score of four and above in all months. On our last inspection early warning scores were not used in the children’s emergency department as priority for treatment and frequency of observations ward determined by the nurse in charge of the department. The children’s emergency department also met the target of 95% for completion of a POPS score in all months scoring 98% and above. Escalation procedures were in place for children awaiting senior review and those children identified as requiring admission. There was a clinical operating
procedure which included prolonged wait for triage and initial assessment; these contained clear algorithms for staff to follow.

Staff could identify sepsis in triage and we saw the sepsis UK pathway was utilised following six steps and NEWS 2 documentation. A sepsis organised response team (SORT) team was identified and allocated at the beginning of the shift; the aim of the team was to optimise response to sepsis. The SORT team consisted of a qualified nurse, doctor and a health care support worker who carried a bleep. When patients triggered for sepsis the team would assess the patient to ensure they received prompt treatment with antibiotics. There was a sepsis trolley which was checked daily and sepsis pathways and guidelines were visible within the department. We observed leaders providing staff with a wallet sized prompt card on sepsis and NEWS 2. The card provided staff with prompts such as screen for sepsis, if red flag and escalate if not responding. The sepsis pathway was available to staff on the trust intranet site and we observed staff completing sepsis documentation. We heard of the role of the sepsis link nurse and how they asked staff pertinent questions around sepsis such as addressing and escalating patients with sepsis and the giving of antibiotics within one hour. There was a paediatric sepsis six pathway in place in the children’s emergency department. If a patient was neutropenic (an abnormally low concentration of neutrophils (a type of white blood cell) in the blood), staff had an up to date pathway to follow, bleep numbers were also available for oncology. The sepsis SORT team provided support to neutropenic patients. Staff told us cubicles were identified for first line treatment for sepsis and neutropenic patients. The cubicles were deep cleaned and logged when cleaned, what time they were cleaned and when ready to use the cubicle again.

Staff knew about and dealt with any specific risk issues. Reception staff alerted medical/nursing staff if a patient came into the department with chest pains or if they became unwell. Streaming staff and triage supported each other, with the streaming nurse being aware of which patients were in the waiting area and streaming patients to the most appropriate area. We saw posters in the waiting area informing patients to immediately make reception aware if they were suffering from conditions such as chest pain, severe abdominal pain or difficulty breathing. Safety messages were discussed in medical handovers and uploaded onto the trust intranet site these included any learning or changes. We looked at the emergency department safety messages on the intranet and saw these included details such as what had happened, why it was important, what was being done about it and what did staff need to do to ensure this occurred. Weekly safety messages were also discussed in the quality improvement patient safety meetings. Leaders told us cancer patients had alert cards, but children went straight to the oncology department.

The service had access to mental health liaison and specialist mental health support. The hospital had access to the Arden Mental Health Acute Team (AMHAT) who were based on site but were employed and managed by another local trust. The AMHAT team were contracted to provide 22.5 hours a day service. Plans were in place to extend those hours to provide support 24 hours a day from January 2020.

The average length of stay for Child and Adolescent Mental Health Services (CAMHS) children and young adults in Children’s ED in Oct 19 was 170 mins. (Source: DR 56)

Shift changes and handovers did not always include all necessary key information to keep mental health patients safe. We looked at an observation ward patient handover form and saw it contained information on the patient presenting condition, allergies, NEWS scores, past mental health diagnosis and a plan for analgesia. It also contained the name of the nurse giving and taking the handover. However, agency mental health nursing staff spoken with said they did feel they received a proper handover when providing support to patients with a mental health need.
There were also concerns raised from a minority of staff that the AMHAT team had limited contact with the registered mental health nurse (RMN) that was providing the one to one care.

Emergency Department Survey 2016
The trust scored about the same as other trusts for all five Emergency Department Survey questions relevant to safety.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke to a nurse or doctor?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>6.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.9</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Median time from arrival to initial assessment (emergency ambulance cases only)
The trust’s median time from arrival to initial assessment was consistently better than the overall England median over the 12-month period from July 2018 to June 2019. In June 2019, the trust’s median time to initial assessment was five minutes compared to the England average of eight minutes.

Ambulance – Time to initial assessment from July 2018 to June 2019 at University Hospital Coventry and Warwickshire NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust
From August 2018 to July 2019 there was an overall reduction in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at University Hospital Coventry emergency department.

The trust board meeting minutes for September 2019 showed that the ambulance turnover rates had improved with 100% being achieved within 60 minutes. Discussions had been held with local ambulance trusts to discuss emergency departments’ drop-off times. Ambulance staff we spoke with told us that access to the rapid assessment area had improved this process with patients being transferred from trolleys immediately when appropriate. NHS Improvement had acknowledged that this trajectory was being achieved by the trust.
Over the same 12-month period, in every month there were journeys with turnaround times of over 60 minutes. (For some months the numbers are too small to display in the chart below.) These ranged from 10 in June 2019 to 197 in December 2018.

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From May 2018 to April 2019 the trust reported 450 “black breaches”. There were more black breaches reported in the second half of this 12-month period (246) than in the first half (204). This may be due to seasonal variance as the second half of this period includes the winter period.
Nurse and midwifery staffing
The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. There were processes in place to review daily staffing levels. Leaders spoke of reviewing staffing levels in daily huddles and in safe care meetings. Matrons oversaw regular staffing reviews. The service had enough nursing and support staff to keep patients safe.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>384.6</td>
<td>16%</td>
<td>11%</td>
<td>5.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>161.8</td>
<td>25%</td>
<td>6%</td>
<td>5.7%</td>
<td>33,275 (10%)</td>
<td>61,264 (19%)</td>
<td>13,187 (4%)</td>
</tr>
</tbody>
</table>

The trust had invested 1.5 million in nurse staffing which had resulted in less agency use and led to an increase in nurse staffing numbers on shifts. It also meant leaders had been able to safeguard critical roles such as band seven nursing staff. Leaders told us how they had employed a large cohort of student nurse associates. We looked at two weeks rotas and found no issues or concerns. Where there were identified gaps, we found this had been filled. Qualified nursing staffing rates within urgent and emergency care at University Hospital Coventry were analysed for the past 12 months.

Vacancy rates
The service had low and/or reducing vacancy rates.
Monthly vacancy rates over the last 12 months for qualified nurses showed a downward trend from October 2018 to February 2019. *(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**
The service had low and/or reducing turnover rates.

Monthly turnover rates over the last 12 months for qualified nurses showed a shift from November 2018 to April 2019. *(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**
The service had low and/or reducing sickness rates.

Monthly sickness rates over the last 12 months for qualified nurses showed a downward trend from May to September 2018. *(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and agency staff usage**
The service had low and/or reducing rates of bank and agency nurses.
Monthly bank usage over the last 12 months for qualified nurses showed a shift from November 2018 to April 2019.

Monthly agency usage over the last 12 months for qualified nurses was not stable and may be subject to ongoing change.
(Source: Routine Provider Information on Request (RPIR) - Nursing bank agency tab)

Medical staffing
The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The table below shows a summary of the medical staffing metrics in urgent and emergency care at University Hospital Coventry compared to the trust’s targets, where applicable:

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<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>All Staff</td>
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<td>16%</td>
<td>11%</td>
<td>5.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>85.7</td>
<td>5%</td>
<td>20%</td>
<td>0.7%</td>
<td>0</td>
<td>90 (&lt;1%)</td>
<td>1,045 (&lt;1%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness or agency medical staff usage. Over the same period there was no bank medical staff usage.
Vacancy rates
The service had low and/or reducing vacancy rates for medical staff.

Monthly vacancy rates over the last 12 months for medical staff showed an upward trend from December 2018 to April 2019.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Staffing skill mix
In May 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average. The proportion of junior (foundation year 1-2) staff was also lower than the England average.

Staffing skill mix for the 77 whole time equivalent staff working in urgent and emergency care at University Hospital Coventry and Warwickshire NHS Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>24%</td>
<td>30%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>2%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>62%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>12%</td>
<td>21%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)

The service always had a consultant on call during evenings and weekends. There was consultant cover seven days a week. There was also an emergency medicine middle grade and paediatric middle grade available 24 hours a day. Leaders told us the department met the Royal College of Paediatrics and Child Health (RCPCH) standard of a dedicated paediatric emergency (PEM) consultation with session time allocated to paediatrics.
Records
Staff did not always keep accurate records of patients’ care and treatment and records were not always stored securely.

Some patient notes had gaps in recording, however, all staff could access them easily. On our initial inspection we reviewed 22 sets of patient records and found gaps in documentation/recording in seven of them. This included a cannula care pathway not being signed, gaps in documentation of intravenous fluids and fluid output recorded, fluid crossed out with no comment, an unreadable signature, and incomplete or non-existent mental health documentation. This was brought to the attention of the trust who reviewed our findings. For example: the trust took additional steps to seek assurance in the documentation of cannula care to identify areas for improvement which included a review of 10 sets of nursing records every working day. Results were reported to the group safety huddle to maintain compliance. To provide assurance regarding fluid balances, the trust informed us they were reviewing 50 patient records over October and November with the results being presented to the emergency department quality improvement panel in November 2019.

When patients transferred to a new team, there were no delays in staff accessing their records. When a patient was discharged from the department a discharge letter was generated to communicate with the patients GP. We reviewed a discharge letter and found it had details of the total number of attendances, the patient’s diagnosis, any investigations and an outcome.

Records were not always stored securely. Patients records were kept in notes cupboards, mainly near or behind nurses’ stations, however these were not kept locked. Electronic patient records such as scan results were accessed via computers which were password protected. On our return to the emergency department in November 2019 we found patient records had been left unattended on the reception desk in the major’s area. We looked at three sets of patient records without being asked who we were, this meant an unauthorised person could have easily accessed these records. This was brought to the attention of the nurse in charge who immediately ensured the records were stored securely.

The department completed records audits. Annual audits of medical records were undertaken in line with the trust clinical audit programme. These results were presented in quality improvement meetings with a corresponding action plan. Staff were also provided with a Nursing and Midwifery Council (NMC) /General Medical Council (GMC) stamp when they started working in the department. Ten nursing records were audited daily by the clinical nurse manager or the modern matron. Results of these were reported to the nurse in charge of the shift who communicated the information in twice daily safety huddles if compliance was below 95%. We reviewed the emergency department documentation audit for 2018-2019. The audit looked at areas such as if entries in records were legible, if GMC numbers were recorded and if records were signed and dated. Areas of good practice were identified as being above 80% and included agreed management plans, clinical reason for attendance, inpatient history with details of previous illnesses. Areas for improvement that scored below 59% included all entries accompanied by designation and patient admitted documentation. We saw that an action plan was in place alongside these recommendations. The audit of documentation in emergency department children 2018-2019 showed areas of good practice including daily senior review by a decision maker, physical examination and management plans. An action plan was in place which identified areas for improvement which included: reassessed pain scores and the patient admitted documentation. (Evidence source: DR20)
**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. An automated electronic medicines storage system ensured medicines were safe and secure with restricted access to authorised staff. Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Due to a lack of resources a full clinical pharmacy service was not provided, however a pharmacist visited the department to provide support and advice when needed. However, it was agreed there were areas where medicine processes could be improved if there was a pharmacist linked to urgent and emergency care. For example, to improve the discharge or transfer process, undertaking medicine histories, checking critical medicines had not been missed as well as patient counselling.

Medicine fridge temperatures were within the recommended range and staff were aware of what action to take if there was a deviation. Controlled drugs (CDs) and controlled stationary were stored and managed effectively. Running balances and stock checks were undertaken twice daily to ensure irregularities or discrepancies were identified as quickly as possible. Audits undertaken by pharmacy ensured processes were being followed. However, although the overall running balance was correct, CD waste records were not always consistently recorded for any remaining CDs not required to be administered to a patient.

Medicines required in an emergency including a separate dedicated trolley for the treatment of sepsis were readily available when needed. Regular checks of emergency medicines and equipment were carried out by staff. Tamper evident seals were in place to ensure medicines were fit for use; however, intravenous fluids (IVs) required in an emergency were not stored using tamper evident seals. This was brought to the attention of the pharmacy team who confirmed this was being looked at and took on board our view that IVs should be protected.

Following the inspection, the trust informed us that they were fully compliant with the storage of all medicines including IV fluids which were being checked daily by ward staff. IV fluids on resuscitation trollies are being stored in double wrapped bags; with tamperproof seals and expiry dates checked daily in accordance with the management of resuscitation policy.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw a weekly safety message had been displayed on the medicines system in the emergency department. The message advised staff people with Parkinson’s disease must always have the correct drugs and correct formulations prescribed as well as having drugs at usual times.

Time critical medicines such as for Parkinson’s Disease were highlighted to staff to ensure doses were not missed. The principles of antimicrobial stewardship were in place. First line antibiotic prescribing and administration information and guidelines were available. However, on our unannounced visit back to the department on the 4 November 2019 we saw a patient had been prescribed antibiotics at 3.41pm and 3.44pm and were signed as given at 4.52 pm and 4.30 pm, we raised this with senior staff at the time.

Staff followed current national practice to check patients had the correct medicines. Patients’ prescriptions and medicines administration records were managed to ensure they were accurate, complete and legible. There was details of the patient’s regular drug therapy within their notes. We looked at a trust wide medicines’ management-controlled drug audit summary report dated May 2019. The audit incorporated 17 regulations and legislation standards and 12 best practice
statements that applied to controlled drugs storage and practice and included the emergency department. Results showed two standards of noncompliance: standard 1.6 is the cabinet free from other non-CD medicines and objects for example money, valuables and mobile phones and standard 1.9 are all CD register entries legible and there are no obliterated entries. The audit report results were e-mailed to the modern matrons and ward managers and presented at an appropriate forum. Additionally, feedback was provided to nursing staff at the time of the audit.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with trust policy. There was an incident management policy which was in date and due for review in 2020. The policy outlined the management of reportable incidents and included definitions of incidents, roles and responsibilities, support for staff and reporting. Senior leaders told us how a consultant completed a primary review of each death that happened in the department. Two consultants sat on morbidity and mortality review meetings and linked with any secondary mortality reviews. We saw that mortality cases were discussed in the quality improvement patient safety meetings. The department produced a mortality report which included any associated learning. We saw that the emergency department mortality report dated November 2018 to April 2019 was submitted to the mortality review committee and contained the data on primary mortality reviews. A procedure was in place around case identification and both primary and secondary review processes. Reports around mortality showed that lessons had been learned.

Staff had some understanding of duty of candour for example: the need to be honest. They were open and transparent and gave patients and families a full explanation if and when things went wrong. There was a duty of candour (being open) policy in place which was in date and due for review in 2020. The policy included notifying a patient or family, communication, results of investigation, consent and candour. There were systems in place to ensure staff responded to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and offer reasonable support to the person. A trust wide duty of candour internal audit report had been completed in October 2018. A sample of 30 patient safety incidents reported within the period April to July 2018 which resulted in harm levels of moderate or above were selected. The audit looked at specific requirements such as if a written record was held to support initial discussion and an apology. The audit also looked at staff undertaking around duty of candour. An action plan was put in place following this audit. Recommendations included: revising the duty of candour policy, a review of how duty of candour requirements were communicated to staff and to introduce routine spot checks on sampled duty of candour investigations.

Managers debriefed and supported staff after any serious incident. Staff who had worked in the resuscitation area told us they how they would gather regularly to speak about anything that had happened. Leaders in the children’s emergency department spoke of consultant led debriefs. Staff could speak to the hospital chaplain if anything affected them or their managers could make a referral to occupational health if appropriate. Leaders told us staff were given a choice if they
wanted to attend formal debriefs such as what had happened/gone well in a situation and how they were feeling.

Incidents were investigated thoroughly. Patients and their families were involved in these investigations. We reviewed three root cause analysis reports (RCA’s) that had been investigated between February and April 2019. The reports contained relevant information including the problems identified, lessons learned, sources of information and what could have been done differently. For example, because of one investigation safety checklists were audited by senior staff and sepsis screening had been enhanced. The RCA reports contained action plans with actions such as discussing at the quality improvement patient safety meeting (QIPS), reviewing policy’s and sending out safety messages to staff. The RCA reports had clear reference to interaction with families. This was evident as questions families wanted answering were included and answered within the reports and the reports were shared with families. Leaders told us how the reports we reviewed had been approved by the serious incident group and approved by the local clinical commissioning group (CCG).

Staff received feedback from investigation of incidents, both internal and external to the service. Staff gave examples of incidents and told us they received feedback from incidents via email. Staff in the emergency department told us how learning from incidents was discussed in handovers. They also told us how each morning the nurse in charge would read out recordings from the communication book, discuss any incidents and highlight to staff any learning. Staff told us of learning from another area from which they worked, for example, as a result of a medicine incident two staff now checked a specific medicine. We saw that root cause analysis feedback was included under clinical effectiveness in the monthly quality improvement patient safety meetings. Learning points were clearly identified from this discussion such as how thoracic dissection could present in different ways. There was evidence that changes had been made because of feedback, for example, low trollies and safety messages had been put in place.

Repose mattresses were evident throughout the department to prevent pressure sores. Procedures were updated quickly when an incident occurred. Staff were able to look at information from other departments on the trust intranet site which enabled them to see learning from other areas.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2018 to June 2019, the trust reported no never events for urgent and emergency care.

*Source: Strategic Executive Information System (STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 20 serious incidents (SI’s) in urgent and emergency care at University Hospital Coventry which met the reporting criteria set by NHS England from July 2018 to June 2019. A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>7</td>
<td>35.0%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>Sub-optimal care of the deteriorating patient meeting SI criteria</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>Incident Category</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm meeting SI criteria</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

**Safety Thermometer**

The service used monitoring results well to improve safety.

Staff used the safety thermometer data to further improve services. The Safety Thermometer was used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection took place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported two new pressure ulcers from July 2018 to July 2019 for urgent and emergency care. Both occurred in July 2018. Over the same period the trust reported no falls with harm or new urinary tract infections in patients with a catheter in medical care.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at University Hospital Coventry and Warwickshire NHS Trust**

<table>
<thead>
<tr>
<th>Total pressure ulcers</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Pressure ulcers levels 2, 3 and 4</td>
<td></td>
</tr>
<tr>
<td>2 Falls with harm levels 3 to 6</td>
<td></td>
</tr>
<tr>
<td>3 Urinary tract infections in patients with a catheter level 3 only</td>
<td></td>
</tr>
</tbody>
</table>

(Source: NHS Digital - Safety Thermometer)

**Is the service effective?**

**Evidence-based care and treatment**

The service mostly provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, staff did not always show awareness regarding the Mental Health Act code of practice.

Staff followed policies to plan and deliver high quality care according to best practice and national guidance. However, some policies were not up to date on the trust intranet site for example, the child and safeguarding vulnerable adults’ policies. Sepsis screening and management was done in line with national guidance such as the UK Sepsis trust. The trust had been able to develop the sepsis outcome response and treatment team (SORT team). This 24 hour a day multidisciplinary...
team responded to all patients who triggered the sepsis criteria in the emergency department. Leaders told us over 90% of their septic patients were screened on arrival, and antibiotic administration within the first hour had increased from 38% at the time of our last CQC inspection to 78% and consequently, trust mortality from sepsis had decreased. We saw that those completing audits such as the internal audit report 2018/19, emergency department (ED) four hour waits and the duty of candour audit report 2018 considered compliance against guidance. Examples included: The Health and Social Care Act 2008 (regulated activities), and the core standards within the NHS constitution.

The medicines management-controlled drug audit was developed and designed to consider various guidance such as: The Department of health: Safer Management of Controlled Drugs, a guide to good practice in Secondary Care (Oct 2007), NHS Business Services Authority, NHS Protect: Medicines Security Ward/Department checklist (Jan 2014) and the Care Quality Commission (CQC) Essential Standards Outcome 9: Management of Medicines (March 2010).

There was a policy in place for the assessment and management of patients presenting at the emergency department with mental illness which was in date and due for review in 2022. The policy covered what staff should do in cases of poisoning or self-harm and contained a mental health assessment pathway summary. It also contained information on self-harm and the mental health triage scale. We found that staff routinely used the prescribed triage tool to identify patients with a mental health issue in need of referral to AMHAT or specialist mental health service. For example, patient records included a completed copy of the tool. Staff also acted on outcomes appropriately for example a patient rated orange was referred to AMHAT, a patient rated green was not. We found that the evidence on the mental health triage forms was concise and supported the decision. Staff told us that mental health patients rated blue or green on the triage system remained in the emergency department awaiting a medical assessment. A referral to AMHAT would then be made if the medical assessment concluded it was appropriate.

**Nutrition and hydration**

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients in the children’s emergency department told us they had been offered food and drink. We observed refreshments being given to children and young people in the paediatric observation area. On the observation ward we observed staff giving patients drinks and toast and staff taking lunch requests. We observed staff giving a patient waiting in the corridor a cup of tea.

We returned to complete a further inspection in November 2019. We spoke to three patients who told us they had been offered a sandwich and a drink. We observed two further patients who were in the process of eating a sandwich. Most patients were attended by a family member or a friend and we observed drinks being provided by family members.

There were vending machines available for patients and their relatives to purchase drinks and snacks in the waiting area. There was also a water cooler, so patients and their families could access drinking water. Staff were able to access food for those patients on specialist diets such as those who required gluten or dairy free or halal foods. Staff could also access pureed food or thickened fluids. We saw a special red beakers were available for patients who had difficulty drinking from a regular cup.
Staff on the observation ward operated protected mealtimes, these were advertised as being between 12pm and 1pm, and 5pm and 6pm. Staff told us they would make exceptions in instances when a family member wished to support a patient who had additional support needs. In the children’s emergency department staff told us how sandwiches, cakes and biscuits were brought in for those who wanted something to eat. Staff could also go to patient wards where they could access any food left over from mealtime which they could then have for patients. Leaders in the children’s emergency department audited the recording of children and young people’s weight. The service met the target rate of 95% in all months (May to September 2019), apart from May when the compliance rate was just short of target at 94%.

Leaders audited fluid balance charts and had good results. During the inspection, we found gaps in the completion of fluid balances. This was discussed with senior staff who confirmed there were some gaps in recordings. Leaders told us that fluid balances were audited monthly as part of the nurse’s audit schedule and results for June and August 2019 showed 100% compliance. Senior staff told us that because of our findings they would be completing a review of 50 patients notes in October and November and would present the results to the QIPS meeting in November 2019.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff told us if they needed any advice or were unsure about a patient’s diet such as their ability to swallow they would request an assessment by the speech and language therapist. Referrals to the speech and language therapist team (SALT) or dietitians could be made electronically.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.9 for the question “Were you able to get suitable food or drinks when you were in the emergency department?”. This was about the same as other trusts.

*(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)*

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. The children’s emergency department used pain scores to determine the level of pain in children. We saw a child friendly pain scale with panda faces was available for staff to use to identify the level of pain in children. A pain score indicator was part of the triage assessment as well as part of the safety check list. Staff could also record patient’s pain on an electronic observation system with compliance audits as part of a daily safety checklist audit by the clinical nurse managers and the nurse in charge out of hours. Leaders also told us that when planning and delivering patients analgesia the emergency department utilised condition specific related pain pathways for fractured neck of femur.

The department had implemented the faculty of pain medicines core standards for pain management 2015 by ensuring all paediatric nurses attended an annual update in their mandatory training which included the use of pain scores, pharmacological and non-pharmacological treatments. Additionally, staff used the face, legs, activity, cry, consolability (FLACC), modified FLACC, neonatal infant pain (NIP) and modified Wong-Baker depending on the age and abilities of the child and recorded pain levels on PEWS charts as required. FLACC scale is a measurement used to assess pain for children between the ages of 2 months and 7 years or individuals that are unable to communicate their pain. The scale is scored in a range of zero to10, with zero
representing no pain while the modified Wong-Baker pain rating scale shows a series of faces ranging from a happy face at zero which represents “no hurt” to a crying face at 10 which represents “hurts worst.” Staff could contact the trust’s acute pain team for any assistance or advice. Records seen showed that patients received pain relief soon after requesting it.

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 4.4 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was about the same as other trusts.

- The trust scored 7.3 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was about the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Following the last inspection, leaders told us that policies relating to pain relief in the children’s emergency department had been amended to ensure staff could give any required pain relief in a timely manner. We saw a doctor had recorded in a patient notes when they had needed a review of their pain medications or when patients had complained of pain and the doctor had provided analgesia.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.

The service participated in relevant national clinical audits. Managers and staff used the results to improve patients’ outcomes. The hospital had participated in the Care of Critically Ill and Critically injured Children Quality Review Visit in September 2018. The visit which was commissioned by the West Midlands Critical Care Network on behalf of commissioners and NHS England. The purpose was to validate the self-assessments made by the trust and to review the pathway for critically ill children attending the emergency department and children’s assessment unit through to inpatient and high dependence inpatient areas when applicable. The review found that out of 21 applicable questions in the emergency department 20 were met (95%). The standard not met was in relation to resuscitation and stabilisation and that hospital wide protocols for resuscitation should be in use including alerting the paediatric resuscitation team, arranging for accessing support for difficult airway management, stabilisation and ongoing care and care of parents during the resuscitation of a child.

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, University Hospital Coventry emergency department failed to meet any of the national standards. The department was in the lower UK quartile for four standards:

- Standard 1a (fundamental): O₂ should be given on arrival to maintain sat's 94-98%. This department: 6.0%; UK: 19%.
- Standard 3 (fundamental): High dose nebulised β₂ agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 5.0%; UK: 25%.
- Standard 4 (fundamental): Add nebulised ipratropium bromide if there is a poor response to nebulised β₂ agonist bronchodilator therapy. This department: 52.2%; UK: 77%.
- Standard 9 (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
- Children 2-5 years: 20mg prednisolone for 3 days
  This department: 23.1%; UK: 52%.

The department’s results for the remaining three standards were all within the middle 50% of results.
(Source: Royal College of Emergency Medicine)

We saw that in response to the audit a RCEM clinical audit action plan had been put in place. The audit contained recommendations, actions required a person responsible and action status. Out of the eight actions identified four were graded as a three which meant recommendations fully implemented. The others were graded as a five which meant other and showed ongoing actions such as raising actions relating to the oxygen audit under a future project and developing pilots.

RCEM Audit: Consultant sign-off 2016/17
In the 2016/17 consultant sign-off audit, University Hospital Coventry emergency department failed to meet any of the national standards. The department was in the upper UK quartile for three standards:

- Standard 1 (developmental): Consultant reviewed: atraumatic chest pain in patients aged 30 years and over. This department: 20.5%; UK: 11%.
- Standard 2 (developmental): Consultant reviewed: fever in children under 1 year of age. This department: 37.5; UK: 8%.
- Standard 3 (fundamental): Consultant reviewed: patients making an unscheduled return to the emergency department with the same condition within 72 hours of discharge. This department: 6.9%; UK: 12%.

The department’s results for the remaining two standards were both within the middle 50% of results.
(Source: Royal College of Emergency Medicine)

We reviewed the RCEM consultant sign off clinical audit action plan 2016/17 and found all the recommendations were graded as a three which meant recommendations had been fully implemented and were to be reassessed in the next audit cycle.

RCEM Audit: Severe sepsis and septic shock 2016/17
In the 2016/17 Severe sepsis and septic shock audit, University Hospital Coventry emergency department failed to meet any of the national standards. The department was in the upper UK quartile for two standards:

- Standard 1: Respiratory rate, oxygen saturations (SaO₂), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival. This department: 100.0%; UK: 69.1%.
- Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival. This department: 44.0%; UK: 18.4%.

The department was in the lower UK quartile for one standard:

- Standard 2: Review by a senior (ST4+ or equivalent) emergency department medic or involvement of critical care medic (including the outreach team or equivalent) before leaving the emergency department. This department: 42.0%; UK: 64.6%.

The department’s results for the remaining five standards were all within the middle 50% of results.
There was a RCEM severe sepsis and septic shock a clinical audit action plan in place dated 2016/17. All recommendations were graded as three recommendations had been fully implemented. Action status included staff being aware that oxygen should be administered when indicated and sepsis six tool including the sepsis six pathway being brought to the QIPS meeting.

**Trauma Audit and Research Network (TARN)**

The table below summarises University Hospital Coventry’s performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a non-medical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Ascertainment</strong> <em>(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)</em></td>
<td>100.0+%</td>
<td>Good</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude median time from arrival to CT scan of the head for patients with traumatic brain injury</strong> <em>(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)</em></td>
<td>32 minutes</td>
<td>Takes longer than the TARN aggregate</td>
<td>Met</td>
</tr>
<tr>
<td><strong>Crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury</strong> <em>(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding)</em></td>
<td>79.6%</td>
<td>Higher than the TARN aggregate</td>
<td>No standard</td>
</tr>
<tr>
<td><strong>Crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care</strong> <em>(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)</em></td>
<td>46.6%</td>
<td>Higher than the TARN aggregate</td>
<td>Did not meet</td>
</tr>
<tr>
<td><strong>Risk-adjusted in-hospital survival rate following injury</strong> <em>(This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.)</em></td>
<td>No additional survivors</td>
<td>As expected</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: TARN)

There was a TARN clinical audit action plan in place. The action sheet contained five actions; three of the recommendations were graded as three (recommendations fully implemented) and two were graded as a two which meant action in progress. Those graded as action in progress included to ensure staff is identifiable on the trauma chart and compliance against documentation.
standards is met and to ensure appropriate patients receive airway management within 30 minutes of arrival.

Managers used information from the audits to improve care and treatment. Managers devised action plans and monitored progress. For example, action plans with recommendations had been put in place for the above audits when areas were not performing as well as expected. The service had a higher than expected risk of re-attendance than the national standard and the England average.

Unplanned re-attendance rate within seven days

From July 2018 to June 2019, the trust’s unplanned re-attendance rate to the emergency department (ED) within seven days was consistently worse than both the national standard of 5% and the England average. Managers were working to identify why this was the case.

Unplanned re-attendance rate within seven days - University Hospital Coventry and Warwickshire NHS Trust

(Source: NHS Digital – A&E quality indicators)

Following the inspection, the trust informed us the data provided by NHS Digital did not distinguish between those patients who were admitted for different conditions or moved between ED locations as appropriate and as part of the patient’s care pathway. The trust informed us that from April to October 2019 patients who were re-admitted to the same facilities across the trust including the ED and the children’s ED had dropped to 6.0% which was approximately 2.5% better than the national average. It was noted that the trust informed us that this information did not differentiate any patients readmitted for a different condition.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The children’s’ emergency department had carried out a local paediatric observation priority score (POPS) and paediatric early warning score (PEWS) audit. Ten percent of casualty cards were audited for children and young people attending the department. The triage data showed 90% of children and young people had a POPS score in December and 82% in January. In the observation bay 98% of children had a PEWS chart in December 2018 and 99% in January 2019. From February 2019 to May 2019 an improvement was seen rising from 91% of patients receiving a POPS score in February 2019 to 99% in May 2019. The reason for the remaining one percent in May 2019 was recorded as being due to being a booked review and triage not being required. The audit also showed 100% of patients had a pain score and analgesia given for pain scores above two. From February 2019 to May 2019 all children and young people with a POPS score above three had a PEWS chart. We reviewed the internal audit report 2018/19 for ED four hour waits dated July 2018. The review was discussed with the group manager, with
action plan responses agreed by the ED group manager, clinical director and modern matron. Additional results were highlighted to the director of operations and chief operating officer. We also saw other audits took place which included hand hygiene, sepsis, records and medicine management.

Managers shared and made sure staff understood information from audits. We reviewed the minutes from the children’s emergency department meeting September 2019 and saw audit results were an agenda item and information on recent audits were shared and discussed with staff.

**Competent staff**

The service made sure staff were competent for their roles. Managers appraised staff’s work performance.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There was an agency registered mental health nurse (RMN) available 24 hours a day who predominantly covered 1:1 enhanced observation for patients with mental health needs.

We spoke with security staff who were supporting patients with mental health needs, they told us they were not given any training on how to manage mental health patients. However, the trust informed us that all security staff had received accredited training which was endorsed by the security industry association (SIA) and the association of chief police officers. The training included a three-day conflict management and physical intervention training that covered spotting signs and trigger points where behaviour may become challenging. Figures provided showed that 100% of security officers had completed the initial training to gain their SIA badge.

All staff apart from three new starters in the children’s emergency department had completed training on the paediatric observation priority score (POPS).

All new staff received a full induction tailored to their role before they started work. New staff worked in a supernumerary role for a minimum of two weeks on commencement of employment. A list was kept of the start date of all new staff, which team they were in and who their receptor was if applicable. A record was also kept of those who still needed to complete their induction. As part of the induction all new starters were given an identification badge, information technology (IT) information and a stamp with their name, they also received a welcome email.

There was an induction policy in place, this was version controlled and in date. The aim of the policy was to demonstrate the trust commitment to employee induction, to promote a climate in which all new employees had the opportunity to attend an induction and to ensure there was a process of continual monitoring, review and evaluation of employees. The policy contained information for staff groups such as doctors in training, internal medical locums, sole specific induction, agency staff and volunteers. It also included duties and responsibilities of staff at executive, strategic and operational levels.

The educational facilitators supported the learning and development needs of staff. There was a team of four educational facilitators in post. Part of their role was to support student nursing associates. The educational facilitators arranged outside speakers and teaching sessions to support staff in their learning needs. Facilitators had made arrangements for the alcohol liaison team, the sepsis team and the react team to speak with staff. A clinical educator spoken with said they provided hands on teaching sessions for nursing staff. The occupational therapist from the REACT team spoke of how they had attended nursing handovers in the past to educate around frailty.
Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff in the paediatric department attended team meetings and minutes were available for all staff to read. Staff in other areas attended multidisciplinary huddles where patients were discussed. Safety briefings were put onto the trust's intranet sites for all staff to read.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Health care assistants spoke of how they had been given the opportunity to complete additional training to help them carry out their role such as: taking patient observations, the completion of a care certificate which included bereavement, being an advocate and patient care. They also told us how they were buddied up to a nurse on shift, this meant it was easy for them to know who to go to if they needed to speak to a nurse.

Managers made sure staff received any specialist training specific for their role. There was a nursing and allied health professional's trauma competencies booklet in place for staff to complete. The nursing and allied health professional trauma competencies booklet in the emergency department had been developed by the National Major Trauma Group formed in July 2015. The booklet provided a national template of competencies in the care of adult and paediatric major trauma patient. Competencies within the workbook included organisational aspects, clinical and technical skills and non-technical skills. Once the staff member had completed the assessment the assessor signed off the achieved competency. We did not see any completed booklets on the inspection as we were told these were kept by individuals.

Managers identified poor staff performance promptly and supported staff to improve. We heard examples from leaders on how they managed staff performance when it was falling below those standards expected and how they liaised with the trust's human resources department when they had concerns.

The trust recruited, trained and supported volunteers to support patients in the service. The trust had over 500 volunteers who were drawn from local communities. Volunteer duties within the emergency department included making refreshments for patients, liaising with nursing staff to ensure patients were allowed refreshments, keeping patients up to date with developments about their wait and spending time with patients who were alone.

Mental wellbeing companions (volunteers) supported patients with mental health needs with the aim of engaging in meaningful and divisional activities; as of July 2019, 23 mental wellbeing companions were recruited. The purpose of the role was to provide companionship to patients within the emergency and observation departments who may be socially isolated or who had been identified as needing support. Volunteers needed to be aged 18 years or over to volunteer, there was no upper age limit providing the volunteer was in good health. All volunteers were required to attend a volunteer induction programme before they started in role. Training included equality and diversity, infection control and hand hygiene, safeguarding children and vulnerable adults, medical emergencies and conflict resolution. At the time of the inspection mental wellbeing volunteers completed two to four hours of voluntary work a day with a vision to increase to six to eight hours a day. Leaders told us they had received positive feedback about the service.

**Appraisal rates**

From May 2018 to April 2019, 81.3% of staff in urgent and emergency care at University Hospital Coventry received an appraisal compared to a trust target of 90%. The breakdown by staff group is shown in the table below.
### Staff group

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals received</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical staff</td>
<td>60</td>
<td>65</td>
<td>92.3%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>107</td>
<td>134</td>
<td>79.9%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>62</td>
<td>78</td>
<td>79.5%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>45</td>
<td>58</td>
<td>77.6%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>0</td>
<td>2</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>274</strong></td>
<td><strong>337</strong></td>
<td><strong>81.3%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

Medical staff were the only staff group for which the 90% completion target was met.  
(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided by the trust showed that an average of 88% of staff working across the emergency department had completed their appraisal which was just below the trust target of 90%.

### Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was good multidisciplinary working, the AMHAT team unit consultant reviewed mental health patients daily handing over any psychological needs of patients. Staff participated in consultant led daily huddles. We observed a 9 am huddle on the observation unit and found it was attended by ward staff, AMHAT, psychiatric decision staff, REACT staff and medics (junior doctors). All patients were discussed in daily huddles including any ongoing plans for discharge.

Staff told us of a recent pilot scheme whereby the rapid emergency assessment care team had worked with social care and the medical team to support a patient with multiple complex issues to return home the next day with a care package. Staff also gave us another example of how the multidisciplinary team had all worked together well to find a patient with no fixed abode somewhere to live when they left hospital. There was a good multidisciplinary working with the Alcohol Liaison Team (ALT). The team supported the emergency department and other wards from 9am to 5pm, Monday to Friday. The service offered advice for inpatient alcohol detoxification and we saw appropriate signposting to services to support patients in the community.

There was no service level agreement in place with the local mental health trust although senior staff informed us there was a memorandum of agreement. However, it was difficult to ascertain what provisions was being provided. The observation ward dealt with a high number of patients with mental health issues including out of hours. During the inspection we saw that better interagency working was needed to minimise the duration of detention and to facilitate a safe discharge from hospital for patients with mental health needs. The Mental Health Act, code of practice states that where patients are subject to compulsory detention, health and social care agencies should work together to deliver a programme of care that, as far as practicable, minimises the duration of detention, facilitates safe discharge from hospital and takes into account patient’s wishes. It also states that commissioners, providers and other relevant organisations should establish effective relationships to ensure efficient working with accountability defined through joint governance arrangements. Joint working should be used to minimise delay in care planning needed to facilitate discharge. Interagency working was not sufficiently robust to support the care and treatment of patients with a mental health issue.

Following the inspection, the trust informed us they were leaders in the sustainability and transformation partnership (STP) mental health and emotional wellbeing programme and were
active members of the acute and crisis care workstream. As a result, the trust was working to improve mental health provision with partners in both adult and child and adolescent mental health services by:

- Creating a joined up and integrated urgent care pathway for individuals with acute mental health distress. This would include an enhanced and improved crisis resolution and home treatment team (CRHTT) treatment and response time. However, this was not due to be implemented until January 2020 which meant that we could not be assured the process was embedded in the service.

The aim of the above was to help reduce out of area mental health inpatient placements by enhancing the alternative urgent care provision in the community and working with partners to reduce delayed discharges from acute units. The trust hoped to establish ‘Safe Havens’ with support from the third sector. The Safe Havens scheme would support people in mental health distress before they reach a crisis point by offering them support in the community outside of business hours.

During our unannounced visit to the department in November 2019 we heard from AMHAT staff who felt patients in acute mental distress did not always have their needs met in the community resulting in patients in acute mental distress attending the department out of hours. It was also felt that patients accessed mental health beds more promptly from other acute hospitals as they did not have an observation ward facility to be admitted. There was no clear understanding about who was responsible for informing patients detained under the mental health act of their rights. On the unannounced inspection in November 2019 we saw that the hospital records of a detained patient did not record that they had been informed of their rights to access an independent mental health advocate (IMHA), appeal against detention to a tribunal or managers hearing or to access free legal advice.

The emergency department was a not a formal place of safety. Both the police and a nurse told us that the emergency department was often used as a place of safety due to the unavailability of a nearby psychiatric unit that was previously used as a place of safety. Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. A place of safety could be a hospital, care home, or any other suitable place where the occupier is willing to receive the person while the assessment is completed. The trust policy: assessment and management of patients presenting at the emergency department with mental illness clearly states that the emergency department is not a place of safety. Senior staff spoken with confirmed that the emergency department was not a place of safety although confirmed this may be misconstrued by staff due to the number of patients presenting.

**Seven-day services**

**Key services were available seven days a week to support timely patient care.**

Staff could call for support from doctors and other disciplines and diagnostic services, seven days a week. There was an information board in the children’s emergency department which informed staff who the doctor on duty was. Staff in the children’s emergency department were able to access the registrar’s rota via a link which meant that staff instantly knew who to call when required.
There were two x-ray machines available to the emergency department, these were available 24 hours a day, seven days a week. Two CT scans were also available 24 hours a day, seven days a week. Staff said they could always contact a reporting radiologist.

There was 22.5 hours access a day from the AMHAT team for patients with a mental health need. The emergency department and children’s emergency department were open to patients needing urgent and emergency care 24 hours a day, seven days a week.

The Rapid Emergency Assessment Care Team (REACT) operated seven days a week from 8.30 am to 7.30 pm Monday to Friday and at weekends from 8.30am to 4.30pm including bank holiday’s the team made referrals to their brokerage teams in social care.

Health Promotion
Staff gave patients information to lead healthier lives

The service had relevant information promoting healthy lifestyles and support. There was information for patients and contact numbers displayed in the waiting room on giving up smoking. Patients could contact the advice line for support to do this.

There was information on mental health displayed which included details of support such as bipolar UK and the Samaritans. Another mental health board in the department had information for staff on suicide red flags, ligature points and information on the Mental Capacity Act 2005.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff referred patients to additional services when required, for example the department had close links with the alcohol liaison team who could visit the patient in hospital and signpost and support patients with any ongoing needs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Staff did not always know how to support patients who were experiencing mental ill health or who lacked capacity to make their own decisions

Staff were not always confident to assess whether a patient had the capacity to make decisions about their care and there appeared to be some confusion between the Mental Health Act and the Mental Capacity Act (MCA) 2005. One staff nurse told us they did not feel confident to assess mental capacity as they had not received the training but said that they had the training coming up soon. They told us if they had any concerns around a patient’s capacity they would ask a competent colleague or the consultant to support with this.

The trust informed us that the responsibility for completing mental capacity assessments, and the decision to impose a section 5 (2) under the Mental Health Act (1983) fell to the consultant or nominated senior staff member. Section 5 (2) of the MHA refers to a temporary hold of an informal or voluntary service user on a mental health ward in order for an assessment to be arranged. The responsibility of completing the MCA would not fall to staff nurses or junior doctors. The decisions to invoke section 2 and 3 of the MHA were completed by external personnel. A service user on a section 2 means that they could be detained for up to 28 days while section 3 means that a patient could be detained up to six months under the MHA.

Mental Capacity Act and Deprivation of Liberty training completion
Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not currently included in the trust’s mandatory training. The trust reported that it was planning to
introduce mandatory training in MCA and DoLS for registered practitioners and medical staff by September 2020. This would be included in a new mandatory safeguarding adults’ level 3 training module. The trust also reported that in the meantime the trust’s safeguarding team had been providing MCA training to priority staff groups since September 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

The trust provided us with MCA training figures which are set out below.

Mental Capacity Training: October 2019

<table>
<thead>
<tr>
<th>Group</th>
<th>Group Total</th>
<th>Nursing and Midwifery</th>
<th>Medical and Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Medicine</td>
<td>95%</td>
<td>94%</td>
<td>93%</td>
</tr>
</tbody>
</table>

(Evidence Source: DR18)

Staff did not always show due regard for the statutory guidance in the Mental Health Act (MHA) code of practice. During the inspection we found staff did not have a clear understanding as to who was responsible for informing patients detained under the MHA of their rights; to access independent mental health advocacy (IMHA), appeal against detention to a tribunal or managers hearings to access free legal advice. The MHA requires hospital managers to take steps to ensure patients who are detained in hospital under the MHA, or who are subject to a community treatment order, understand important information about how the MHA applies to them.

Two of the three records we reviewed referred to the use of the Mental Capacity Act 2005 as the legal framework for restricting patients’ movements and we did not see any formal assessments in place. We saw that a detained patient was described as appearing to lack any capacity, it was not clear what decisions this assessment referred to. Another patients’ record described the patient as being on a mental capacity act. It was not clear if this should have referred to the Mental Health Act especially as staff believed the MCA provided powers to prevent the patient from leaving or if the staff believed the patient lacked capacity and if so to what decision. However, during our unannounced inspection we reviewed the detention records of a detained patient who met the criteria for detention. We found these included appropriate medical recommendations, an outline approved mental health professional (AMHP) report and that the nearest relative had been informed of their detention. The patient was detained rather than delaying admission until a bed could be identified on a suitable mental health ward, this meant that the patient was not unlawfully deprived of their liberty while on the observation ward and had followed the MHA code of practice.

We spoke with a patient during the inspection who informed us they had not been updated on their support plan, all they knew was that they had been placed on a section two under the Mental Health Act 1983 with no further updates and they had not been given a copy of their rights for the section. Section two of the Mental Health Act allows people to be detained in hospital to have their mental health condition assessed. This meant that we could not be assured that there were processes and procedures in place to support patients who had been placed under a Mental Health Act section.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff told us they gained verbal consent. There was a consent for examination or treatment policy in place dated June 2019. The policy contained information such as what is consent and what isn’t, written consent and details of places to look for other information such as the website of the Department of Health. We observed a nurse asking a patient for consent to take their observations during triage and saw an example in a patient’s notes when consent had been recorded as obtained. We observed staff asking patients for permission to enter their cubicle. One
nurse told us how they had gained a patient’s consent to make a referral for a support service.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLS) and made sure staff knew how to complete them. Staff told us how they completed DoLS referrals electronically and emailed these remotely to the safeguarding team. There was a mental capacity coordinator in post who sent any DoLS referrals to the safeguarding team and completed any associated CQC documentation. Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

**Is the service caring?**

**Compassionate care**

*Staff mostly treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.*

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff interacted with patients waiting to be seen and explained the process to them. We observed staff introducing themselves and letting patients know their title. Staff addressed patients by their name and engaged with them in friendly conversation. We saw reception staff treating patients in a respectful and considerate manner and patients and carers were greeted at reception with warmth. There were signs in the waiting area to advise patients and their families no photography or filming was allowed.

Patients said staff treated them well and with kindness. One patient who had attended the hospital emergency department regularly told us they would recommend the trust. Patients were happy with the way staff treated them. Staff did not always keep patient care and treatment confidential in all areas. When we returned to the emergency department on an unannounced visit, we found the main set of double doors into the resuscitation area were open. Adjacent to the doors were patients who were being held in the corridor and waiting to be seen. There was the potential risk of all patients and visitors seeing and hearing everything that was happening in a resuscitation bay, particularly the end bay which was directly opposite the open doors. Although the curtains were closed staff and relatives needed to come and go so privacy could not always be protected. This was highlighted to senior staff during the inspection.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The trust had a department of spiritual care which comprised of a multi faith and multi denominational team of chaplains. Bereavement support was offered by way of informal drop in groups for adults both within the hospital and in the community. The hospital switchboard was able to contact the on-call chaplain out of hours or in an emergency. Patients were welcome to ask their own religious leader to visit them in hospital or the chaplaincy would do this on the patient’s behalf if this was their wish. One of the responsibilities of the chaplains was for the provision of support to patients, relatives, carers and staff in situations where bad news was being given or received and this was available on request. There was a guide to culture and spiritual awareness in the bereavement room within the children’s emergency department.

The Patient Friends and Family Test (FFT) asks patients whether they would recommend the services they have used based on their experiences of care and treatment. Response rates for the trust from July 2017 to June 2019 are shown below.

**University Hospital Coventry and Warwickshire NHS Trust – response rates from July 2017 to June 2019**
The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data. The trust scored between 76.5% and 84.9% from July 2017 to June 2019. The trust’s performance over these 24 months was not stable and may be subject to ongoing change.

**University Hospital Coventry and Warwickshire NHS Trust – recommendation rates from July 2017 to June 2019**

![Chart](chart.png)

(Source: Friends and Family Test – NHS England)

The trust provided us with a breakdown of the FFT data for the urgent and emergency care speciality which showed that most people would recommend the service.

**Friends and Family Test activity and performance**

<table>
<thead>
<tr>
<th>Recommend %</th>
<th>April 2019</th>
<th>May 2019</th>
<th>June 2019</th>
<th>Trust recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED all areas</td>
<td>79.46%</td>
<td>82.23%</td>
<td>81.29%</td>
<td>87%</td>
</tr>
<tr>
<td>Response %</td>
<td>April 2019</td>
<td>May 2019</td>
<td>June 2109</td>
<td>Target %</td>
</tr>
<tr>
<td>ED all areas</td>
<td>12.7%</td>
<td>13.5%</td>
<td>14.8%</td>
<td>15%</td>
</tr>
</tbody>
</table>

(Evidence source: Trust board meeting minutes September 2019)

We asked for further details of any actions taken because of the friends and family test. Changes that had happened because of feedback included the revision of the chest pain pathway, all patients with chest pain were now treated as an emergency transfer and portering and domestic staff had been trained to provide food and drink to support nursing teams.
Friends and family comments were shared with clinical teams and fed back to staff at huddles, in briefings and team meetings. An action plan was in place in relation to the national emergency department patient experience survey 2017 showing progress since 2017 to October 2019 with all actions recorded as completed.

Staff on the observation ward completed comfort rounds. This involved staff going to each patient and doing various checks such as checking the patients pillow height, offering the patient the toilet, completing any incontinence pad changes, supporting with position changes, offering drinks and food and checking if the patient had their call bell.

**Emotional support**

*Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs. Better communication and understanding was needed to inform patients of their rights under the Mental Health Act.*

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a member of nursing staff comforting a patient who was upset. There was a privacy and dignity area where staff could support patients with personal care needs if needed.

**Understanding and involvement of patients and those close to them**

*Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. However better communication was needed with mental health patients about their rights.*

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The hospital website had several easy read documents which included an easy read guide to the hospital which included useful information and pictures on how to get to the hospital, staying overnight in hospital and leaving hospital. Patients we spoke with had understood the information that had been relayed to them from staff involved in their care and treatment. For example, they knew what they were waiting for and we observed staff explaining further processes such as following a referral for an x-ray.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients told us they felt included in all treatment conversations and that treatment had been discussed and explained.

**Emergency Department Survey 2016**

The trust scored worse than other trusts for one of the 24 Emergency Department Survey questions relevant to the caring domain. The trust scored about the same as other trusts for the remaining 23 questions. The question where the trust scored worse than other trust was question 23, “Were you involved as much as you wanted to be in decisions about your care and treatment?”.  

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>3.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a doctor or nurse</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>explain your condition and treatment in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>examining and treating you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>weren't there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to</td>
<td>7.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>a doctor, did they have enough opportunity to do so?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment was given to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>medical or nursing staff to help you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing, and</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>another will say something quite different. Did this happen to you in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about</td>
<td>7.0</td>
<td>Worse than other trusts</td>
</tr>
<tr>
<td>your care and treatment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>department, did a member of staff help to reassure you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results</td>
<td>7.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>of your tests?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q29. Did a member of staff tell you about medication side effects to</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>watch out for?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q30. Did a member of staff tell you when you could resume your usual</td>
<td>4.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q31. Did hospital staff take your family or home situation into</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>account when you were leaving the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q32. Did a member of staff tell you about what danger signals</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>regarding your illness or treatment to watch for after you went</td>
<td></td>
<td></td>
</tr>
<tr>
<td>home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q33. Did hospital staff tell you who to contact if you were worried</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q34. Did a member of staff explain the purpose of the medications you</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>were to take at home in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q35. Did hospital staff tell you who to contact if you were worried</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q36. Did a member of staff explain why you needed these tests in a way</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q37. Did a member of staff tell you about medication side effects to</td>
<td>8.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>watch out for?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q38. Did a member of staff tell you when you could resume your usual</td>
<td>4.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>activities, such as when to go back to work or drive a car?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q39. Did a member of staff explain the results of the tests in a way</td>
<td>5.1</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you about what danger signals</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>regarding your illness or treatment to watch for after you went</td>
<td></td>
<td></td>
</tr>
<tr>
<td>home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>account when you were leaving the emergency department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q42. Did a member of staff explain the purpose of the medications you</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>were to take at home in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>about your condition or treatment after you left the emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q44. Overall... (please circle a number)</td>
<td>7.7</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Is the service responsive?)
Service delivery to meet the needs of local people
The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the changing needs of the local population. There was a business continuity plan in place which was in date and due to be reviewed in 2021. The business plan provided guidance on maintaining services and dealing with business interruptions which may have disabled services or required special arrangements to be put in place. The plan included information such as incident assessment criteria, initial response arrangements, command and control and various templates and an incident risk assessment template. A major incident plan was in place which provided a framework if a major incident was to occur. The plan had numerous action cards for Individuals to follow, details of plan activation and the major incident team hierarchy.

Facilities and premises were mostly appropriate for the services being delivered. Leaders in the children’s emergency department told us how they were able to use the bereavement room for autistic children who needed to have a quiet space. There were specific rooms available for patients with mental health needs where they could go to be assessed or if somewhere quiet was needed. Staff told us how they gave patients time for prayer.

The main waiting area was large and had plenty of seating. Leaders in the children’s emergency department were looking at improving the seating area to make it more comfortable and able to accommodate more children and their families. Access to the emergency department from outside was via the road or steps. This meant it could be difficult for patients with poor mobility to access the service easily. At the time of the inspection we saw someone who was struggling to carry a pram up the stairs. There was no clear signage near the steps outside to inform patients on foot of another way into the department.

Staff could access emergency mental health support 22.5 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Plans were in place to extend those hours to provide support 24 hours a day from January 2020.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff on the children’s department told us how they could bleep a play specialist if they were needed but they were not part of the staffing numbers. There was a learning disability nurse on rotation in the children’s emergency department. The trust had a clinical nurse specialist (CNS) for cancer located within the trust. Staff told us how they could contact them for support. During the inspection we observed the CNS attending the observation ward to take a patient to the haematology department.

Meeting people’s individual needs
The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

There was a rapid early assessment team co-located in the emergency department. The team mostly saw patients who were over seventy-five with the aim of facilitating a safe discharge. There was criteria in place to determine if a patient met the criteria or partially met the criteria such as suspected sepsis, head injury and news scores. There was a rapid emergency assessment care team (REACT) in place. The service sat under the accident and emergency team and acute medicine and followed a screening process. The team of 25 staff consisted of occupational therapists and assistants. The team looked at admission avoidance and the patients wish such as
supporting the patient to be discharged home with a package of care and signposting patients to other services. The service operated seven days a week from 8.30 am to 7.30 pm Monday to Friday and at weekends from 8.30am to 4.30pm including bank holiday’s the team made referrals to their brokerage teams in social care.

The children’s emergency department was decorated in a way that was child friendly, there were child friendly friends and family test forms for children and their families to complete. There was a breast-feeding room in the children’s emergency department. Within the room there was a changing area, seating, a highchair and a sink. This meant patients wishing to breastfeed their babies had a private area they could go to do this if they wished.

There was a bereavement room available for those who had suffered a bereavement whilst in the children’s emergency department; families could visit as many times as they wished. The room had a ‘moses’ basket, a fold out bed and air conditioning in place. Having air conditioning meant those who were bereaved could spend more time with their loved one who had deceased. Inside the bereavement room there was a bereavement folder, staff were able to do hand and foot prints and take a lock of hair from the deceased to give to families as a keepsake. There were also spare children’s clothes of different sizes available if needed. Staff in the main emergency department placed a dove sign on doors when there had been a bereavement. There was a policy in place for sudden and unexplained deaths.

Staff had access to a diabetic link nurse. Leaders told us health care assistants acted as links for pressure ulcers and had received training for this. Other link nurse roles noted in the children’s emergency department included bereavement, pain, sepsis and handwashing. Staff told us how they had made reasonable adjustments for patients such as ordering bariatric chairs, commodes and beds.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. We observed a patient with confusion leave the hospital trolley they were on. Staff reacted quickly and guided them back whilst treating them with compassion. There was a sign with a flower that staff placed on the door or wall of patient’s cubicles if they were living with dementia. There was a trust wide dementia strategy group who met monthly and followed a set agenda which included education, standards and clinical practice issues. There were disabled toilets available for patients and their families to use if they had a disability.

The service had information leaflets available for patients. We saw some information was available in other languages. We saw a file containing patient menus in other languages such a Hindi, Urdu, and Punjabi. Users of the trust website had the opportunity to select a language which meant that patients or their families could select their chosen language and the website would be interpreted into this language. The patient advice and liaison service (PALS) leaflet advised patients and their families if they needed the PALS information in other languages to contact them.

There was a variety of information leaflets available to patients who attended the emergency department. For example, we saw leaflets on head injury, neck pain, wound care, bruised and broken ribs, dementia and sedation. In the children’s department we saw medical discharge sheets with various advice about skin conditions, childhood diseases and allergies. We observed staff handing out to patients.

On our unannounced visit in November 2019, we found that one patient had not been given a leaflet on why they were being cared for in the corridor. Senior staff told us that all corridor patients were given a leaflet about why they were being cared for in the corridor. Patients spoken with said they had not been given any information and staff spoken with were unable to locate any leaflets.
Following this, a senior staff member printed a copy off the trust’s intranet to show us. This meant that staff were not following trust guidance in provide patients with information about corridor care.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us they would contact an interpreter from language line if a person was unable to communicate in English. Staff spoke of the befrienders who were volunteers who could communicate with patients in British Sign Language, however they did not provide any medical interpreting but could communicate any relevant patient information to nursing staff.

Staff had access to communication aids to help patients become partners in their care and treatment. There was a communication book for deaf and hard of hearing patients and staff, it had information on communicating clearly, supporting people with hearing loss, supporting people with visual impairments, Makaton signs as well as pictures of the alphabet, personal care, symptoms and personal care.

Emergency Department Survey 2016
The trust scored about the same as other trusts all three Emergency Department Survey questions relevant to the responsive domain.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>9.0</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Access and flow
Patients could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Managers monitored patient transfers and followed national standards.

Median time from arrival to treatment (all patients)
The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for 11 months over the 12-month period from July 2018 to June 2019. From August 2018 to March 2019 the trust’s performance against this standard deteriorated. In May and June 2019 performance improved.

Median time from arrival to treatment from July 2018 to June 2019 at University Hospital Coventry and Warwickshire NHS Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)
The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department. From August 2018 to July 2019 the trust consistently failed to meet the standard. The trust performed worse than the England average in February and March 2019. The trust’s performance was similar to the England average in the remaining 10 months.

Four hour target performance - University Hospital Coventry and Warwickshire NHS Trust

![Graph showing four hour target performance](source: NHS England - A&E Waiting times)

From August 2018 to July 2019 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was better than the England average in 10 out of 12 months. In the remaining two months the trust’s performance was similar to the England average. There was a sharp deterioration in the trust’s performance from November 2018 to February 2019. This was followed by an improvement from February to May 2019. This probably reflected winter pressures, as the period of poor performance coincided with the winter months.

We asked the service for information on any actions taken to improve performance around the percentage of patients admitted, transferred or discharged within four hours. Actions taken included a medical decision unit improvement plan, revised standard operating procedure (SOP) which provided guidance for improved direct streaming. Increase of nursing workforce, workstreams in patient flow for simple discharge and waste reduction programmes and a tracker: tracers had been moved under management of the Operations team (October 2019). Additionally, an NHSI improvement plan was in place.

There was an emergency department minors’ paper with an overview of actions and timelines. This included a review of minors’ activity over a 24-hour period against performance highlights, staff engagement plan, operational clinical lead focus and support and streaming process training led by a consultant nurse. We reviewed the internal audit report dated July 2018 on ED four hour waits. The review noted that robust controls were operated by the trust in terms of the processes for calculating and reporting monthly compliance scores against the ED four-hour wait access strategy. It was felt that data held on the clinical systems were reliable and valid for operating periods February to March 2018. However, they did find in a small number of instances that ED pathways had been incorrectly reported as a breech/non-breach due to incorrect information being held on a system. The review highlighted that the emergency department reviewed breaches against the four-hour wait on a day to day basis to validate any breaches against the wait and to ensure lessons were learned. It also noted casualty cards continued to be used but reliance was placed on a specific system when performing daily breach analysis in the department.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - University Hospital Coventry and Warwickshire NHS Trust
Number of patients waiting more than 12 hours from the decision to admit until being admitted
Over the 12 months from August 2018 to July 2019, none of the trust’s patients waited more than 12 hours from the decision to admit until being admitted.
(Source: NHS England - A&E Waiting times)

The number of patients leaving the service before being seen for treatments was low.

Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment
From July 2018 to June 2019, the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was better than the England average in eight out of 12 months.

Percentage of patient that left the trust’s urgent and emergency care services without being seen - University Hospital Coventry and Warwickshire NHS Trust

Median total time in A&E per patient (all patients)
From July 2018 to June 2019 the trust’s monthly median total time in ED for all patients was consistently lower than the England average. There was a deterioration in the trust’s performance from 113 minutes in August 2018 to 137 minutes in March 2019. However, this was followed by an improvement to 115 minutes in June 2019.
The national standard for triage within 15 minutes was measured by the service using the median and compliance was monitored through the trust emergency care improvement board. Results from August 2018 to November 2019 showed the standard had been met consistently in all months. To manage times when triage was above 15 minutes an escalation procedure was followed which leaders told us was on the intranet. Leaders also told us that as part of the department’s safety huddles (which were held three times a day) the breakdown of the timed pathway was discussed, actions agreed to improve and for the actions to be reviewed at the next huddle.

The children’s emergency department (CED) also completed a local audit of triage times to drive improvement within the team. This was shared in team meetings and as part of their improvement board. The national standard for triage within 15 mins had been met in the CED consistently for the last 12 months. The trust measured the standard using the median and compliance was monitored through the trust’s emergency care improvement board. To manage triage times in CED when the time triggers > 15 mins, the service had an escalation procedure which was available on the intranet. As part of the ED safety huddles held three times a day the breakdown of the timed pathway was discussed, and actions agreed to improve. These actions were then re-reviewed at the next huddle. We reviewed five triage times of children in the children’s emergency department and found three children were triaged within the 15 minutes and the other two within 19 minutes.

We saw the figures for September and October 2019 which are set out below:

<table>
<thead>
<tr>
<th>Children’s emergency department triage time</th>
<th>Local target</th>
<th>September 2019</th>
<th>October 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean time arrival to triage walk in (minutes)</td>
<td>15 minutes</td>
<td>9 minutes</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Median time arrival to triage walk in (minutes)</td>
<td>15 minutes</td>
<td>6 minutes</td>
<td>6 minutes</td>
</tr>
</tbody>
</table>

(Source: NHS Digital - A&E quality indicators)
Data provided by the trust showed that the national standard for triage within 15 minutes had been met consistently since July 2019. The trust measured the standard using the median and compliance was monitored through the improvement board using an electronic system. To manage triage times an internal escalation trigger tool and was in place to support staff. The process was that the nurse in charge recorded the trigger scores every hour into a daily log and escalate by bleeping the manager of the day for support if required. The trust aimed to achieve 15-minute targets through a variety of means such as escalation protocol triggers, trust investment in workforce and monitoring and reviewing performance against the standard as part of weekly operational reporting. We were told the national standard for triage within 15 minutes had been met consistently for the last 12 months. We looked at data provided from August 2019 to November 2019 which confirmed the median time to triage met this.

We reviewed three sets of patients notes for triage times and saw the patients had been triaged within 15 minutes. We looked at the triage time information board on three separate occasions and found the 15-minute standard was met on two of these. We returned to the emergency department unannounced in November 2019 and found that the time to triage for adults recorded was one hour 42 minutes and for children it was one hour 14 minutes. We noted that three patients we spoke with had been in the corridor for over four hours and were waiting to be seen by a doctor. They confirmed that they had been seen often by a nurse who had taken their blood pressure and asked if they needed anything.

There were delays in accessing mental health beds. The AMHAT team were commissioned to respond to the emergency department within 90-minutes and the observation ward within 12 hours, all other wards were 36 hours. There were plans in place to reduce these waiting times. The AMHAT team reviewed patients who had been detained daily except for weekends. The Child and Adolescent Mental Health Service saw children and young people between 9am and 5pm Monday to Friday, out of hours AMHAT would see them but they would not see children under the age of 16 years. Young adults aged between 16 and 17 years old were given the opportunity to be seen in the adult or paediatric emergency department. They also assessed patients with dementia or a learning disability.

Staff monitored patients waiting for a mental health bed. There were bed management meetings and daily calls which considered patients waiting for mental health beds. There were delays for patients awaiting mental health beds. Whilst waiting for a mental health bed, patients mainly stayed in their room with the ward reliant on wellbeing volunteers to provide one to one companionship. Delays in accessing mental health beds were identified as a risk on the departmental risk register. When we returned to the emergency department in November 2019, we looked at two records of patients with mental health concerns. One of the patients was at risk of flight/suicide and had not been seen by the AMHAT team since their arrival at 15.55pm. We made enquiries as to when the referral was made but staff couldn’t immediately tell us, and this was not referenced in the documentation. However, within 15 minutes of making the enquiry, staff had managed to find the patients a bed within the observation room.

Managers monitored waiting times and aimed to ensure patients received treatment within agreed timeframes and national targets. When patients arrived in accident and emergency they went to the main reception desk to book in. The patient details then went through to the meet and greet desk and any notes were placed in a tray. The meet and greet staff had access to a list of unseen patients on the computer. At this point it was determined if the patient needed triage or to go to minors where they were assessed by an emergency care practitioner (ECP). Reception areas displayed current waiting times for triage and to see a doctor. Staff in the emergency department used the Manchester triage tool and a streaming nurse directed patients following pathways such
as maxillofacial or surgery. The Manchester triage system is a clinical risk management tool used by clinicians to enable them to safely manage patient flow when clinical need exceeds capacity. Triage nurses documented if patients were waiting longer than 15 minutes and escalated this to the co-ordinator.

At the time of the inspection there was no GP primary care centre. Posters displayed in waiting areas informed patients and their families that patients were seen in priority of clinical need. The department had introduced vertical streaming to the most suitable service such as the medical decision unit. We observed boards highlighting who had been seen. A green board meant that the patient had been seen and a red one meant they were still awaiting to be seen. We spoke to a hospital ambulance liaison officer (HALO) who was based in the department. The role of a HALO is to ensure ambulance crews are not delayed at hospital handover and are able to move to their next job as soon as possible. The HALO told us that they felt the new RAT (Rapid Access to Treatment) system was working well and spoke of how it had improved the handover process, they felt the handover process was much more efficient and had no concerns. This echoed the opinion of two ambulance staff we spoke with.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had introduced the role of flow co-ordinator to stream patients more quickly. There was a paediatric emergency nurse practitioner in the children’s emergency department, this was a six-day service to help streamline discharges and referrals. Managers monitored that patient moves between wards/services were kept to a minimum. Staff from the REACT team told us how they tried to keep patient transfers to a minimum and that they would escalate situations where they felt patients could go direct to another area or place such as elderly care.

Learning from complaints and concerns
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. Staff ensured leaflets were available about the Patient Advice and Liaison Service (PALS). This let patients and their families know how to make a complaint. PALS is a National Health Service body created to provide advice and support to NHS patients and their relatives and carers. Staff understood the policy on complaints and knew how to handle them. There was a complaints policy in place which was due for review in 2021. The policy contained information on the resolution of complaints, investigation of complaints and receipt procedure. Staff were able to tell us how they dealt with any complaints such as giving an apology and referring the patient to PALS as well as informing the person in charge. Complaints were acknowledged, and response letters to patients were very well laid out and contained a lot of information.

Managers investigated complaints and identified themes. Leaders in the children’s emergency department told us that complaints usually involved the waiting area as the seats were hard and there were no vending machines due to lack of space although drinks machines were available in the main waiting area. Leaders identified communication as a key complaint theme.

Summary of complaints
From May 2018 to April 2019 the trust received 90 complaints about urgent and emergency care at University Hospital Coventry (14.1% of total complaints received by the hospital). For the 86 complaints that had been closed at the time of data submission, the trust took an average (mean) of 31.9 working days to investigate and close these complaints. This was longer than the trust’s
target of 25 working days. The four complaints that were open at the time of data submission, had been open for an average of 37.5 working days. This was longer than the trust’s target of 25 working days. A breakdown of complaints by ward or unit is shown below:

<table>
<thead>
<tr>
<th>Ward / unit</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency department</td>
<td>64</td>
<td>71.1%</td>
</tr>
<tr>
<td>Children’s emergency department</td>
<td>10</td>
<td>11.1%</td>
</tr>
<tr>
<td>Ward 12 - observation / assessment unit (emergency department)</td>
<td>9</td>
<td>10.0%</td>
</tr>
<tr>
<td>Emergency department - resuscitation</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Ward 30 – respiratory</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>CT department</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>X-ray department - general</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>PALS - patient advice &amp; liaison service</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Emergency department - majors</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

A breakdown of complaints by subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>53</td>
<td>58.9%</td>
</tr>
<tr>
<td>Patient care including nutrition / hydration</td>
<td>6</td>
<td>6.7%</td>
</tr>
<tr>
<td>Communications</td>
<td>6</td>
<td>6.7%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>5</td>
<td>5.6%</td>
</tr>
<tr>
<td>Trust admin / policies / procedures including patient record management</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Admissions, discharges &amp; transfers (excluding delayed discharge due to absence of care package - see integrated care)</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>3</td>
<td>3.3%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3.3%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; wellbeing</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>90</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From May 2018 to April 2019 the trust received 127 compliments about its urgent and emergency care services at University Hospital Coventry. The trust noted that the main theme arising from 1,600 compliments received across the trust over the same 12-month period were how well staff demonstrated the trust’s values, particularly compassion, pride and respect. Recent compliments mentioned the professionalism and responsiveness of their staff.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

We asked for details of actions taken to improve the response rates of complaints. This included having weekly complaints meetings with each clinical group, daily huddles and a production board to support monitoring. Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were an agenda item in the any other business section of the children’s emergency department meeting in September 2019, however no complaints had
been received that month to discuss. Complaints were also discussed in the monthly quality improvement patient safety meetings.

**Is the service well-led?**

**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The children’s emergency department fell under the emergency medicine directorate and accountable to the emergency medicine group. Leaders told us how the move had begun in February 2019 until May 2019. This meant it had been able to take place in a safely measured way.

The triumvirate was made up of a group clinical director, a group operations director and a group director of nursing and allied health professionals. Staff told us that leaders were supportive and accessible, and they felt they were treated equally. They told us they were confident to speak to senior staff at any level of management. We heard examples of staff progressing into senior roles. There was a new matron in post, the plan was that the matron would have oversight of both the children’s and adult’s emergency department, leaders were visible within the children’s and the emergency department.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had reviewed the vision and values of the services. The trust vision was to be a national and international leader in healthcare by ensuring patients received the very best care possible while their mission was to care, achieve and innovate. The service focussed on providing and improving quality of care which included patient experience, safety and outcomes.

The trust’s values reflected what was important and this had been developed by staff to reflect the culture they trusted wanted to achieve. The trust used the UHCW improvement (UHCWi) methodology in their strategy to deliver the values which included:

- Compassion – to treat everyone with courtesy and compassion.
- Partnership – to work in partnership to deliver and improve the service we provide for patients.
- Respect – to treat everyone with respect and dignity.
- Improve – be open to change and seek to innovate to improve what is done
- Learn – see education, research and learning as central to improvement.
- Openness – to act with openness, honesty and integrity in all that staff do.
- Pride – take pride in all that is done and aspire to do.

Staff we spoke with were aware of and demonstrated the trust values. They could direct us to the trust’s strategy triangle by ensuring the patient was at the forefront of everything they did. This was based on the trust’s vision, mission, values and objectives. We saw the strategy triangle on display throughout the ED.

The trust’s strategic solution was to achieve their vision, mission and values by empowering staff, integrating the services and building on strong foundations.
There was an organisational strategy in place dated 2018-2021 which had been refreshed and approved by the trust board in 2018. Strategic objectives to determine if they were delivering their strategy included being a model employer, deliver the safest care and excellence in patient experience and to be a front runner in research, innovation and education. Engagement sessions were held with chief officers meeting key stakeholders including clinical directors, groups and senior leaders in January to February 2018. A series of open sessions were arranged in February 2018 with all staff being invited and which was led by the chief officer.

Senior staff were very clear about what they wanted the service to achieve. Some of this required education and skills training for both nursing and medical staff. There were some environment structures in the department which formed part of the improvement plan, including the addition of beds within the resuscitation area. It was hoped that the changes would improve department efficiency and patient flow.

**Culture**

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers across the service promoted a positive culture that supported and valued staff. Staff said they were offered support following challenging or difficult cases or incidents in the department. There was a strong culture for delivering high-quality care. Staff felt valued and supported to deliver care to the best of their ability.

Staff told us they loved working at the hospital and how they were proud to work at the trust, how every day was different, and how they liked the variety of their work. They spoke of an open and honest culture; and when they had a difficult day the team supported one another. Staff told us they felt valued and respected and felt their professional opinion was respected.

Across all areas, staff said they were committed and very passionate about the care they provided to patients. We observed staff working well as a team and told us they could access the executive team if required to escalate concerns. There was regular communication from the chief executive officer and staff received newsletters which provided them with updates across the trust.

We reviewed the minutes from the children’s emergency department meeting in September 2019 and saw leaders said well done to staff, in this instance it was in relation to a 100% compliance with an audit on pain scores. Leaders in the children’s emergency department spoke of a team that had bonded together well.

Staff were encouraged to show their appreciation to others using an appreciation card. The card had a list of values on the front and on the back the sentence “I want you to know that I really appreciated you”. Leaders on the children’s emergency department had implemented a staff idea to have a brilliance box where staff could nominate one another. Winners received a brilliance certificate and a bar of chocolate. Staff felt they had the opportunity to develop for example working with other teams such as the end of life care team and completing qualifications such as National Vocational Qualifications (NVQ’s) (healthcare assistants). We heard from leaders who were supportive of a no blame culture where learning from incidents were prioritised. There were appropriate security arrangements to keep staff and others safe and protected from violence. For example, close circuit television (CCTV) and panic buttons. Security staff were present in the emergency department 24 hours a day, seven days a week. We spoke with a mental health
volunteer whose role was to sit with patients living with a mental health condition. They told us how they were aware of how to keep themselves safe such as sitting near the door and pressing the call bell in an emergency. We returned to the accident and emergency department unannounced and visited the resuscitation area. Staff did not challenge the inspector as to who they were; as there were lots of relatives and staff in the area we were concerned how staff would identify an unauthorised person.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. However, more robust oversight was needed around the management of patients with a mental health need.

The service used a systematic approach to improve the quality of its services and was clear about how quality was monitored, and learning shared across the team. Since the last inspection leaders had implemented systems for monitoring and mitigating risk in the children’s emergency department. They had implemented escalation policies for children who were waiting for senior review and requiring admission.

Regular governance and divisional meetings took place during which there was discussion regarding operational risks, quality, patient experience and staffing. For example, we reviewed the public trust board paper for September 2019 and saw sepsis was on the agenda. The trust had undertaken a series of sepsis workshops and presentations including an emotional patient story. Over 2018-19, the sepsis team has seen many changes and improvements across the trust which resulted in the reduction of mortality attributed to sepsis in patients and the number of observed deaths dropping below the number of expected. We reviewed an improvement board in the children’s emergency department. The board had details of what people had said they wanted changing, it also contained details of the leader’s goals for the service such as obtaining a quote for a blood gas machine and to improve the seating area.

Senior leaders told us how they had daily huddles with leaders of the children’s and adult’s emergency department. Because of this they felt their oversight had much improved. We saw leaders in the observation ward had recorded on a notice board for everyone to see a section on improvement and morale. Improvements included the recruitment of mental health companions, a staff suggestion box and decluttering an area. The board also identified key messages such as saying well done to a staff member who had achieved an award, to complete intentional rounding’s (comfort rounds) and to ensure mandatory training was up to date.

The department and speciality held monthly quality improvement patient safety meetings (QIPS) where quality was reviewed. Quality was also reviewed through safety huddles. The meetings reviewed patient safety, clinical effectiveness and patient experience in line with the trust strategy. Outcomes of these meetings were submitted to the group management board to provide assurance any actions were undertaken in a timely manner.

We reviewed the minutes from September 2019 and October 2019 and found they were well attended and included senior staff from both the children’s and emergency department. Agenda items included patient safety, clinical effectiveness and patient experience. The minutes also contained an action matrix with the name of the person responsible and any escalations. QIPS
messages from September 2019 included using the term category not grade when recording pressure areas and that there was new ketamine discharge information. We saw issues relevant to the emergency department were discussed in detail at the trust board. For example, the public board paper dated September 2019 detailed figures and steady improvements in sepsis management.

More robust oversight was needed around the management of patients with a mental health need. For example, ensuring mental health patients were informed of their rights and that this was well documented within patients notes, that risk assessments including ligature risk assessments were completed and that multidisciplinary working and policies were in place that aimed to improve the timeliness of discharging detained patients to a more appropriate facility. This was brought to the attention of the trust who informed us the trust were leaders in the sustainability and transformation plan (STP) mental health and emotional wellbeing programme and members of the acute and crisis care workstream. The trust acknowledged there was historic underfunding of mental health provision and was pursuing improved mental health provision with partners in both adult and CAMHS services. The trust had areas which it was looking at implementing in 2020.

Areas identified included:

- The creation of a joined up and integrated urgent care pathway for individuals with acute mental health distress by:
  - Enhancing and improving Crisis Resolution and Home Treatment Teams (CRTHTT) treatment and response times. Phased implementation is due to commence in January 2020 with the introduction of fast response hubs followed by an enhanced home treatment team.
  - To increase the AMHAT service standard to 24 hours a day, seven days a week from January 2020.

- The trust informed us that the above would reduce out of area mental health inpatient placements by enhancing the alternative urgent care provisions in the community and working with partners to reduce delayed discharges from acute units. The trust was currently awaiting a response/approval from NHS England.

- Enhance the street triage mental health service by extending the hours in Coventry and exploring and implementing an appropriate model of provision for Warwickshire. An evaluation report is due in January 2020.

- A six-bay psychiatric clinical decision unit at the local mental health centre was introduced in February 2019. The aim of the centre was to provide a more appropriate environment for assessment rather than a busy emergency department. An evaluation of the service is due in December 2019.

- Establish and test “safe havens” with the support from a third sector. The safe havens would support people in mental health distress before they reached a crisis point by offering them support in the community outside of business hours. A safe haven was due to be established in Coventry in January 2020.

- We noted that most of these new services were not due to commence until January 2020 and therefore we could not be assured there were processes in place to manage the oversight of patients’ needs when presenting with mental health concerns.
Management of risk, issues and performance
Leader and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was good leadership oversight of the daily management of the department. Throughout the inspection, there was a clear line of responsibility which ensured that tasks such as equipment checks, departmental cleaning and escalation and recording of risks were completed.

There was a risk register in place. At the time of the provider information request it contained twenty risks. We reviewed the risk register and found it was colour coded to highlight the most urgent risks which were red, it contained the current controls the hospital was using to mitigate the risks and any gaps in control. There was a review date and a column for assurance and gaps in assurance. We saw that the risk register was discussed in monthly quality improvement patient safety meetings.

We reviewed the minutes from the risk committee dated April 2019 and saw the meeting had considered any open risks including the risk around delays in admission to a mental health unit for patients with serious mental health problems.

We discussed risk with senior staff in the children’s emergency department. Leaders showed us a copy of the current risks within the department as of October 2019 these included the recruitment of paediatric nurses, psychology support for oncology patients and the ability to keep CAHMS patients safe. Leaders in the children’s emergency department has a risk assessment list where risks were graded as low, medium or high risk. It also contained details of when risks were next due to be updated. These included violence and aggression towards staff, debriefing after a clinical incidents and hygiene hand rub.

The emergency department had emergency backup generators in place should there be for example a power failure to ensure the safety of patients attending the department.

We returned to the department on 4 November 2019 and observed a site huddle. During the huddle we observed bed management providing an update of how many beds were available, staffing being discussed for example that the emergency department was fully staffed with an extra health care assistant for the reception area, extra nurse/doctor escalated due to numbers.

Information management
The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff received helpful data daily, which supported them to adjust and improve performance as necessary. Staff had access to up-to-date, and comprehensive information on patients’ care and treatment. Staff were aware of how to use and store confidential information.

We observed locked blue waste paper bins located around the department, where staff could dispose of any confidential waste. Relevant IT information was provided to staff during their induction. Staff used hand held electronic systems to record patient observations. Staff needed to sign these out when they used them. Results from these could also be viewed on the IT system, for example if a doctor wanted to look at the results.
Computers in the department were password protected to protect unauthorised access. The service collected, monitored and reported ED attendance times as required by the Department of Health. Electronic information was displayed on waiting times to see doctors and for triage. This information refreshed automatically meaning patients were kept up to date with the most recent information at regular intervals.

**Engagement**

*Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.*

Staff told us leaders kept them informed. Health care assistants told us how there was a folder where they could write any issues or any concerns they needed to raise, and these were acted upon. On the observation ward leaders had implemented a cube suggestion box in order to boost staff morale. This was kept in the treatment room and staff could leave a suggestion; any staff member could do this. Staff engaged with patients and their families around sepsis; for example, there was a highly visible think sepsis sign in the main emergency department waiting area with details around sepsis. Additionally, there were details displayed of sepsis support groups including upcoming dates and venues for anyone affected by sepsis.

The team worked collaboratively with the AMHAT team to support the needs of patients attending the department and when planning for discharge. The service worked with local healthcare providers and commissioners to plan patient care.

There were information boards alerting patients and their families of the friends and family test and advising them that staff would like to know about their experience. Staff names, photographs and roles were on display for patient and their families to see. This meant staff would be able to identify staff more easily if they needed to find or speak to a particular person.

Leaders engaged with staff through a variety of means. We saw notice boards advising staff how the department had been working to improve. For instance, how, the rapid assessment team had been working to improve the handover times of patients arriving at the department by ambulance. In the children’s emergency department, we saw leaders had shared key issues with staff in staff areas, for example, for staff to ensure patient healthcare records were read at every shift change. There were production boards on display, in minors we saw the board shared information on safety, complaints, quality and performance and action points. Staff told us how they communicated via closed social media groups.

Information about the complaint’s procedure and patient advice and liaison service was available in clinical areas. Feedback was also gathered through social media forums, such as NHS Choices, Facebook and Twitter. We saw effective communication between doctors and nurses throughout the inspection. We saw that patient care was discussed between staff. The service followed a collaborative MDT approach to handovers three times a day, reviewing all patients in the department, checking progress and developing management plans to ensure all patients had a plan in place. The aim was to reduce unnecessary delays and to improve communication between nursing and medical teams.

**Learning, continuous improvement and innovation**
All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The emergency department leaders acted to make improvements in the running of the service. They had regular meetings where learning was discussed. For example, quality and governance meetings. There was evidence of improved culture across the services alongside good leadership.

Improvements had been made since our last inspection in June 2018, where we had raised concerns in relation to the lack of systems in place to monitor and mitigate risks relating deteriorating patients, the assessment of pain while ensuring there were enough nursing staffing levels with the right skills, updated mandatory training and qualifications to meet the needs of all patients. During the inspection we saw escalation policies in place for:

- Children awaiting a senior review.
- Children identified as requiring admission.
- Introduction through training and competency program of POPS at triage and the use of PEWS for POPS score which was greater than three.
- Use of a pain tool.

The trust had re-organised the management of the children’s ED by ensuring the matron for ED also managed the children’s ED. There was joint representation on the paediatric and emergency department quality improvement and patient safety (QIPS) reviews.

The service had also implemented:

- An escalation protocol across clinical teams in the ED and acute medicine services to improve performance.
- Three times daily huddles to review operational position with senior leadership teams.
- Vertical streaming out of ED for medical patients clinically appropriate for the medical decision unit or ambulatory emergency care.
- In triage a risk assessment for children in crisis was in place.

The service worked with the local mental health trust with a view of reducing delays in admission to a mental health unit for patients with serious mental health problems. The service had created daily board rounds and safety huddles on the observation ward as well as monthly joint clinical meetings between the ED and AMHAT.

The ED participated in the UHCW Improvement (UHCWi) method which was the trust’s management system based on lean principles designed to help deliver continuous improvement that could be used at every level of the organisation. It supported the development of leaders to frame problems and empower staff to develop and sustain locally led improvements. The children’s emergency department was developing a value stream. A value stream is an area for focused work.

The top tray re-assessment tool contained details of the patients presenting complaint, details for the re assessment, any investigation results, any concerns and ongoing issues and plans for next review/escalation. The form which was purple was placed in the urgent to be seen tray (top tray). The next available doctor would then reassess the patient. We heard examples which
demonstrated this was working well such as the identification of deteriorating patients at an earlier stage.

There was a colour coded system in place to identify patients’ specialities. For example, a yellow tray for medical patients, a red tray for cardio thorax patients, a blue tray for surgery patients, a clear tray for the emergency department patients and a green tray for orthopaedic patients.

One doctor from the emergency department founded and ran civility saves lives, a campaign that aimed to raise awareness of the power of civility in healthcare and who had been working with staff at the trust around this. The doctor had completed various technology, entertainment, design (TED) talks about this in addition to talks in Europe. They had also worked with the general medical council (GMC) and had a website which anyone could use. The ethos of civility saves lives was that how we behave towards each other matters. The department completed exit interviews when any doctor or junior doctor left the department.

Leaders told us how a consultant from the emergency department ran a national course on thoracotomy. This was directed by the clinical lead for major trauma. A thoracotomy is a surgical procedure to gain access into the pleural to the thoracic organs, most commonly the heart, the lungs, or the oesophagus. Staff told us how all emergency department consultants had completed a cricothyroidotomy course. A cricothyrotomy is an incision made through the skin to establish a patent airway during certain life-threatening situations, such as airway obstruction. Every consultant except for two new starters had completed the programme at least once.

The emergency department had research nurses who were involved in many national trials. To improve patient experience the emergency department was undergoing a trial of criteria-based nurse led discharge for children after ketamine sedation. Ketamine is a safe and effective procedural sedation option for children in the emergency department setting. This formed part of a local quality improvement project in the department. Emergency department/children’s emergency department consultants or anaesthetists/intensive care consultants and anaesthetist middle grades were the only people authorised to perform paediatric sedation. Staff were not able to deliver ketamine sedation without completion of a competency package and sedation was only given under the direct supervision of a consultant.

Leader in the children’s emergency department told us how they were looking at implementing a rapid process improvement workshop (RPIW) to improve waiting and referral times and how this was part of the Virginia Mason improvement process. They were also looking towards requesting approval for triage nurses to be able to request x-rays so that they would be ready for review by the doctors. RPIW workshops were run over five days and followed a 6-week period of direct observations to capture the current state of a process from a patient’s perspective and the burden of work on staff. Patients were also invited as part of the team on the week and each RPIW had sponsors and process owners to help support teams and remove barriers to the testing of ideas.

We heard of a recent pilot scheme when the rapid emergency assessment care team had worked with social care, the medical team to support a patient with multiple complex issues to return home the next day with a care package.

We heard how the children’s emergency department had implemented a self-discharge stamp to use to show the reason for discharge. This most recent local audit of this showed a 100% compliance in May, July and September.

A staff member had been recognised for a long-standing care award and tireless work and had been awarded with a certificate, statue and a meal. The department had also won an award for being an exemplary learning environment for which they had received a certificate and a trophy.
In the children’s emergency department there was a sepsis box with everything needed for a child less than three months old. This included gloves, syringes, dressings, blood bottles, sterile towels and cannulas. Staff checked the contents regularly and it was kept sealed.

A new staffing role had been developed within the emergency department. The role involved staff being trained to complete multiple roles (porter, cleaner and caterer). Staff worked in teams of seven and provided a 24-hour service. The team were very visible to patients and staff as they wore an orange uniform. We returned to the department to do an unannounced visit and observed good rapport between the team, nursing staff and patients. Nursing staff told us they found the role to be beneficial whilst doctors felt unsure about the continuity of work due to flexing duties.

### Medical care

#### Facts and data about this service

The medical care service at University Hospital Coventry provides care and treatment for specialties including cardiology, care of the elderly, dermatology, diabetes and endocrinology, gastroenterology, haematology, infectious diseases, nephrology, neurology, oncology, renal medicine, rheumatology and respiratory medicine. The hospital’s acute medicine services are provided using a consultant-led shift system (0800-2200), supplemented with 24/7 cover by a general internal medicine on-call rota. Advanced clinical practitioners are also embedded within acute medicine services. Non-elective medical services include specialty on-call rotas for cardiology, gastroenterology (including a distinct acute gastro-intestinal haemorrhage rota), haematology, nephrology, neurology and stroke, oncology and respiratory medicine. The Hospital of Rugby St Cross has sub-acute medical beds for patients who are repatriated from Coventry after their initial assessment and need ongoing care, along with rehabilitation beds for elderly patients. The wards are supported by physiotherapists, occupational therapists, dieticians, audiologists and speech and language therapists based at St Cross. Cardiac rehabilitation is also available to support all patients who have recently undergone treatment for a heart attack, angina, heart failure, and heart surgery.

(Source: Routine Provider Information Request (RPIR) - Acute context tab)

University Hospital Coventry has 568 medical inpatient beds located across 28 wards and units:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute medical unit (AMU) 1 (Ward 12)</td>
<td>-</td>
<td>34</td>
</tr>
<tr>
<td>AMU 2 (Ward 2)</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>AMU 3 (Ward 3)</td>
<td>-</td>
<td>26</td>
</tr>
<tr>
<td>Cardiology day unit (Ward 10)</td>
<td>Cardiology</td>
<td>15</td>
</tr>
<tr>
<td>Catheter lab</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Chemotherapy suite</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continuous ambulatory peritoneal dialysis unit</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Coronary care unit</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Haematology day centre</td>
<td>Haematology</td>
<td>-</td>
</tr>
<tr>
<td>Haematology day unit / outpatients</td>
<td>Haematology</td>
<td>-</td>
</tr>
<tr>
<td>Haemodialysis unit</td>
<td>-</td>
<td>30</td>
</tr>
<tr>
<td>Medical decisions unit (MDU) / ambulatory care</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

20200205 UHCW evidence appendix
<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology day unit</td>
<td>Neurology</td>
<td>-</td>
</tr>
<tr>
<td>Renal dialysis unit</td>
<td>Renal</td>
<td>30</td>
</tr>
<tr>
<td>Rheumatology day unit</td>
<td>Rheumatology</td>
<td>-</td>
</tr>
<tr>
<td>Ward 1</td>
<td>Endocrinology</td>
<td>34</td>
</tr>
<tr>
<td>Ward 10</td>
<td>Cardiology</td>
<td>28</td>
</tr>
<tr>
<td>Ward 20</td>
<td>Gerontology</td>
<td>43</td>
</tr>
<tr>
<td>Ward 21</td>
<td>Gastroenterology and care of the elderly</td>
<td>24</td>
</tr>
<tr>
<td>Ward 30</td>
<td>Respiratory medicine and infectious diseases</td>
<td>41</td>
</tr>
<tr>
<td>Ward 31</td>
<td>Respiratory medicine and infectious diseases</td>
<td>48</td>
</tr>
<tr>
<td>Ward 34</td>
<td>Haematology</td>
<td>17</td>
</tr>
<tr>
<td>Ward 35</td>
<td>Oncology</td>
<td>31</td>
</tr>
<tr>
<td>Ward 40</td>
<td>Acute gerontology</td>
<td>43</td>
</tr>
<tr>
<td>Ward 41</td>
<td>Stroke</td>
<td>36</td>
</tr>
<tr>
<td>Ward 42</td>
<td>Neurology</td>
<td>36</td>
</tr>
<tr>
<td>Ward 50</td>
<td>Renal services</td>
<td>22</td>
</tr>
</tbody>
</table>

Hospital of St Cross, Rugby has 72 medical inpatient beds located across five wards and units:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Specialty or description</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematology day unit</td>
<td>Day-case treatments for patients with haematological conditions and outpatient clinics for haematology patients.</td>
<td>-</td>
</tr>
<tr>
<td>Hoskyn Ward</td>
<td>Care of the elderly.</td>
<td>25</td>
</tr>
<tr>
<td>Mulberry Ward</td>
<td>Rehabilitation, including stroke rehabilitation.</td>
<td>22</td>
</tr>
<tr>
<td>Oak Ward</td>
<td>Inpatient rehabilitation service. Hosts a nurse-led cardiac clinic for outpatients.</td>
<td>22</td>
</tr>
<tr>
<td>Rugby cardiology day unit</td>
<td>Day-case services for emergency coronary procedures; supports a mobile catheterization lab unit.</td>
<td>3</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Sites tab)

The trust had 85,186 medical admissions from March 2018 to February 2019. Emergency admissions accounted for 30,105 (35.3%), 1,610 (1.9%) were elective, and the remaining 53,471 (62.8%) were day case.

Admissions for the top three medical specialties were:
- General medicine: 26,000.
- Gastroenterology: 16,022.
- Clinical oncology: 14,076.

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Misuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

Nursing staff received and kept up-to-date with their mandatory training. Whilst on site we reviewed nurse staffing figures on wards and found they were meeting the trust target. For example, on endoscopy it was 100%, on ward 20 it was 99% and on ward 50 it was 96.6%.

A breakdown of compliance for mandatory training courses as of April 2019 at trust level for qualified nursing staff in medical care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling – object</td>
<td>11</td>
<td>11</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>In-hospital resuscitation</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Paediatric life support update</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene - non-clinical (initial)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 1)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>626</td>
<td>629</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>642</td>
<td>646</td>
<td>99.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>620</td>
<td>630</td>
<td>98.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>635</td>
<td>646</td>
<td>98.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>634</td>
<td>646</td>
<td>98.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety – annual</td>
<td>623</td>
<td>646</td>
<td>96.4%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling – people</td>
<td>600</td>
<td>623</td>
<td>96.3%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>604</td>
<td>628</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NPSA preparing and administering a transfusion of blood or blood products</td>
<td>472</td>
<td>491</td>
<td>96.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Advanced life support update</td>
<td>26</td>
<td>28</td>
<td>92.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>586</td>
<td>633</td>
<td>92.6%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NPSA obtaining venous blood</td>
<td>140</td>
<td>154</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital resuscitation including Automated External Defibrillators (AEDs)</td>
<td>542</td>
<td>604</td>
<td>89.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>497</td>
<td>554</td>
<td>89.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NPSA collection and transportation of blood and blood products</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Immediate life support (annual)</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
In medical care at University Hospital Coventry the 95% target was met for 14 of the 22 mandatory training modules for which qualified nursing staff were eligible.

Medical staff received and kept up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses as of April 2019 for medical staff in medical care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling – object</td>
<td>22</td>
<td>22</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>190</td>
<td>196</td>
<td>96.9%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>175</td>
<td>182</td>
<td>96.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>184</td>
<td>196</td>
<td>93.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>161</td>
<td>177</td>
<td>91.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Information governance</td>
<td>178</td>
<td>196</td>
<td>90.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety – annual</td>
<td>169</td>
<td>196</td>
<td>86.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support update</td>
<td>35</td>
<td>42</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Infection prevention (level 2)</td>
<td>149</td>
<td>184</td>
<td>81.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>151</td>
<td>188</td>
<td>80.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>101</td>
<td>127</td>
<td>79.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>103</td>
<td>130</td>
<td>79.2%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling - medical and dental</td>
<td>130</td>
<td>173</td>
<td>75.1%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support</td>
<td>11</td>
<td>16</td>
<td>68.8%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NPSA obtaining venous blood</td>
<td>3</td>
<td>8</td>
<td>37.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Neonatal life support update</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In medical care at University Hospital Coventry the 95% target was met for 14 of the 22 mandatory training modules for which qualified nursing staff were eligible. 
(Source: Routine Provider Information Request (RPIR) – Training tab)

The mandatory training was comprehensive and met the needs of patients and staff. Staff told us that the training was a variety of online, face to face and booklet training. Staff told us that the training was of good quality.

Clinical staff did not complete mandatory training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. However, the dementia team went around the wards and delivered training on dementia to its staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service had a system in place which RAG rated people based on when their training was due. If a person was green they were in date, amber meant they were 3 months away from expiring and red meant they were expired. Ward managers told us they regularly reminded staff when they were due to update their mandatory training.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
The trust set a target of 95% for completion of safeguarding training. The tables below include preventing radicalisation training as a safeguarding course. This training module works to stop individuals from getting involved or supporting terrorism or extremist activity.

Nursing staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as of April 2019 for qualified nursing staff in medical care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>1</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>639</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>633</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>625</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>631</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>51</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>2</td>
</tr>
</tbody>
</table>

At University Hospital Coventry the 95% target was met for five of the seven safeguarding training modules for which qualified nursing staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as of April 2019 for medical staff in medical care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>3</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>189</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>185</td>
</tr>
<tr>
<td>Safeguarding adults (level 1)</td>
<td>184</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>171</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>97</td>
</tr>
<tr>
<td>Safeguarding children (level 3)</td>
<td>1</td>
</tr>
</tbody>
</table>

In medical care at University Hospital Coventry the 95% target was met for three of the seven safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

As of October 2019, medical staff training compliance with safeguarding children level 3 training was at 76%. (Source DR 53) Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff across several wards were able to give examples where they had safeguarded patients. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff could make safeguarding referrals. Staff knew how to contact the hospital safeguarding team who would investigate incidents and spoke to them if they needed advice. Staff would also discuss safeguarding in multidisciplinary meetings. Staff followed safe procedures for children visiting the ward.
Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. On the wards furnishings and fittings were clean and in good repair. Work-surfaces and cupboards were visibly clean. All trolleys and clinical equipment were clean and stored appropriately. Sharps containers were free from protruding needles, stored safely above floor level, and dated accurately. Basins for hand-washing were accessible and visibly clean, with soap dispensers for single use. Paper towels were available from enclosed dispensers. Staff consistently followed best hand hygiene practices in clinics, they always washed their hands before and after new patients were seen. Staff always used alcohol hand gel during treatments when necessary.

The service generally performed well for cleanliness. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service had up to date cleaning checklists for each of the locations which were completed. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff told us the trust supplied them with all the appropriate PPE they needed to follow infection control principles when delivering care. Staff across all teams within the service used appropriate PPE when delivering patient care. Staff followed infection control procedures when patients needed isolation in side rooms. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw correctly dated ‘I am clean’ stickers on equipment across all wards when it had been cleaned.

The service’s infection control dashboard for October 2019 showed overall good compliance:

(Source: DR 51)
Environment and equipment
The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Whilst we were on site we witnessed staff answering call bells promptly at all times. The design of the environment was appropriate and maintained patient safety. The service was upgrading areas and equipment on a regular basis. The service had plans to upgrade the catheter labs which were at the renovation stage. The service had plans to upgrade the labs one at a time so three remained open at all times. The service also had plans to adapt the two respiratory and infectious diseases wards into three separate wards. Infectious control and diseases would be its own separate ward along with two separate respiratory wards. Staff carried out daily safety checks of specialist equipment. Staff carried out daily checks on resuscitation trollies. We checked that staff carried these out, in all the books we checked all the check lists were completed and signed by staff. There were not tags on resuscitation trollies across all wards. Whilst on inspection we checked that electrical equipment testing had been carried out, all equipment we checked was in date. The service mostly had suitable facilities to meet the needs of patients’ families. However, there were examples where the service did not have suitable facilities to meet patients’ needs. There were environmental limitations within the neurology day case unit. The service saw up to 20 patients a day but did not have the capacity to cope with this comfortably. There were no reclining chairs, the ice machine was broken, there was no water boiler, no sluice, no storage area and the toilets were not disability friendly. We raised this at the time of the inspection and managers took action to address this. After the inspection, the trust sent us a detailed action plan to address these issues by the end of November 2019. (Source: DR 45). The equipment in the endoscopy unit needed regular maintenance due to regular breakdowns. Washing machines and drying units were all around 10 years old and staff told us they needed replacing. Staff therefore had to occasionally wash the scopes by hand. The service was able to continue because they have a reserve of scopes ready in the drying cabinets. Staff disposed of clinical waste safely in accordance with trust policy. After the inspection, the trust sent us a detailed action plan to address these issues including the replacement of the endoscopy washer disinfectant machines by Summer 2020. (Source: DR 44)

The summary update of the outcome of the Patient-Led Assessments of the Care Environment (PLACE) 2018. PLACE assessments are an annual appraisal of the non-clinical aspects of the patient environment and its suitability for patients with specific needs, e.g.: disability or dementia. PLACE assessments provide a framework for assessing quality against common guidelines and standards in order to quantify the environment’s cleanliness, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.
Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All hospital staff used national early warning scores (NEWS2) when assessing patients if they suspected problems. Records seen demonstrated adherence to trust policy.

Staff completed risk assessments for each patient on admission to each ward, using a recognised tool, and reviewed this regularly, including after any incident. We saw evidence of this across all care plans we reviewed. Sepsis protocols were followed appropriately.

Staff knew about and dealt with any specific risk issues. If patients had specific risk issues, for example potential sepsis or pressure ulcers, staff carried out the appropriate risk assessments, monitoring and actions.

The service had 24-hour access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Staff on different wards shared key patient information when patients moved between different wards or into the community.
Staff on wards had access to an enhanced care team who provided support for patients who required one to one care. They assessed patients’ needs on the wards and had access to healthcare assistant staff if they were required.

Shift changes and handovers included all necessary key information to keep patients safe. Staff at the service did nurse handovers followed by board rounds. There were two handovers a day, one between each shift change. These meetings were multidisciplinary and included all the key information to keep patients safe. We observed two handovers and one board round and found them to be timely and effective.

**Nurse and midwifery staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Staff members were busy on wards but whilst on inspection they appeared calm and staff appeared to have manageable caseloads. The table below shows a summary of the nursing staffing metrics in medical care at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>2,233.5</td>
<td>15%</td>
<td>8%</td>
<td>4.1%</td>
<td>229,112 (17%)</td>
<td>84,061 (6%)</td>
<td>153,093 (11%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>781.1</td>
<td>18%</td>
<td>4%</td>
<td>3.8%</td>
<td>229,112 (17%)</td>
<td>84,061 (6%)</td>
<td>153,093 (11%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Qualified nursing and midwifery staffing rates within medical care at University Hospital Coventry were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly turnover rates, or bank staff usage.

**Vacancy rates**

The service had varying vacancy rates, which had reduced slightly overall in the last 12 months.
Monthly vacancy rates over the last 12 months for qualified nurses were not stable and may be subject to ongoing change.

Some wards within the service had high vacancy levels. On respiratory wards vacancy rates for qualified nurse staffing was over 50%. The service were filling shifts with bank and agency staff to ensure patients were kept safe. Clinical leaders were also trying to recruit staff using different methods in order to fill staffing gaps.
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Sickness rates
The service had varying sickness rates. They had increased overall slightly in the last 12 months.

Monthly sickness rates over the last 12 months for qualified nurses showed an upward trend from August 2018 to January 2019.
(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Ward managers could adjust staffing levels if they needed and could apply for additional bank and agency staff if they were required. The number of nurses and healthcare assistants matched the planned numbers. Whilst on site, nurse and healthcare assistant numbers mostly matched the required level. There were occasions wards were down one staff nurse or healthcare assistant, but it was rarely worse than this.

Agency staff usage
The service had varying rates of bank and agency nurses, which had reduced slightly over the last 12 months.
Monthly agency usage over the last 12 months for qualified nurses showed a downward trend from August to December 2018.  
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff familiar with the service. On wards which had high numbers of regular bank and agency staff managers ensured as many agency staff as possible were regulars on the ward. Managers made sure all bank and agency staff had a full induction and understood the service.

**Medical staffing**

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The table below shows a summary of the medical staffing metrics in medical care at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Medical care annual staffing metrics</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
</tr>
<tr>
<td>All Staff</td>
<td>2,153.1</td>
</tr>
<tr>
<td>Medical staff</td>
<td>380.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within medical care at University Hospital Coventry were analysed for the past 12 months. Over this period there was no bank medical staff usage reported.

**Vacancy rates**

The service had varying vacancy rates for medical staff, which had increased slightly in the last 12 months.
Monthly vacancy rates over the last 12 months for medical staff showed a downward trend from October 2018 to February 2019.  
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**  
The service had reducing turnover rates for medical staff.

Monthly turnover rates over the last 12 months for medical staff showed a shift from November 2018 to April 2019. This could be an indicator of change.  
(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**  
Sickness rates for medical staff varied. There had been a slight increase in the last 12 months.

Monthly sickness rates over the last 12 months for medical staff were not stable and may be subject to ongoing change.  
(Source: Routine Provider Information Request (RPIR) – Sickness tab)
The medical staff matched the planned number on shift. Whilst on inspection we saw numbers of medical staff matched the planned numbers. The service had a dedicated rota co-ordinator for acute medicine, so gaps were identified early and filled. The service always had a consultant on call during evenings and weekends.

**Agency staff usage**

The service had varying rates of bank and locum staff, which had reduced over the last 12 months.

Monthly agency hours over the last 12 months for medical staff showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) – Bank and agency usage tab)

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

**Staffing skill mix**

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In May 2019, the proportion of consultant staff reported to be working in medical care at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was lower than the England average. The proportion of middle career medical staff working at the trust was similar to the England average. Conversely, the proportion of registrars was higher than the England average.

**Staffing skill mix for the 291 whole time equivalent staff working in medicine at University Hospital Coventry and Warwickshire NHS Trust**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>45%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>37%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>15%</td>
<td>20%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital - Workforce Statistics - Medical (01/05/2019 - 31/05/2019)

**Records**

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff had access to care records on trollies on the wards as well as bedside folders which contained relevant risk assessments and observation charts. We reviewed 18 records whilst on inspection and found that they contained relevant, clear and up to date information. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely. Whilst on inspection the wards we visited all had their records stored securely.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Whilst on inspection we reviewed drug charts, on all we reviewed drugs had been recorded appropriately. Staff locked the clinic and drug rooms. Staff stored controlled drugs appropriately. Staff carried out regular fridge temperature checks. Whilst on inspection we reviewed three fridge temperature checks and they had all been completed daily.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Staff reviewed patient’s medication at board rounds. Staff spoke to patients during board rounds about medications and provided advice if it was needed. Relatives and carers could approach staff with any questions whilst they were visiting the ward.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Decision making processes were in place to ensure people’s behaviour was not controlled by excessive and inappropriate use of medicines.

**Incidents**

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff were clear about how to report incidents and they all had access to the electronic incident reporting system. Staff reported all incidents that they should report. The trust promoted an incident reporting culture and managers took a no blame approach towards staff who reported incidents. Staff told us there was a low threshold for reporting incidents and they reported everything that they should.
Never Events
The service had no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2018 to June 2019 the trust reported no never events for medical care.
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS
Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported 39 serious incidents (SI’s) in medical care at University Hospital Coventry which met the reporting criteria set by NHS England from July 2018 to June 2019. A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>16</td>
<td>41.0%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>9</td>
<td>23.1%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>Diagnostic incident including delay meeting SI criteria (including failure to act on test results)</td>
<td>4</td>
<td>10.3%</td>
</tr>
<tr>
<td>Treatment delay meeting SI criteria</td>
<td>3</td>
<td>7.7%</td>
</tr>
<tr>
<td>Pending review (a category must be selected before incident is closed)</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>Medical equipment/ devices/disposables incident meeting SI criteria</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td>HCAI/Infection control incident meeting SI criteria</td>
<td>1</td>
<td>2.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of candour means the service must be open and honest with patients and other relevant persons when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff could explain what duty of candour is and gave examples of when they would use it. Staff received training in duty on candour. We saw evidence of duty of candour in incident reports.

Managers debriefed and supported staff after any serious incident. Staff told us they felt well supported by managers during investigations. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. In incidents we reviewed and were told about managers thoroughly investigated incidents. Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff discussed all incidents at governance meetings. There was evidence that changes had been made as a result of feedback. Staff in the dialysis unit were able to give examples of learning from delays with the new IT system. They worked with the IT service provider in order to make changes to the system. There had been two category four pressure ulcers on one of the wards. Staff had introduced measures, including education and equipment, which had improved performance with regards to pressure ulcers.

Safety Thermometer
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 35 new pressure ulcers, 12 falls with harm and 12 new urinary tract infections in patients with a catheter from July 2018 to July 2019 for medical services.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and urinary tract infections patients with a catheter at University Hospital Coventry and Warwickshire NHS Trust

Safety thermometer data was displayed on wards for staff and patients to see. Whilst on site we saw harm free care scored displayed on the wards. The safety thermometer data showed the service achieved harm free care within the reporting period. The safety thermometer showed the service had reduced the incidence of harm within the reporting period. Staff used the safety thermometer data to further improve services. Staff at the service had done work on reducing pressure ulcers. The service had introduced equipment which went under patients' legs in order to reduce the likelihood of pressure ulcers. The service had specialist link nurses on wards for tissue viability. Staff had an appropriate system for managing falls. For example, staff grouped patients at high risk of falls within the same bay and had a staff member observe that bay at all
times. Patients at risk of falls had a clear indicator displayed above their beds. The sign was amber if the patient was at risk and red if the patient was a high risk.

**Is the service effective?**

**Evidence-based care and treatment**

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff could access clinical guidelines on the trust intranet. The clinical guidelines were traffic light coded: green indicated in date; amber indicated near the expiry date; red identified guidelines past their review date. When staff opened guidelines, they were tagged with a warning that they should be checked for relevance. Examples of guidelines that were in date were; vancomycin, alcohol withdrawal, diabetic ketoacidosis. Examples of guidelines that required a review were; non-invasive ventilation, COPD, asthma, skin prick testing for allergy. Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Whilst on inspection staff provided patients with enough food and drink throughout the day. Staff on the gastroenterology ward could begin total parenteral nutrition (TPN) feeding out of hours and at weekends as well as in the week so there were no delays. TPN was a method of feeding that bypasses the gastrointestinal tract. Fluids were given into a vein to provide most of the nutrients the body needs. Staff fully and accurately completed patients’ fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. In all records reviewed where appropriate staff had undertaken risk assessments related to nutrition and fluid management. Whilst on inspection where appropriate staff had completed nutrition charts and fluid balance charts. Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it. Staff knew how to access additional support via the intranet and would do so when appropriate. Dieticians and speech and language therapists worked closely with staff on wards where they were required, such as gastroenterology.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Whilst on inspection, we observed staff asking patients about pain levels and providing pain relief to those
who requested it. Staff prescribed, administered and recorded pain relief accurately.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Relative risk of readmission

From February 2018 to January 2019, patients at University Hospital Coventry had a lower than expected risk of readmission for elective admissions when compared to the England average.

- Patients in clinical oncology and clinical haematology had lower than expected risks of readmission for elective admissions.
- Patients in gastroenterology had a higher than expected risk of readmission for elective admissions.

**Elective Admissions - University Hospital Coventry**

The service had a lower than expected risk of readmission for elective care than the England average overall. It had higher than average risk for gastroenterology.

[Graph showing relative risk of readmission for elective admissions]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

From February 2018 to January 2019, patients at University Hospital Coventry had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

- Patients in general medicine and cardiology had lower than expected risks of readmission for non-elective admissions
- Patients in respiratory medicine had a higher than expected risk of readmission for non-elective admissions.

**Non-Elective Admissions - University Hospital Coventry**

The service had a lower than expected risk of readmission for non-elective care than the England average overall. It had a higher than average risk for respiratory medicine.

[Graph showing relative risk of readmission for non-elective admissions]

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific site based on count of activity.

(Source: Hospital Episode Statistics - HES - Readmissions (01/02/2018 - 31/01/2019))
Sentinel Stroke National Audit Programme (SSNAP)
University Hospital Coventry takes part in the quarterly Sentinel Stroke National Audit programme. The hospital’s performance is shown in the tables below. On a scale of A-E, where A is best, the hospital’s overall SSNAP level was either grade A or grade B for the four audit periods covering the 12 months from April 2018 to March 2019.

<table>
<thead>
<tr>
<th>Overall Scores</th>
<th>Apr 18 - Jun 18</th>
<th>Jul 18 - Sep 18</th>
<th>Oct 18 - Dec 18</th>
<th>Jan 19 - Mar 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSNAP level</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Case ascertainment band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Audit compliance band</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>Combined total key indicator level</td>
<td>A</td>
<td>B</td>
<td>A</td>
<td>B</td>
</tr>
</tbody>
</table>

The hospital’s performance for patient-centred stroke unit indicator was grade E for the audit period from April to June 2018. Performance improved to grade D for the two audit periods from July to December 2018. However, performance deteriorated to grade E for the most recent audit period, covering January to March 2019. The hospital’s patient-centred total key indicator level was either grade A or grade B for the four audit periods covering the 12 months from April 2018 to March 2019. The hospital’s performance for patient-centred discharge processes was grade A for the three audit periods from April to December 2018, and grade B for the most recent audit period from January to March 2019. The hospital’s performance for patient-centred speech and language therapy was grade C for the two audit periods from April to September 2018. Performance improved to grade B for the audit period from October to December 2018, before deteriorating to C for the most recent audit period from January to March 2019.

The hospital’s performance for team-centred stroke unit indicator was grade D for the two audit periods from April to September 2018. Performance improved to grade C for the audit period from October to December 2018. However, performance deteriorated to grade E for the most recent audit period, covering January to March 2019. The hospital’s team-centred total key indicator level was either grade A or grade B for the four audit periods covering the 12 months from April 2018 to March 2019. The hospital’s performance for team-centred discharge processes was grade A for the three audit periods from April to December 2018, and grade B for the most recent audit period from January to March 2019. The hospital’s performance for team-centred speech and language therapy was grade C for the two audit periods from April to September 2018. Performance improved to grade B for the audit period from October to December 2018, before deteriorating to C for the most recent audit period from January to March 2019.
Lung Cancer Audit
The table below summarises the trust’s performance in the 2018 National Lung Cancer Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other Trusts</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude proportion of patients seen by a cancer nurse specialist (Access to a cancer nurse specialist is associated with increased receipt of anticancer treatment)</td>
<td>71.9%</td>
<td>N/A</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Case-mix adjusted one-year survival rate (Adjusted scores take into account the differences in the case-mix of patients treated)</td>
<td>38.1%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery (Surgery remains the preferred treatment for early-stage lung cancer; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>20.1%</td>
<td>Good practice</td>
<td>Met</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of fit patients with advanced NSCLC receiving systemic anti-cancer treatment (For fitter patients with incurable NSCLC anti-cancer treatment is known to extend life expectancy and improve quality of life; adjusted scores take into account the differences in the case-mix of patients seen)</td>
<td>74.2%</td>
<td>Within expected range</td>
<td>Met</td>
</tr>
<tr>
<td>Case-mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy (SCLC tumours are sensitive to chemotherapy which can improve)</td>
<td>61.1%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
survival and quality of life; adjusted scores take into account the differences in the case-mix of patients seen)

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls
The table below summarises University Hospital Coventry’s performance in the 2017 National Audit of Inpatient Falls. The audit reports on the extent to which key indicators were met and grades performance as red (less than 50% of patients received the assessment/intervention), amber (between 50% and 79% of patients received the assessment/intervention) and green (more than 80% of patients received the assessment/intervention).

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national aspirational standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the trust have a multidisciplinary working group for falls prevention where data on falls are discussed at most or all the meetings?</td>
<td>Yes</td>
<td>N/A</td>
<td>Met</td>
</tr>
<tr>
<td>Crude proportion of patients who had a vision assessment (if applicable) (Having a vision assessment is indicative of good practice in falls prevention)</td>
<td>31.8%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) (Having a lying and standing blood pressure assessment is indicative of good practice in falls prevention)</td>
<td>20.0%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients assessed for the presence or absence of delirium (if applicable) (Having an assessment for delirium is indicative of good practice in falls prevention)</td>
<td>22.2%</td>
<td>Red</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude proportion of patients with a call bell in reach (if applicable) (Having a call bell in reach is an important environmental factor that may impact on the risk of falls)</td>
<td>96.3%</td>
<td>Green</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>

(Source: National Audit of Inpatient Falls)

Chronic Obstructive Pulmonary Disease Audit
The table below summarises University Hospital Coventry’s performance in the 2018/19 Chronic Obstructive Pulmonary Disease Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen by a member of the respiratory team within 24hrs of admission (Specialist input improves processes and outcomes for COPD patients)</td>
<td>63.6%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients receiving oxygen in which this was prescribed to a stipulated target oxygen saturation (SpO2) range (of 88-92% or 94-98%)</td>
<td>99.6%</td>
<td>Better than the national aggregate</td>
<td>Did not meet</td>
</tr>
</tbody>
</table>
(Inappropriate administration of oxygen is associated with an increased risk of respiratory acidosis, the requirement for assisted ventilation, and death)

<table>
<thead>
<tr>
<th>Percentage of patients receiving non-invasive ventilation (NIV) within the first 24 hours of arrival who do so within 3 hours of arrival (NIV is an evidence-based intervention that halves the mortality if applied early in the admission)</th>
<th>17.6%</th>
<th>Worse than the national aggregate</th>
<th>Did not meet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of documented current smokers prescribed smoking-cessation pharmacotherapy (Smoking cessation is one of the few interventions that can alter the trajectory of COPD)</td>
<td>72.4%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients for whom a British Thoracic Society, or equivalent, discharge bundle was completed for the admission (Completion of a discharge bundle improves readmission rates and integration of care)</td>
<td>64.4%</td>
<td>Worse than the national aggregate</td>
<td>Met</td>
</tr>
<tr>
<td>Percentage of patients with spirometry confirming FEV1/FVC ratio &lt;0.7 recorded in case file (A diagnosis of COPD cannot be made without confirmatory spirometry and the whole pathway is in doubt)</td>
<td>76.2%</td>
<td>Better than the national aggregate</td>
<td>Met</td>
</tr>
</tbody>
</table>

(Source: Chronic Obstructive Pulmonary Disease Audit)

For this audit, the trust informed us that the COPD national audit results were compared against an ‘Aspirational National Standard’ of 100% rather than a fixed ‘National Standard’ as set by HQIP in the national audit programme. NHS Trusts do not achieve a perfect 100% but with compliance of 99.6% UHCW was performing better than the National Aggregate of 99.3% (England & Wales).

**National Audit of Dementia**

The table below summarises University Hospital Coventry’s performance in the 2017 National Audit of Dementia. There are currently no national standards for any of the metrics in the audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Audit’s Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of carers rating overall care received by the person cared for in hospital as excellent or very good (A key aim of the audit was to collect feedback from carers to ask them to rate the care that was received by the person they care for while in hospital)</td>
<td>66.7%</td>
<td>N/A</td>
</tr>
<tr>
<td>Percentage of staff responding “always” or “most of the time” to the question “Is your ward/ service</td>
<td>80.8%</td>
<td>Similar</td>
</tr>
</tbody>
</table>
able to respond to the needs of people with dementia as they arise?”
(This measure could reflect on staff perception of adequate staffing and/or training available to meet the needs of people with dementia in hospital)

<table>
<thead>
<tr>
<th>Mental state assessment carried out upon or during admission for recent changes or fluctuation in behaviour that may indicate the presence of delirium</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Delirium is five times more likely to affect people with dementia, who should have an initial assessment for any possible signs, followed by a full clinical assessment if necessary)</td>
</tr>
<tr>
<td>31.4%</td>
</tr>
<tr>
<td>Similar</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multi-disciplinary team involvement in discussion of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Timely coordination and adequate discharge planning is essential to limit potential delays in dementia patients returning to their place of residence and avoid prolonged admission)</td>
</tr>
<tr>
<td>71.4%</td>
</tr>
<tr>
<td>Similar</td>
</tr>
</tbody>
</table>

(Source: National Audit of Dementia)

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. Managers shared and made sure staff understood information from the audits. Improvement was checked and monitored.

We saw the service had the following actions plans in place and these were being monitored:

- Sentinel Stroke National Audit Programme (SSNAP) – action plan in response to the latest national report.

(Source: DR 46)

Specialities within the service had the appropriate accreditations. The endoscopy service was accredited by joint advisory group on GI endoscopy (JAG).

**Competent staff**

Doctor, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. New staff members told us that they felt inductions were thorough. Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they received appraisals on a yearly basis. Staff told us they found the appraisals meaningful and they provided an opportunity to talk to managers about training options and plans for the upcoming year.

Appraisal rates
From May 2018 to April 2019, 87.3% of staff in medical care at University Hospital Coventry received an appraisal compared to a trust target of 90%. The trust did not meet the trust target of 90% however they were close to the target. The breakdown by staff group is shown in the table below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals received</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>112</td>
</tr>
<tr>
<td>Healthcare scientists</td>
<td>115</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>589</td>
</tr>
<tr>
<td>Medical staff</td>
<td>160</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>146</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>447</td>
</tr>
<tr>
<td>Additional professional, scientific and technical</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>1,590</td>
</tr>
</tbody>
</table>

With the exception of allied health professionals, the 90% completion target was not met for any staff groups in medical care.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported medical and nursing staff to develop through regular, constructive clinical supervision of their work. Staff told us they had access to formal and informal learning from their team members and leaders. Leaders told us they encouraged staff to engage in clinical supervision if they wanted to access it. The clinical educators supported the learning and development needs of staff. Some wards had their own clinical educators and other wards were in the recruitment process. Staff on wards with clinical educators told us they were valuable and helped improve the ward. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers arranged ward meetings on a monthly basis. Staff took meeting minutes and they were available for staff who did not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Specialist link nurses did ‘mini’ reminder sessions on topics such as tissue viability on the wards to remind staff about specific topics. Staff told us these quick sessions worked well in a busy environment.

Staff identified a gap in skills within some of the areas. There were not enough non-invasive ventilator (NIV) trained staff within the respiratory wards or in the assessment medical unit (AMU).

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they were given opportunities for training and managers would send them on courses that benefit both staff and the ward. For example, healthcare assistants could do training on using blood glucose measuring machines and
Managers made sure staff received any specialist training for their role. Managers identified poor staff performance promptly and supported staff to improve. Managers were able to provide examples of where they had managed poor staff performance. Managers recruited, trained and supported volunteers to support patients in the service.

**Multidisciplinary working**

*Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.*

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All relevant staff groups were involved in handovers and board rounds. These meetings were quick and effective with everyone contributing to the meetings. Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked with social workers when required to care for patients. Staff spoke about positive working relationships with social workers. Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. Patients had their care pathways reviewed by the relevant consultants.

**Seven-day services**

*Key services were available seven days a week to support timely patient care.*

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway. Staff told us board rounds took place on a regular basis. Consultants reviewed patients on a regular basis on most wards. Allied health professionals were not available seven days a week on the neurology wards. Physiotherapists, occupational therapist and speech and language therapists attended during the week. Weekend cover for all specialities, other than gerontology, consisted of two physiotherapists, one occupational therapist and one therapy support worker. Within gerontology, weekend cover consisted of one physiotherapist and one therapy support worker. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

**Health Promotion**

*Staff gave patients practical support and advice to lead healthier lives.*

The service had relevant information promoting healthy lifestyles and support on wards/units. There was a variety of information leaflets across all of the wards. Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

*Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.*
Mental Capacity Act and Deprivation of Liberty training completion

Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is not currently included in the trust's mandatory training. The trust reported that it was planning to introduce mandatory training in MCA and DoLS for registered practitioners and medical staff by September 2020. This will be included in a new mandatory safeguarding adults level 3 training module. The trust also reported that in the meantime the trust's safeguarding team had been providing MCA training to priority staff groups since September 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Nursing and clinical staff did not receive mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, staff we spoke with on inspection had a good understanding of mental capacity. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Within the endoscopy unit, the consent, clerking and WHO-modified checklist are all parts of the same document and were carried out prior to each procedure staff carried out. Staff clearly recorded consent in the patients’ records. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. We saw evidence of this in patients care records. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. We reviewed this whilst on inspection and in each record, it was in line with approved documentation.

Is the service caring?
Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Whilst on inspection we always observed staff treating patients in a discreet way and they interacted with patients and relatives in a positive way. Patients said staff treated them well and with kindness. Most patient feedback we received whilst on inspection was positive. Patients told us, ‘Staff are fantastic, can’t do enough for you’, and, ‘Staff are really helpful and make time for you even when they are busy’. One patient told us, ‘I’ve been very happy, it’s been like a holiday’. There were examples of staff going the extra mile for patients. For example, staff set up a skype link to a relatives wedding abroad that they couldn’t attend because they were on the ward. Staff also arranged musicians on the wards for patients. Staff allowed a patients dog onto the hospital ward for a patient on an end of life pathway. The service is looking into whether or not it can introduce dog therapy.

Staff followed policy to keep patient care and treatment confidential. Staff across all wards always treated patients in a confidential way and used curtains when carrying out personal care or assessing patients. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social and religious
needs of patients and how they may relate to care needs.

**Friends and Family test performance**
From July 2018 to June 2019, the Friends and Family Test response rate for medical care at the trust was 20.1%. This was based on 3,742 responses. This was lower than the England average of 24%.

**University Hospital Coventry Friends and Family Test scores**
From July 2018 to June 2019 the Friends and Family Test response rate for medical care at University Hospital Coventry was 19.9%. This was based on 3,535 responses. This was worse than the England average of 24%. A breakdown of FFT performance by ward for medical wards at University Hospital Coventry from July 2018 to June 2019 is shown below. The lowest annual recommendation rates were reported for Ward 1 (72%) and the MDU (74%). There were some very low monthly scores. In March 2019 only 65% of patients surveyed said that they would recommend AMU 1 to family and friends. In February 2019 only 56% of patients said that they would recommend AMU 2. In addition in September 2018 only 47% of patients said that they would recommend Ward 3 to family and friends.

<table>
<thead>
<tr>
<th>Ward name</th>
<th>Total Resp</th>
<th>Resp Rate</th>
<th>Percentage recommended</th>
<th>Annual perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMU 1</td>
<td>315</td>
<td>18%</td>
<td>74%</td>
<td>80%</td>
</tr>
<tr>
<td>AMU 2</td>
<td>147</td>
<td>17%</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Corona care unit</td>
<td>294</td>
<td>38%</td>
<td>88%</td>
<td>100%</td>
</tr>
<tr>
<td>MDU</td>
<td>383</td>
<td>16%</td>
<td>74%</td>
<td>64%</td>
</tr>
<tr>
<td>Ward 1</td>
<td>165</td>
<td>19%</td>
<td>69%</td>
<td>83%</td>
</tr>
<tr>
<td>Ward 10</td>
<td>334</td>
<td>25%</td>
<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Ward 3</td>
<td>248</td>
<td>16%</td>
<td>83%</td>
<td>43%</td>
</tr>
<tr>
<td>Ward 30</td>
<td>269</td>
<td>16%</td>
<td>96%</td>
<td>75%</td>
</tr>
<tr>
<td>Ward 31 - respiratory medicine</td>
<td>268</td>
<td>17%</td>
<td>84%</td>
<td>93%</td>
</tr>
<tr>
<td>Ward 33</td>
<td>134</td>
<td>23%</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 34 - inpatient haematology</td>
<td>119</td>
<td>21%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Ward 35</td>
<td>249</td>
<td>21%</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>Ward 41 - stroke</td>
<td>145</td>
<td>20%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Ward 42</td>
<td>162</td>
<td>17%</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>Ward 50</td>
<td>267</td>
<td>36%</td>
<td>95%</td>
<td>97%</td>
</tr>
</tbody>
</table>

Key
---
100% 50% 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.
2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard. *(Source: NHS England Friends and Family Test)*

Staff displayed their most recent friends and family test scores on each of the wards.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.
Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff at the service had access to a specialist palliative care and end of life team who assisted the wards whenever they were necessary. Staff told us this team was responsive to patients and relatives and provided extra emotional support. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We saw staff draw the curtains to protect patients privacy and dignity and provide emotional support when they became upset. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Patients and relatives told us consistently that they were kept informed by staff on the ward. Relatives and carers told us they were kept up to date over the phone if they were unable to visit the ward. The service had introduced communication rooms where staff could talk to relatives and carers. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There was a variety of information on wards which explained how patients could give feedback. Staff supported patients to make advanced and informed decisions about their care. Patients gave positive feedback about the service. Patients gave consistently positive feedback about the service.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The service operated within the standards for mixed sex accommodation throughout the course of our inspection. Facilities and premises were appropriate for the services being delivered. Signage around the hospital was consistent and clear which made it easy for patients to find their way round. Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia. Staff knew how to access these services via the trust intranet. The service had systems to help care for patients in need of additional support or specialist intervention. Staff knew how to access speciality teams via the trust intranet. Staff reviewed outliers daily. Consultants rotated this responsibility.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Wards were designed to meet the needs of patients living with dementia. Staff had also created a dementia friendly ward, introducing contrasting colours, dementia-friendly signage and activity co-ordinators. The service supported patients living with dementia. The service supported ‘Johns campaign’ allowing carers of dementia patients onto wards. The service had a dedicated dementia team who delivered support to patients and staff alongside training. Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw staff had access to communication aids on wards where they were required for patients. There were activity co-ordinators on wards where they were required. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to interpreters and signers via the trust intranet and would book them if they were required. Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff had access to communication aids to help patients become partners in their care and treatment.

**Access and flow**

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

**Average length of stay**

From March 2018 to February 2019 the average length of stay for medical elective patients at University Hospital Coventry was 5.7 days. This was similar to the England average of 5.9 days.

Average length of stay for elective specialties:

- Average length of stay for elective patients in clinical oncology was longer than the England average.
- Average length of stay for elective patients in gynaecological oncology was shorter than the England average.
- Average length of stay for elective patients in cardiology was similar to the England average.

**Elective Average Length of Stay - University Hospital Coventry**

![Graph showing average length of stay](image)

**Note:** Top three specialties for specific site based on count of activity.

From March 2018 to February 2019 the average length of stay for medical non-elective patients at University Hospital Coventry was 6.5 days. This was similar to the England average of 6.1 days. Average lengths of stay for non-elective patients in general medicine, cardiology and respiratory medicine were similar to the respective England averages.
Non-Elective Average Length of Stay - University Hospital Coventry

Referral to treatment (percentage within 18 weeks) - admitted performance
From July 2018 to June 2019 the trust's referral to treatment time (RTT) for admitted pathways for medicine worse than the England average in four months. In the remaining eight months the trust's performance was similar to the England average. In June 2019 the trust's performance was 81.3% compared to the England average of 87.5%.

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty
Eight specialties were above the England average for admitted RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>100.0%</td>
<td>96.6%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>100.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>98.4%</td>
<td>94.8%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>97.6%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Neurology</td>
<td>95.4%</td>
<td>88.8%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>93.4%</td>
<td>92.5%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>82.4%</td>
<td>80.9%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>81.2%</td>
<td>80.8%</td>
</tr>
</tbody>
</table>

Over the same period there were no specialties that were below the England average for admitted RTT (percentage within 18 weeks).

(Source: NHS England)

Patients moving wards per admission
The service moved patients only when there was a clear medical reason or in their best interest.

The trust reported that they do not currently record whether ward moves are for clinical or non-clinical reasons. They supplied data for all ward moves, rather than moves for non-clinical reasons only.
Patients moving wards at night
Staff did not move patients between wards at night unless it was for medical reasons.

From May 2018 to April 2019, there were 1,067 patient ward moves at night within medical care at University Hospital Coventry. The highest numbers of ward moves were reported in August 2018 (116), April 2019 (116) and February 2019 (115). AMU 1 accounted for the highest number of ward moves at night (494 moves over the year, based on the reporting unit that the patient moved from). This was followed by Ward 21 (care of the elderly and gastroenterology, 90), Ward 10 (cardiology, 63), AMU 2 (63) and AMU 3 (62).

We were advised by the trust that as AMU1 was a short-stay ward, where patients were assessed prior to transfer for a specialist ward, it was expected that the number of patients moved would be high. Patients were transferred at night where necessary so that they could access specialist care without delay.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

In the cardiology day unit (CDU) beds were often used for medical outliers. Between 1 January 2019 and 9 October 2019 45.63% of beds were used for medical outliers. As a result of this there is a restriction on the ability of the catheter lab to carry out all its operation lists. The service had moved some patients to Hospital St Cross to mitigate this. Another consequence of this was increased admission onto the Cardiology Unit as angiograms were delayed, so more patients are being admitted as emergencies with chest pain. Staff told us this was frustrating the cardiology ward and impacting on the care patients received.

The day case beds were not ring fenced for cardiological investigation. The three side rooms and four beds therefore tend to become an escalation area for acute medical admissions. This has been the case for the past 11 months. The outcome is a severe restriction on the ability of the catheter lab to function. Many whole lists have been cancelled. The waiting lists have become prolonged to the point where some deferred patients have been admitted as emergencies. Some patients have been rerouted to the catheter lab at Hospital St Cross.

From January 2019 to October 2019, there were a total of 266 patients that were postponed due to the lack of availability of recovery beds in the day unit (CDU). On average this breaks down to one day per week of lost activity and patient care. The cardiac catheter lab generally saw eight patients per day and averaged across the week this equates to 6.5 patients cancelled per week (one days lost activity). (Source: DR 48)

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff started planning for discharge as soon as possible. Managers and staff worked to make sure that they started discharge planning as early as possible. Some wards had discharge nurses whose full-time job it was plan for patient discharges from the time they came on the ward. Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. Staff told us sometimes discharging staff could be a slow process due to social factors and having the time to make the appropriate arrangements for patients.
The service was introducing a simple discharge process which was being trialled on nine of the medical wards. This had been based on the trust’s quality improvement methodology (UHCWi) and had shown improved early discharges and reduced length of stay. Leaders were trying to create an attitude of non-acceptance of delayed discharges within medicine. This was in line with the simple discharge process and aimed to create a more efficient discharge system which was embedded in staff culture. The service had ‘discharge Wednesdays’ where anyone who has been an inpatient for over seven days was reviewed by matrons and ward managers. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The service held daily bed management meetings, so staff could discuss discharges and movement between wards.

Staff supported patients when they were referred or transferred between services. Staff experienced delays with cleaning of rooms during the afternoon, evening and night. This led to delays of patient transfers between wards. Managers monitored patient transfers and followed national standards. Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. For the period of 1 October 2019 to 31 October 2019 there were no reported delayed admissions due to rooms not being cleaned. (Source DR: 47)

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Patients, relatives and carers we spoke with during the inspection knew how to raise concerns and complain if they needed to. The service clearly displayed information about how to raise a concern in patient areas. Staff gave leaflets to patients when on visits to patients homes. This included information on the complaints procedure and patient advice liaison service (PALS).

Summary of complaints

From May 2018 to April 2019 the trust received 162 complaints about medical care at University Hospital Coventry (25.3% of total complaints received by the hospital). For the 148 complaints that had been closed at the time of data submission, the trust took an average (mean) of 32.6 working days to investigate and close these complaints. This was longer than the trust’s target of 25 working days. The 14 complaints that were open at the time of data submission, had been open for an average of 68.4 working days. This was longer than the trust’s target of 25 working days. A breakdown of complaints by ward or unit, for those with five or more complaints, is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 30 – respiratory</td>
<td>10</td>
<td>6.2%</td>
</tr>
<tr>
<td>Ward 1 – medicine</td>
<td>10</td>
<td>6.2%</td>
</tr>
<tr>
<td>Ward 3 (AMU3)</td>
<td>8</td>
<td>4.9%</td>
</tr>
<tr>
<td>Ward 42 – neurology</td>
<td>7</td>
<td>4.3%</td>
</tr>
<tr>
<td>Ward 12/CDU - AMU1</td>
<td>7</td>
<td>4.3%</td>
</tr>
<tr>
<td>Ward 21 - acute frailty unit</td>
<td>6</td>
<td>3.7%</td>
</tr>
<tr>
<td>Ward 10 – cardiology</td>
<td>6</td>
<td>3.7%</td>
</tr>
<tr>
<td>Ward 35 – chemotherapy</td>
<td>6</td>
<td>3.7%</td>
</tr>
<tr>
<td>Wisdom centre</td>
<td>6</td>
<td>3.7%</td>
</tr>
<tr>
<td>Subject</td>
<td>Number of complaints</td>
<td>Percentage of total</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Clinical treatment</td>
<td>54</td>
<td>33.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>20</td>
<td>12.3%</td>
</tr>
<tr>
<td>Admissions, discharges &amp; transfers (excluding delayed discharge due to absence of care package - see integrated care)</td>
<td>20</td>
<td>12.3%</td>
</tr>
<tr>
<td>Patient care including nutrition / hydration</td>
<td>19</td>
<td>11.7%</td>
</tr>
<tr>
<td>Appointments</td>
<td>14</td>
<td>8.6%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>11</td>
<td>6.8%</td>
</tr>
<tr>
<td>End of life care</td>
<td>5</td>
<td>3.1%</td>
</tr>
<tr>
<td>Access to treatment or drugs</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Commissioning</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Privacy, dignity &amp; wellbeing</td>
<td>4</td>
<td>2.5%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Trust admin / policies / procedures including patient record management</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
<td>0.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>162</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Number of compliments made to the trust
From May 2018 to April 2019 the trust received 361 compliments about its medical care services at University Hospital Coventry. The trust noted that the main theme arising from 1,600 compliments received across the trust over the same 12-month period were how well staff demonstrated the trust’s values, particularly compassion, pride and respect. Recent compliments mentioned the professionalism and responsiveness of their staff.  
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service was overseen by three leaders who reported to the trust executive team. The medical services’ team was split into two groups which had their own leaders. Within the two teams there
were wards and areas with their own matrons and ward managers. Leaders in the service had the right skills and abilities to run the service. The group directors told us they worked well as a team and had good support from the trust board. The trust were involved with the Virginia Mason institute. Staff on the wards were engaged with the Virginia Mason project and staff told us it helped create better leaders. Leaders in the service were visible to the teams and supportive. Staff told us that leaders across all of the wards were supportive and approachable. The service had a leadership strategy that involved succession planning for the future. Staff in the service at various roles were given roles and responsibilities in order to prepare them.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust had a vision in place and this applied to medical services. Leaders of the service had a realistic vision and strategy which they were putting into action. The service was working on its rota to make it multi-site and include all available consultants. This would reduce pressure on some consultants and reduce locum usage. Staff told us they believed this would increase discharge at weekends as most consultants would be full time staff. The service had plans in place to increase the capacity of its endoscopy unit across both sites and achieve a target of two week patient waits. They planned to increase specialist nursing and administrative support to achieve this. Leaders acknowledged they had recruitment problems in some areas and staff groups. The service had expanded its recruitment and bought in clinical fellows from overseas to increase the medical staffing. The service had also changed its policy on student nursing mentoring, so it could have more student nurses on more areas and this will help to increase nursing numbers in the future. For example, endoscopy can now have student nurses placed there. The medical services formed part of the trust structure and also worked with other external organisations.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff at the service had a highly positive morale. Staff, including leaders, told us that morale was positive across the teams. The service also had a drive to improving staff health and wellbeing across all its services. Whilst we were on site the trust had put on one stop shops for staff to engage and talk about mental health and also receive flu jabs. Staff had access to the appropriate staff network groups and undertook equality and diversity training. The service took appropriate measures to protect staff. Staff on the gastroenterology unit said abusive and violent behaviour was unusual, but staff had training to deal with this. There was also a panic button under the desk at the nurses’ stations. Staff told us security were responsive when they were called in there were ever any violent incidents where staff required assistance. Staff at the service had a patient focused culture. The service had a clear whistleblowing policy in place and staff were aware how to use it. Staff told us they would feel comfortable raising any concerns with their leaders. Staff were aware of who to report concerns to above local leadership. The trust had a Freedom to speak up guardian in line with national guidance. Freedom to speak up guardians (FTSUG) were
introduced following Sir Robert Francis’s Freedom to Speak up Review (2015). Their role is to work with leadership teams to create a culture where people can speak-up to protect patient safety. Most staff we spoke to were aware of the FTSUG and knew how to raise concerns with them.

**Governance**

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There service had a clear governance structure in place. The medicine service changed into one large group eight months before this inspection. Medicine is now overseen by three group directors and it is split into two sub groups which have two clinical leaders. Prior to this it was split into four separate groups. Staff on the wards told us they felt this change had been positive for them. Leaders told us they felt this change had, ‘integrated medicine into a united front’. The specialities within these sub groups were over seen by a total of seven matrons. There were clear and effective governance structures, processes and systems in place within the service. The service was overseen by an overall governance meeting Each of the two divisions had their own divisional governance meetings. Then each of the specialities has a governance meeting. Staff at the service engaged in clinical governance meeting and QIP meetings on a monthly basis. We saw the minutes of the medicine group governance and medicine sub group management board meetings for October and November 2019 and they were well attended by relevant managers and staff and the minutes were detailed. *(Source: DR 49).* Leaders and staff in all teams were clear about where they fit into the governance this governance structure and were able clear about who they were accountable to. Ward managers attended all clinical governance meeting on behalf of their teams. As part of the Virginia Mason institute staff there was a focus on ‘quality and safety services are designed to empower your health care team to develop and champion standardized protocols that can dramatically improve patient outcomes’. Staff told us that they felt involved in the trust governance processes and this focus on quality improvement had benefitted on the wards.

**Management of risk, issues and performance**

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had clear and robust service performance measures, which were reported and monitored. There were assurance systems in place, and performance issues were escalated appropriately through clear structures and processes. There were processes to manage current and future performance, which were regularly reviewed at specialty meetings. There was a systematic programme of clinical and internal audit to monitor quality, and systems were in place to identify where action should be taken. For example, most audits had an associated action plan, which included measurable actions and recommendations.

Arrangements for identifying, recording, and managing risks, issues, and mitigating actions were in place. There was alignment between the recorded risks and what staff told us was ‘on their worry list’. For example, staffing, recruitment, capacity and performance. The risk register for each clinical group described the risk and how it was relative to each specialty within the clinical group where applicable. Control measures and mitigating actions were clear and regularly updated. Risks were
discussed and updated at performance meetings and QIPS meetings. Nurses and medical staff we spoke with were aware of what was on the risk register and most were able to describe what actions were being taken to mitigate risks. Risks seen on inspection were clearly shown on the risk register, which had clear actions, risk owners and timescales for action. Risks had been reviewed regularly. (Source: DR 50)

Potential risks were taken into account when planning services, for example seasonal pressures. There were arrangements in place, which ensured performance in regard to sepsis management and antimicrobial prescribing were fed back to the trust board. For example, the trusts performance in relation to timely identification of sepsis and antibiotics within one hour was presented to the trust board. The trust had a business continuity plan, which provided guidance on maintaining services and dealing with business interruptions, which might disable services or require special arrangements to be put in place to allow them to continue. The trust was working towards a more structured approach with the involvement from patients and carers. The patient partners would be involved in environmental audits, mystery shopper activities and staff interview panels. Leaflets regarding how to become involved in this partnership were present within the reception areas of the hospital. There was a systematic programme of clinical and internal audit to monitor quality.

**Information management**

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Audit data was reviewed at clinical speciality and group level meetings. This meant that there was a service awareness of performance. Leaders had oversight of all specialties within their service and escalated to the trust board appropriately. This enabled decision makers to have the relevant, up to date information to inform decisions being made about the service. SHMI and HSMR data were routinely used to monitor performance and review performance against other trusts. Investigation into diagnosis groups as part of the mortality review process had been identified as an area for improvement in the recording and coding of comorbidities and complications. The clinical coding team was working with medical specialties to improve the recording of comorbidities for patients including the use of the discharge summary and forms within healthcare records.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had mechanisms which allowed the public to feed information about the service to the trust. The service reviewed public feedback and made changes to the service. The service had mechanisms which allowed staff to feed information about the service to the trust. The service reviewed staff feedback and made changes to the service. The service worked with local organisations to improve services for patients. Advanced nurse practitioners from care of the elderly wards worked with local community teams and nursing homes to try and prevent inpatient hospital admissions.
Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a commitment to ongoing learning and continued professional development within the division. For example, the Virginia Mason Institute, who assisted health care organisations around the world to create and sustain a ‘lean’ culture of continuous improvement, were working alongside University Hospitals Coventry and Warwickshire NHS Trust. Wards participated in the UHCW Improvement (UHCWi) method which was the trust’s management system based on lean principles designed to help deliver continuous improvement that could be used at every level of the organisation. It supported the development of leaders to frame problems and empower staff to develop and sustain locally led improvements. One example was the front door frailty pilot in September 2019, which had the positive outcome of saving 35 bed days in the 10 day pilot with a successful MDT approach. (Source: DR 52).

Critical care

Critical care includes areas where patients receive more intensive monitoring and treatment for life-threatening conditions. The Department of Health has defined levels of care dependent on the severity of the patient’s condition. The critical care service at University Hospitals Coventry includes care at levels 2 and 3. Patients that require a more detailed observation or intervention that includes an extended post-operative care, receiving support for a single failing organ system and requiring additional respiratory, renal, neurological or dermatological support fall under level 2 care. Patients that require support for multi-organ failure and basic respiratory support, or for advanced respiratory support alone falls under level 3 care. (Source: Department of Health Comprehensive Critical Care 2000)

We inspected critical care services at University Hospitals Coventry on 8, 9 and 10 October 2019 and the inspection was unannounced.

Our inspection team consisted of one lead inspector, two specialist critical care nurse advisors and a specialist critical care consultant advisor. During the inspection, we spoke with 26 staff, including consultants, junior doctors, clinical leads, critical care nurses, outreach nurses, ward clerks, care support workers, therapists and housekeepers. We spoke with one patient and seven family members and observed care and treatment for all inpatients, during inspection. We looked at 10 patient’s medical records and eight medication charts.

We previously inspected this service between 23 and 27 April 2018 and found some areas for improvement.

- To monitor that all members of staff are compliant with the trust’s infection control and prevention policy.
- To review adherence to the Guidelines for the Provision of Intensive Care Services (GPICS) for multidisciplinary meetings. The GPICs standard stated that a consultant intensivist led multidisciplinary clinical ward rounds within intensive care must occur every day (including weekends and national holidays). The ward round must have daily input from nursing, microbiology, pharmacy and physiotherapy.
• To monitor that all records within Cardiothoracic critical care (CTCC) are kept to a good quality and be comprehensive; namely legible and in sequence with evidence of assessments for post-operative delirium risk and falls.
• To review the medical arrangements of the CTCC met intensive care core standards, which require that an intensive care consultant leads the care on all intensive care units.
• To consider how the CTCC can effectively monitor outcomes for patient care to drive improvements.

Facts and data about this service

As of June 2019, the trust reported that it had 64 critical care beds. A breakdown of these beds between adult and neonatal critical care is shown below. As of this date there were 37 adult and 27 neonatal critical care beds across the trust.

Breakdown of critical care beds by type, University Hospital Coventry and Warwickshire NHS Trust and England

This trust

- Neonatal, 42.2%
- Adult, 57.8%

England

- Neonatal, 24.5%
- Paediatric, 5.5%
- Adult, 70.0%

(Source: NHS England)

University Hospital Coventry has a general critical care unit and a cardiothoracic critical care unit. The hospital is a level 1 major trauma centre. Please note that the information below is taken from the routine provider information request. This was completed by the trust in July 2019 and the bed numbers therefore do not exactly match those supplied by the trust to NHS England in June 2019.

In the routine provider information request (RPIR) the trust reported that its general critical care unit had 21 level 3 critical care beds as of July 2019. These could be flexed to facilitate 15 level 3 and 12 level 2 beds as required. The unit takes emergency admissions from the emergency department (complex polytrauma), theatres and all other departments as well as planned elective surgical activity.

The cardiothoracic critical care unit is primarily a surgical post-operative unit. In the RPIR the trust reported that on weekdays 13 beds were funded as of July 2019. These are generally configured as seven level 3 beds and 6 level 2 beds, though the dependency is flexed as required. At weekends the number of beds is reduced to eight, flexed according to need.

As of April 2019, there were 206.8 nursing whole time equivalents (WTE) and 43.0 other clinical WTE, in post in critical care at the trust.

(Source: Trust Routine Provider Information Request)

The critical care service was provided over two locations but were managed as one service.
Cardiothoracic critical care was provided on a ward with 22 beds and 11 were allocated and funded as critical care beds.

The main critical care ward was divided into three teams, each had a nurse in charge that covered these areas. There were 26 beds in total with four of them located in side rooms.

The general consultant intensivists managed the care of patients located in the main critical care ward. The cardiothoracic surgeons managed the care of patients located in cardiothoracic critical care ward.

The nursing staff worked across the two wards and worked as one team. Specialist cardiothoracic nurses mainly worked on the relevant ward, however, a rotation process was in place to allow staff to gain experience across the whole of the critical care service.

**Is the service safe?**

**Mandatory training**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up-to-date with their mandatory training. The trust set a target of 95% for completion of mandatory training. Nursing staff on the unit exceeded the trust’s target and 98% had completed their training by April 2019. This remained at 98% during our inspection.

**University Hospital Coventry**

A breakdown of compliance for mandatory training courses as of April 2019 at trust level for qualified nursing staff in critical care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual handling - object</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene - non-clinical (initial)</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>218</td>
<td>218</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>220</td>
<td>220</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>219</td>
<td>220</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>216</td>
<td>217</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>214</td>
<td>217</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire safety - annual</td>
<td>216</td>
<td>220</td>
<td>98.2%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>215</td>
<td>220</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>213</td>
<td>218</td>
<td>97.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>173</td>
<td>182</td>
<td>95.1%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>NPSA preparing and administering a transfusion of blood or blood products</td>
<td>202</td>
<td>214</td>
<td>94.4%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Advanced life support update</td>
<td>33</td>
<td>36</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NPSA obtaining venous blood</td>
<td>50</td>
<td>55</td>
<td>90.9%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>190</td>
<td>215</td>
<td>88.4%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
NPSA collection and transportation of blood and blood products

|        | 47 | 55 | 85.5% | 95% | No |

In critical care at University Hospital Coventry the 95% target was met for 11 of 16 mandatory training modules, for which qualified nursing staff were eligible. However, on inspection we saw that the rate of compliance had increased in all five modules that were below 95% in June 2019. *(Source: Routine Provider Information Request (RPIR) – Training tab)*

On inspection medical staff told us that they were able to access training and were supported in developing specialist skills. Staff would cover each other to allow time to be freed up for training. The lead consultant for critical care, maintained oversight for medical staff training within the service. However, it was recognised a more robust monitoring process was required. Medical staff training compliance as of October 2019 was:

<table>
<thead>
<tr>
<th>Training Title</th>
<th>10-19</th>
<th>Compliant</th>
<th>Not Compliant</th>
<th>Target</th>
<th>% Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>218 [MAND]: Advanced Life Support Update Ref 20</td>
<td>12</td>
<td>3</td>
<td>15</td>
<td>80.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Advanced Life Support</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>50.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Automated External Defibrillation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Blood Transfusion</td>
<td>12</td>
<td>3</td>
<td>15</td>
<td>80.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Collection and Transportation of Blood and Blood Products</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Equality &amp; Diversity - Initial</td>
<td>14</td>
<td>3</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: European Paediatric Advanced Life Support (EPALS / APLS) - 6 Yearly</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: European Paediatric Advanced Life Support (EPALS / APLS) Annual Update</td>
<td>6</td>
<td>5</td>
<td>13</td>
<td>61.54%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Hand Hygiene - Clinical (Annual)</td>
<td>12</td>
<td>2</td>
<td>14</td>
<td>85.71%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Hand Hygiene - non clinical (initial)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Immediate Life Support (ILS) - Annual</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Infection Control - non clinical (initial)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Moving &amp; Handling - Clinical (2 Yearly)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Moving &amp; Handling - Medical &amp; Dental (3 yearly)</td>
<td>12</td>
<td>3</td>
<td>15</td>
<td>80.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Moving &amp; Handling Clinical/Non-clinical - 3 Yearly</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Neonatal Life Support (NLS) Update</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Neonatal Life Support (NLS)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Obtaining Venous Blood</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Paediatric Basic Life Support</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Paediatric Immediate Life Support Course / Update (1 Yearly)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Preparing and Administering a Transfusion of Blood or Blood Products</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Safeguarding Adults Level 1</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Thrombophrophaxis (Ref 19)</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Adult Basic Life Support - 1 Year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Conflict Resolution - 3 Years</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Fire Safety - 1 Year</td>
<td>13</td>
<td>2</td>
<td>15</td>
<td>86.67%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Health and Safety - 3 Years</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Infection Control - 1 Year</td>
<td>12</td>
<td>3</td>
<td>15</td>
<td>80.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Information Governance - 1 Year</td>
<td>13</td>
<td>2</td>
<td>15</td>
<td>86.67%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Safeguarding Adults Level 2 - 3 Years</td>
<td>12</td>
<td>0</td>
<td>12</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Safeguarding Children Level 1 - 3 Years</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Safeguarding Children Level 2 - 3 Years</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Safeguarding Children Level 3 - 3 Years</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Preventing Radicalisation - Basic Prevent Awareness - 3 Years</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>93.33%</td>
<td></td>
</tr>
<tr>
<td>218 [MAND]: Preventing Radicalisation - Prevent Awareness - No Specified Renewal</td>
<td>15</td>
<td>0</td>
<td>15</td>
<td>100.00%</td>
<td></td>
</tr>
</tbody>
</table>

*(Source: DR 43)*

The mandatory training was comprehensive and met the needs of patients and staff. There were 16 mandatory training modules that covered the essential areas in keeping patients safe. Staff were proactive in their approach to training and managed development needs well. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Additional specialist training was available, and staff were competent in supporting vulnerable patients. Managers monitored mandatory training and alerted staff when they needed to update their training. Leaders had good oversight of mandatory training across the critical care unit. Education and development leads managed the programme for training and ensured that all nursing staff had received or were booked onto relevant training. Mandatory training compliance rates were displayed in the staff
rooms and staff also received email reminders when training was due.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. All staff we spoke with understood their responsibilities and adhered to safeguarding policies and procedures. Nursing staff received training specific for their role on how to recognise and report abuse. Staff were trained to the appropriate level for safeguarding adults and children. Staff knew how to make a safeguarding referral and who to inform if they had concerns. They could provide examples when a referral had been made and for what reasons, even if they were not directly involved. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw examples within patient records of staff using the correct documentation to protect patients and provide care in their best interests. Staff followed safe procedures for children visiting the ward.

The trust set a target of 95% for completion of safeguarding training. The tables below include preventing radicalisation training as a safeguarding course. This training module works to stop individuals from getting involved or supporting terrorism or extremist activity.

University Hospital Coventry

A breakdown of compliance for safeguarding training courses as of April 2019 for qualified nursing staff in critical care at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes/No)</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>218</td>
<td>218</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 1</td>
<td>2</td>
<td>2</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2</td>
<td>219</td>
<td>220</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>(basic prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>219</td>
<td>220</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5</td>
<td>217</td>
<td>220</td>
<td>98.6%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>(prevent awareness)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At University Hospital Coventry the 95% target was met for all six safeguarding training modules for which qualified nursing staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Medical staff compliance with safeguarding training as of October 2019 was:

<table>
<thead>
<tr>
<th>Module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Infection Control - 1 Year</td>
<td>12</td>
<td>15</td>
<td>80.00%</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Information Governance - 1 Year</td>
<td>13</td>
<td>15</td>
<td>86.67%</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Adults Level 2 - 3 Years</td>
<td>12</td>
<td>12</td>
<td>100.00%</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 1 - 3 Years</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 2 - 3 Years</td>
<td>14</td>
<td>15</td>
<td>93.33%</td>
</tr>
<tr>
<td>NHS</td>
<td>MAND</td>
<td>Safeguarding Children Level 3 - 3 Years</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Preventing Radicalisation - Basic Prevent Awareness - 3 Years</td>
<td>14</td>
<td>15</td>
<td>93.33%</td>
</tr>
<tr>
<td>NHS</td>
<td>CSTF</td>
<td>Preventing Radicalisation - Prevent Awareness - No Specified Renewal</td>
<td>15</td>
<td>15</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

(Source DR 43)
Cleanliness, infection control and hygiene

The service managed infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

We saw the service had made improvements to infection, prevention and control measures since the last inspection visit. Hand hygiene was a priority and facilities were available for staff and visitors to use. We saw staff observing the “arms bare below the elbow” principles and hand washing between patient’s care being given. Signs were in place instructing visitors to see the nurse in charge before entering side wards. This was in place when there was an identified case or a higher risk of infection. Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. All clinical areas we visited during the inspection including the sluices and bed spaces were visibly clean and free from clutter. An external contractor provided cleaning services for the critical care environment. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff told us that cleaning standards were regularly monitored through audits and we observed an audit taking place by a member of the critical care staff and a contract manager. The area attained a 97% compliance score which was above the 95% standard set.

Staff could request cleaning services outside of the routine programme to ensure that areas were kept to a high standard of cleanliness and to improve infection control. Deep cleaning was available, and the service also used a technique called fogging, which uses Hydrogen peroxide gas to decontaminate large areas. Environment and flooring was compliant with national standards, ensuring that areas were easier to maintain and clean. We observed good waste management that complied with national standards and the European Waste Directive 2008/98/EU.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Records were updated, and contractors signed on completion of different tasks. We saw the floor areas being cleaned using suitable equipment and operated by a competent person. The nurse in charge of the bay also noted when and where had been cleaned to aid in monitoring the cleaning schedule. Staff followed infection control principles including the use of personal protective equipment (PPE). All staff we saw followed ‘arms bare below the elbows’ principles and wore personal protective equipment as required which was available throughout the unit. We saw staff using aprons and gloves appropriately. Each side room had enough PPE located outside for staff to use. We observed good hand hygiene and there was enough hand gel or hand washing facilities for all visitors to the ward. Trust policies were adhered to and staff wore minimal jewellery in line with the trust’s infection prevention and control policy.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was visibly clean, and most equipment had green “I am clean” stickers confirming when the equipment had been cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Call bells were available and close to patients that were able to use them. There were nursing stations at the end of the bed.
where staff stayed to continuously monitor their patients. Staff could also observe other beds in case of emergency and to support colleagues in responding to patient needs quickly.

The design of the environment followed national guidance. We saw that equipment listed in the HBN04-02 section 4, was available for each bed space and they were able to accommodate the equipment required whilst allowing staff to access the patient in an emergency. We saw an example where a patient required support from seven staff members, this was achieved in a safe way. Flooring and static equipment was compliant to the relevant standards and fit for purpose.

Staff carried out daily safety checks of specialist equipment. Staff documented checks of all resuscitation trolleys, daily. All trolleys had photographs of the equipment that should be present on the trolley to enable consistency and support safer checks to be done. The nurse in charge oversaw the frequency and registering of all checks within their defined area. The maintenance and use of equipment kept people safe. We saw that equipment was serviced and maintained regularly. We checked a range of equipment and they had been serviced within the last 12 months. This information is kept on an electronic register as part of the trust facilities management.

We observed six different pieces of equipment which all had in date portable appliance test (PAT) certificates. Equipment was clean and plugged into a supply, ready for use when required.

The service had suitable facilities to meet the needs of patients’ families. The entrance to critical care was secure and required visitors to be let in once identification was verified. There was a large reception and waiting area upon arrival at the unit that had staff there to welcome and assist visitors. It had seated area and side rooms to facilitate meetings. Information and support from a receptionist was available to visitors and was supported by volunteers during the week and at weekends. Drinks and snacks were available from a vending machine located within this area.

There were two relative’s rooms that had beds for overnight stays, furnishings and amenities suitable for people to sleep close to the critical care unit. We spoke with families using the facilities and were told that the rooms were clean and fit for purpose. The service had enough suitable equipment to help them to safely care for patients and staff disposed of clinical waste safely. We saw staff using electronic monitoring for patients, which supported care by continuously monitoring and recording data. Staff disposed of sharps safely in sharps bins and ensured they were not overfilled. It was the responsibility of the nurse in charge of the area to monitor waste as part of their daily checks. Waste was removed by the cleaning contractor upon request or routinely during the day. We saw colour coded bags being used to separate waste appropriately.

**Assessing and responding to patient risk**

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration**

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff identified and responded appropriately to changing risks to people who used services, including deteriorating health and wellbeing. They used National Early Warning Score (NEWS2) reporting system in the critical care unit. The system required staff to record patients’ vital signs and calculate NEWS scores, which would identify acutely unwell or deteriorating patients. We checked the observation charts of 10 patients and found the NEWS2 score was recorded and escalated appropriately.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. Risk management plans were developed in line with national guidance.
Staff followed NICE CG179 (Pressure Ulcers: Prevention and Management) and used appropriate risk assessments to record. Daily skin integrity assessments were done for every patient in the critical care unit. Falls assessments were used appropriately and reviewed when patients were due to be discharged from critical care. Malnutrition universal screening tool (MUST), bed rail and continence assessments were completed depending on patient needs and ability at the time of admission. All incidents of hospital acquired pressure ulcers were subject to a root cause analysis (RCA) with learning being shared at daily handover and team meetings.

A mental capacity assessment to assess the patient’s ability to consent for treatment and whether this was in their best interest was completed where appropriate. Staff completed psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. During the inspection, we found that the patient’s capacity to consent to treatment was routinely checked. Staff said they completed Deprivation of Liberty Safeguards (DoLS) documentation for patients with suspected delirium and scores were recorded and monitored using the patient care plan.

Staff shared key information to keep patients safe when handing over their care to others. The handover between staff followed a set method that covered patient history. A background, assessment and recommendation (SBAR) style method was documented, if appropriate to the patient. Information for emergency admissions was shared on electronic information systems and with a face to face handover. Shift changes and handovers included all necessary key information to keep patients safe. We observed handovers on several days during inspection and found that they were comprehensive and included appropriate staff caring for the patient. Handover notes were kept and made available to staff involved with the patient care.

World health organisation (WHO) checklists were used to ensure correct procedures were followed and recorded when using some invasive techniques on critical care units.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing staff of all grades to keep patients safe. Senior staff told us that staff retention had improved and that agency was rarely used but relied on nurses to do bank shifts. Daily staffing meetings supported the service in balancing staffing risks across the trust. In many cases the critical care unit provided staff to other areas and rarely required support from other wards. The service had enough nursing and support staff to keep patients safe. On inspection, we saw staffing levels displayed appropriately and found that they were within recommended guidance. The unit maintained a one nurse to one patient ratio for level three patients and one nurse to two patients for level two patients. Senior nurses were available on each shift to cover when required and facilitate some protected time for staff to complete other tasks. We saw that 48% of the nursing staff that had achieved a post graduate qualification in critical care. This was below the recommended professional standard of 50%. However, we saw a plan to increase this to the required level by supported those without the qualifications, to attain them. Critical care managers were proactive in recruiting qualified staff to the service and advertised positions as part of the recruitment and succession planning for the unit.

Managers regularly reviewed and adjusted staffing levels and skill mix. Daily reviews took place to maintain adequate staffing and issues escalated appropriately. We were told that agency staff had
not been used since February 2019 and all new staff to the unit were given an induction, by a senior member of the nursing staff. The unit used an acuity tool to determine safe levels of staffing and appropriate skill mix. Senior nursing staff assessed the staffing number against the patient numbers and acuity for the next day’s shift. This was discussed at a specific meeting that took place at 4.30 PM, seven days a week. An electronic system was used to review the nursing needs throughout the hospital and to identify where additional staffing was required. Critical care unit was often approached to supply nurses to work on other wards. Throughout our inspection we saw that the planned and actual staff numbers were the same and on two occasions we saw that a spare member of staff had been made available to support training and personal development. The team used a social media tool to communicate with staff to cover shortfalls within the unit.

The table below shows a summary of the nursing staffing metrics in critical care at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>265.6</td>
<td>11%</td>
<td>5%</td>
<td>3.9%</td>
<td>59,081 (13%)</td>
<td>11,253 (2%)</td>
<td>23,404 (5%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>217.7</td>
<td>11%</td>
<td>5%</td>
<td>4.0%</td>
<td>59,081 (13%)</td>
<td>11,253 (2%)</td>
<td>23,404 (5%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Qualified nursing and midwifery staffing rates within critical care at University Hospital Coventry were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly vacancy, turnover or sickness rates, or bank staff usage. From February 2019, the agency use had reduced and was at zero percent at the time of inspection. (Source: Routine Provider Information Request (RPIR) – Vacancy, turnover, sickness and bank and agency staff usage tabs)

Monthly agency usage over the last 12 months for qualified nurses was not stable and may be subject to ongoing change. (Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)
Information received before inspection, which was confirmed on inspection, indicates that there was no agency staff used to cover the critical care unit. The service relied on bank staff to support the right numbers of nurses.

**Medical staffing**

The service had access to enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The Faculty of Intensive Care Medicine’s (FICM) Guidelines for the Provision of Intensive Care Services and Guidelines for the Provision of Intensive Care Services (GPICS), state that the resident medical trainee, specialty and associate specialist (SAS) doctor or an advanced critical care practitioner (ACCP) to patient ratio, should not exceed one to eight patients. We found that the service was compliant with these guidelines. We saw an improvement in medical cover from the last inspection which was facilitated by staff monitoring and taking a flexible approach to cover gaps in the rota. There were adequate numbers of specialist doctors and junior doctors to support patient care in the unit. Junior doctors told us that they received specialist training and support in working in critical care. Three consultants were scheduled to work on the unit from 8am to 4pm, Monday to Friday and two working on the main critical care unit (CCU), from 8 am to 2 pm at weekends. This meant that the cardiothoracic critical care did not have a dedicated consultant on the ward at weekends. Cover was provided by the main CCU consultants.

This service therefore fell short of the recommended requirements set out in Guidelines for the Provision of Intensive Care Services (GPICS) latest version – June 2019, for cardiothoracic critical care, which states there should be consultant cover seven days a week. We were told that this was being addressed with a business plan submitted to increase the consultant numbers by four. Appropriate on call arrangements were in place for all other times.

The table below shows a summary of the medical staffing metrics in critical care at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>265.6</td>
<td>11%</td>
<td>5%</td>
<td>3.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical staff</td>
<td>17.2</td>
<td>19%</td>
<td>0%</td>
<td>3.0%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within critical care at University Hospital Coventry were analysed for the
past 12 months. Over this period the trust reported no turnover for medical staff in critical care. There was no bank or agency medical staff usage reported.

Monthly vacancy rates over the last 12 months for medical staff showed a shift from November 2018 to April 2019.

Monthly sickness rates over the last 12 months for medical staff were not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patients had individual care plans which were revised and adapted as treatment progressed. Records were comprehensive and easy to follow. We reviewed 11 sets of nursing and medical notes and found these to be in good order. This was an improvement from the last inspection. Records were accurate, complete, legible and up-to-date. Staff had stamps for use on patient records to provide clear information to identify the entry. We saw that a consistent approach had been adopted across both critical care wards as part of the integration into one critical care unit.

Risks to patients, for example malnutrition and skin pressure damage, were assessed and managed on a day-to-day basis, using nationally recognised risk assessment tools. National Early Warning System (NEWS2) was used to identify and monitor deteriorating patients. Patient records were stored securely when not in use and located on trollies for ease of use, when staff required them.

Staff always had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. When patients transferred to a new area, there were no delays in staff accessing their records. We saw examples where patients had moved onto the critical care unit and both electronic information and paper notes were immediately available.

Staff maintained patient confidentiality by storing paper records appropriately. Daily observation charts, medicine charts and patient care plans were stored within the allocated trolley in the patient bed space. Information from the electronic monitoring systems was also documented.
within the patient notes. This appeared to be repeating entries, however, was necessary due to the combination of electronic and paper-based information.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

There were no recorded medicine related incidents for critical care between April 2018 and March 2019. At the time of inspection this remained at zero for medicine related incidents, attributed to critical care. Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. During our inspection, we observed staff following the safe administering of medicines in accordance with guidance. We observed two nurses checking controlled drugs in line with trust policy which included checking the medicines against the prescription chart and correctly identifying the patient. We observed staff asking patients if they had any known allergies. Nurses wore red aprons to indicate that they were on drugs rounds and to prevent them being disturbed. Newly installed automated electronic medicines storage systems across critical care ensured medicines were available, safe and secure with restricted access to authorised staff. A training programme for staff on using the new system was in place.

Medicine fridge temperatures were monitored by ward staff and were within the recommended range. Staff were aware of what action to take if there was a deviation. The trust used electronic medicine cupboards for storing medicines. These cabinets had continuous monitoring of the temperature within the cabinet i.e. the location that the medicines were stored rather than a remote probe in the room. This continuous monitoring temperature was fully recorded, allowed full remote monitoring and supports automated provision of reports to staff. The ward nurses did not need to monitor the temperature as a report was automatically generated and reviewed by senior staff and allowed action to be taken in a timely way. Staff understood how long the medicine has been at any temperature deviation so appropriate action can be taken, and all retrospective data is stored. There was a trust wide clinical operating policy for dealing with elevated temperatures in drug storage. In addition, the medicines stocked on wards in the automated cabinets were determined by the medicines used within the clinical specialty in agreement with ward managers and the specialist pharmacist. Pharmacy teams restocked the automated cabinets either daily or weekly depending on the area.

Medicines required in an emergency were readily available when needed. Regular checks of emergency medicines and equipment were carried out by staff. Tamper evident seals were in place to ensure medicines were fit for use, however, risk was present of intravenous fluids required in an emergency, being accessed. Following the inspection, the trust informed us that they were fully compliant with the storage of all medicines including IV fluids which were being checked daily by ward staff. IV fluids on resuscitation trollies were being stored in double wrapped bags; with tamperproof seals and expiry dates checked daily in accordance with the management of resuscitation policy. Allergy statuses or medicine sensitivities of patients were routinely recorded on medicine administration charts. Venous Thromboembolism (VTE) risk assessments were routinely recorded for patients on the Clinical Results Reporting System which identified if treatment was required.

Staff knew how to contact pharmacy staff and how to access medicines out of hours when pharmacy was closed. Prescribers did not always write separate prescriptions for medicines that could be given by either the oral or intravenous route. Risk was identified for paracetamol, if given...
intravenously to patients with lower body mass, at the same dose as administered orally. It was therefore not always possible to determine what route a medicine had been given to a patient. Making separate entries for each route is good practice to ensure clarity in the medicine administration record. We raised this with the trust’s director of pharmacy who initiated a review into this issue to ensure prescribers were making clear which route was to be used. Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. A specialist critical care pharmacist worked with the critical care multidisciplinary team aiding in reducing patient medication errors, providing advice and support on treatment plans and medicine regimens. There were guidelines on the choice of antibiotic therapy with evidence of reason for choice recorded. Clear review dates of treatment were in place and evidence of advice from pharmacy documented onto medicine administration charts. Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Controlled drugs (CD) and controlled stationary were managed effectively. Quarterly CD Audits undertaken by pharmacy ensured processes were being followed. CD medicines were handled in line with CD legislation. Staff followed current national practice to check patients had the correct medicines. A process of medicine reconciliation was in place to facilitate the review of patient’s current medicines including non-prescribed medicines when admitted to hospital. Any areas of discrepancy were identified, highlighted and actioned.

Incidents
The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. We found that there was a good culture for reporting incidents. We observed the use of the electronic reporting system that was demonstrated by staff. They told us that they reported all incidents and near misses to ensure patient safety was a priority and to aid in learning if something did not go well. Staff raised concerns and reported incidents and near misses in line with trust policy. All incidents were reported to the senior staff and managers on duty and staff recorded incidents on an electronic incident reporting system. Managers reviewed incidents quickly and supported staff in managing the situation when possible. A weekly review of incidents took place to proactively manage any risks identified.

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SI’s) in critical care at University Hospital Coventry which met the reporting criteria set by NHS England from July 2018 to June 2019. Both were of type “pressure ulcer meeting SI criteria”. We saw the service had identified learning from the incidents and introduced increased frequency of checks for potential pressure injuries caused by equipment and the introduction of a manager to have oversight of pressure injuries within critical care.

Staff received feedback from investigation of incidents, both internal and external to the service and learning was shared appropriately. They had access to information in a folder on the unit and this information was shared by the matron at the unit meetings and by email to all staff. Daily handover meetings were used to share any immediate concerns with staff and this information recorded to provide a record. We reviewed notes from handovers, as well as minutes from governance meetings, that demonstrated the sharing of information from incidents.

Staff understood the duty of candour (DoC), they were open and transparent and gave patients
and families a full explanation when things went wrong. From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and reasonable support to the person. Managers investigated incidents thoroughly and patients and their families were involved in these investigations. Incidents that met the threshold for DoC, were managed appropriately in accordance with trust policy. We saw an example where a patient had fallen at home, prior to admission on critical care and the event was documented appropriately and relatives informed.

Managers debriefed and supported staff after any serious incident. We observed a supportive culture amongst the staff on the critical care unit and time was taken to discuss any serious situation that arose. Two staff members had set up an informal support network to give staff the opportunity to share feelings and talk about distressing incidents. Managers protected this time to ensure that staff could debrief appropriately.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2018 to June 2019 the trust reported no never events for critical care. (Source: Strategic Executive Information System (STEIS).) Managers shared learning with their staff about never events that happened elsewhere, if appropriate.

**Safety Thermometer**

**The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.**

Safety thermometer data was displayed on wards for staff and patients to see. The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Data from the Patient Safety Thermometer showed that the trust reported five new pressure ulcers and one new urinary tract infection in a patient with a catheter from July 2018 to July 2019 in critical care. Over the same period there were no falls with harm reported to the Patient Safety Thermometer. The safety thermometer showed the service had reduced the incidence of harm within the reporting period. There had been a reduction in the number of pressure injuries recorded in critical care from July 2019 to October 2019. We saw on inspection that this had been zero in August and September 2019. All staff we spoke with described the evacuation procedures which included how to evacuate patients. All fire safety equipment checked on the critical care unit/units were fit for use.

**Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and urinary tract infections patients with a catheter at University Hospital Coventry and Warwickshire NHS Trust**

1
Total Pressure ulcers (5)

Total CUTIs (1)

1 Pressure ulcers levels 2, 3 and 4
2 Urinary tract infections in patients with a catheter level 3 only
(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Although staff had access to trust policies and procedures through the intranet, we identified some policies and procedures which were out of date and in need of renewal at the time of the core service inspection. We reviewed 12 critical care specific policies and found that three required reviewing or renewing. These were endotracheal/tracheostomy suctioning policy, which expired 31/08/2019, oxygen therapy by critical care outreach team, which expired 31/09/2019 and sepsis pathway policy, which expired 31/08/2019. We noticed that some generic guidance had also missed review dates or had expired. We saw that new guidance and best practice was discussed at some meetings and we observed staff providing care and treatment which was in line with best practice. Policies specific to the critical care unit referenced a range of relevant national guidance and best practice guidelines, such as National Institute for Health and Care Excellence (NICE), Guidelines for the Provision of Intensive Care Services (GPICS) and The Faculty of Intensive Care Medicine (FICM). We raised this with the trust who took action to address this by the time of the well led review. The trust informed us that it used an electronic document management system called E-library to enable trust-wide access to clinical guidelines, policies and patient information leaflets. Policies were in place outlining the uploading, review and approval of these documents within the trust. The trust implemented a policy for clinical guidelines to be reviewed and updated, approved at specialty QIPS and uploaded within three years. As guidelines were due for review or expire they were still available on the E-library system for use in an emergency situation (as amber and red rated respectively). However, before the document could be accessed, a visual warning on the system alerted the user that the guideline had expired which they had to acknowledge before the guideline could be accessed. This limited the risk of any out of date care being provided.

Policies were version controlled, had review dates clearly noted and had quality impact assessments. However, we saw that some policies were past their review date and therefore required to be updated, including electronic versions of policies located on the trust intranet.
Staff protected the rights of patient’s subject to the Mental Health Act and followed the Code of Practice. They followed guidance and protocol detailed in a Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) policies. Staff were aware of their role under the Mental Health Act and ensured mental capacity assessments were carried out when a patient showed signs of lacking capacity. We saw examples of both DoLS and MCA assessments being completed appropriately. We spoke to staff and observed them following the procedure for DoLS on a patient that was required to wear special mittens to protect a patient from injuring themselves accidentally.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients’ religious, cultural and other needs.

Staff made sure patients had support with nutrition and hydration to meet their needs. Individuals were assessed to ensure the correct nutrition and hydration was in place to meet their ability and needs. Many patients were sedated, and we saw that appropriate measures were in place to support good hydration and nutrition. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Patient’s nutrition and hydration needs were assessed on admission and monitored using the Malnutrition Universal Screening Tool (MUST). Staff fully and accurately completed patients’ fluid and nutrition charts where appropriate and specialist support from staff such as dietitians, was available for patients who needed it.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff said they would also observe patients’ facial expressions, body language and a change in behaviour if they were unable to communicate with them. We saw patients’ pain levels being assessed using pain assessments tools, when appropriate to do so. Pain was assessed regularly, when the patient was able to indicate the level and scored on a scale from one to 10. We saw that patients with acute pain had plans appropriate to their condition and was monitored regularly. Patients received pain relief soon after it was identified they needed it and a specialist pain team was available to support the critical care staff in providing the best pain relief. Specialist pharmacy support was also available daily.

**Patient outcomes**

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The cardiothoracic critical care had introduced the process for collecting information to contribute to national audits. This was an improvement from the last inspection. Managers and staff used the results to improve patients’ outcomes. The service had two staff members that reviewed, managed and reported on data about patient outcomes. The data was used to produce reports for managers in critical care to help drive improvement within critical care. We examined data during inspection and found that there was improvement with the most recent information, when compared to the published data.
for 2017/18 below. The service had focused on managing the information to help drive improvement. We saw evidence that since February 2019, when the critical care unit combined with cardiothoracic critical care ward, the manager had developed a plan to improve patient outcomes, following a more shared and consistent approach. Local audits were completed to assess patient care, environment and cleanliness. We saw results from several, including pain relief and medication audits. Equipment safety checks were completed to ensure that unusable items were removed and replaced to provide access. A tracheostomy audit was in progress and the service was awaiting results. The service participated in relevant national clinical audits. The trust submitted data for its general critical care unit to the Intensive Care National Audit Research Centre (ICNARC) 2017/18, which meant that the outcomes of care delivered, and patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 Annual Report.

ICNARC results: General critical care unit, University Hospital Coventry
The table below summarises performance at the for the general critical care unit at University Hospital Coventry in the 2017/18 ICNARC Audit.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other units</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non-clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>0.4%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>1.6%</td>
<td>Within expected range</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than eight hours) (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td>0.7%</td>
<td>Not in the worst 5% of units</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio (all patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.1</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% (‘lower risk’ patients) (Risk-adjusted measures take into account the differences in the case-</td>
<td>1.0</td>
<td>Within expected limits</td>
<td>No current standard</td>
</tr>
</tbody>
</table>
ICNARC results: Cardiothoracic critical care unit, University Hospital Coventry

Data for the trust’s cardiothoracic critical care unit were not submitted to the 2017/18 ICNARC audit. However, the trust advised that they now submit data for this unit to the audit. Data for 2018/19 audit were supplied to us directly by the trust and can be seen below. It is expected that this data will be published in late November or December 2019. The table below summarises performance for the cardiothoracic critical care unit at University Hospital Coventry in the 2018/19 ICNARC Audit. This data is being used to form part of the current year’s information and is not indicative of a full 12 months data. It should be noted that the data for 2018/19 below were supplied to us directly by the trust.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other units</th>
<th>Met national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crude non-clinical transfers (Transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)</td>
<td>0.1%</td>
<td>Better than expected</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude, non-delayed, out-of-hours discharge to the ward proportion (Discharge out-of-hours is associated with increased risk of mortality)</td>
<td>0.4%</td>
<td>Better than expected</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than eight hours) (Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day)</td>
<td>0.4%</td>
<td>Not in the worst 5% of units</td>
<td>Did not meet</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio (all patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.22</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients) (Risk-adjusted measures take into account the differences in the case-mix of patients treated)</td>
<td>1.58</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

It should be noted that the comparisons shown in the table above are to all critical care units of all types that submit data to ICNARC, not only cardiothoracic critical care units. Therefore, a direct
comparison is difficult to establish from the current data. After the inspection, the trust told us that the cardiothoracic critical care specialty along with all specialties in the trust attended the Mortality Review Committee every six months to share learning from deaths and feedback from their QIPS or morbidity and mortality meetings. The specialty mortality profile (SMP) report that was presented by the specialty includes a peer comparison of mortality rates across other centres of similar type. After the core service inspection took place, the trust told us that cardiothoracic critical Care ICNARC data was discussed at Critical Care QIPS and was reported at the 25th October 2019 meeting. Cardiothoracic critical care staff attended the Mortality Review Committee on 28 October 2019 and shared the latest ICNARC data.
(Source: Intensive Care National Audit Research Centre (ICNARC))

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that had received an appraisal during the last 12 months. We saw data that had been collated to show which staff members had been appraised and when. The information we saw indicated that 98% of staff in critical care had received an appraisal. From May 2018 to April 2019, 94.4% of staff in critical care at University Hospital Coventry received an appraisal compared to a trust target of 90%. The breakdown by staff group is shown in the table below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals</td>
</tr>
<tr>
<td></td>
<td>received</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>216</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>5</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>235</td>
</tr>
</tbody>
</table>

The 90% completion target was met for qualified nurses but was not met for administrative and clerical or additional clinical services staff. However, at the time of inspection we saw plans were in place to improve this.
(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff an induction tailored to their role before they started work. We spoke with staff that had received induction on critical care that described it as a full and thorough induction. Staff on induction were spare and not included in the staffing figures for the unit. The service had introduced dedicated clinical educators to support staff development and manage mandatory training. The clinical educators supported the learning and development needs of staff. Staff told us that there had been an increase in support to get training and that personal development was treated as a priority. Clinical educators were given protected time each month to monitor and manage nurse staff training. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us that they attended meetings when on duty and that notes were available if they were not. The manager was proactive in getting staff to attend meetings and used the email system to reinforce the requirement to attend. Staff would be reminded and if unable to attend they were sent an email with the notes.
Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Nurses and allied health professionals told us that they had regular discussions with the clinical educators to ensure that training was up to date. Line managers were involved in the training planning and discussions were had during one to one meetings and appraisals. New starters were given six weeks where they were not included in the staffing numbers, to support the induction process. This could be extended if required.

Training and development lead nurses shared responsibility to ensure that critical care staff were supported in the appropriate training. This included the skills required for cardiothoracic critical care. Managers made sure staff received any specialist training for their role.

As of June 2019, the trust reported that 101 out of 219 qualified nursing staff in critical care at University Hospital Coventry (46.1%) had a post registration award in critical care nursing. This included 73 out of 161 qualified nurses (45.3%) on the general critical care unit and 28 out of 58 (48.3%) on the cardiothoracic critical care unit. Therefore, both units did not meet the Faculty of Intensive Care Medicine’s standard that a minimum of 50% of registered nursing staff should be in possession of a post registration award in critical care nursing. Managers had recognised the shortfall from the target of 50% and had plans to increase the availability of qualified nurses. We saw an action plan that included an increase in training available to staff and a recruitment and retention initiative to try and redress the balance. We were told that a number of qualified staff had moved to new posts, as part of their development and this had been a factor in the numbers being lower than the target of 50%.

At the time of inspection, the Matron shared information that indicated the percentage had increased to 48% from the 45.3% in June 2019 and was on target to reach the required 50%, by December 2019. All 219 qualified nursing staff across both units had training in specialised equipment. However, none of the six unqualified nursing staff on the general critical care unit, or the 11 unqualified nursing staff on the cardiothoracic critical care unit, had training in specialised equipment. However, we saw that unqualified staff were being included in the training plans for the service and the training levels were predicted to improve. (Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)

On inspection, we saw the training plans and clinical educators told us, that all critical care staff were now included in training and development, appropriate to their roles. This included the unit receptionist and administration staff.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multi-disciplinary meetings to discuss patients and improve their care. We saw an improvement of multi-disciplinary team working from the last inspection. Meetings were consultant led and specialists were involved in meetings to discuss patient care. Throughout the inspection, we saw multidisciplinary team (MDT) working practices were established and teams worked well together to improve care. We observed four different handover meetings on different days and at different times. The times for the meetings were set and completed seven days a week. They included all staff involved in patient care. We saw input from doctors, nurses, physiotherapists and dietitians in the discussions about patient progress and palliative care specialist when appropriate. We saw dedicated pharmacy staff visited critical care daily and were available to support at team meetings and handover meetings. Staff worked across
health care disciplines and with other agencies when required to care for patients. On one occasion we saw prison service staff included in the discussions about a patient they were supervising in the critical care ward.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Staff told us that the rota was managed well to ensure that there was appropriate medical cover seven days a week. This included consultants being available to lead ward rounds and supervise patient care. Appropriate on call arrangements were in place to cover at all times. Pharmacy support was available six days a week and the service are reviewing provision to increase this. Critical care had a named pharmacist to ensure consistency and develop good continuity of care for patients. On call pharmacist support could also be accessed if required. A pressure injury manager was available seven days a week to support in the management of pressure ulcers. Patients had access to the therapy team based in critical care, seven days a week from 8:00am – 8:00pm and on call overnight.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient’s health when admitted and patients or families, needing extra support, were identified, included those people near to the end of their lives. Advice and support about managing a healthier lifestyle, was available for all patients when leaving the critical care unit. There were leaflets and contact details of relevant organisations to offer support and advice to patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe the process for completing a mental capacity assessment and assessment for a patient’s best interest. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients’ records. We saw that consent was gained for those patients that were able to. However, when patients could not give consent, staff made decisions in their best interest, considering patients’ wishes, culture and traditions. This was always done in collaboration with the patient’s next of kin, or carer, if appropriate.

Mental Capacity Act and Deprivation of Liberty training completion

Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is not currently included in the trust's mandatory training. The trust reported that it was planning to introduce mandatory training in MCA and DoLS for registered practitioners and medical staff by September 2020. This will be included in a new mandatory safeguarding adults’ level 3 training module. The trust also reported that in the meantime the trust’s safeguarding team had been providing MCA training to priority staff groups since September 2018.
Staff understood the relevant consent and decision-making requirements of legislation and guidance. They demonstrated a good knowledge of managing patients that lacked capacity or could not communicate well and always provided care in the best interest of the patient. We saw the best interests of a patient being discussed at a staff huddle. This was recorded appropriately on patient records. Handovers took place at shift changes and patients’ best interests were discussed. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff implemented DoLS in line with approved documentation. We saw examples of when DoLS was used to apply protective mittens on a patient to reduce the risk of harm whilst they were sedated.

**Is the service caring?**

**Compassionate care**

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff genuinely cared about their patients, their relatives and carers. We saw a consistent, compassionate approach to patients and nurses talked to them even when sedated. They were mindful of others around and on one occasion we saw a nurse comforting a patient that appeared distressed by the noise coming from another bay. We observed staff introducing themselves to patients and explaining what their role was. Staff names were displayed on their uniforms and first or preferred names were used with patients. Friends and family test and local compliance audits indicate high levels of satisfaction from patients and families. We saw compliments displayed which praised staff for their high level of care and support for patients in difficult circumstances.

Patients said staff treated them well and with kindness. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Comments had been displayed on the unit’s “pride tree” indicating positive experiences. We spoke with four visitors who told us that the staff were kind and demonstrated “excellent” care. Staff followed policy to keep patient care and treatment confidential. Staff ensured patients’ privacy and dignity was respected during physical and intimate care. They drew curtains around bed spaces, when intimate care was being provided to the patient and when family members asked for privacy. Discussions could be taken away from the ward area and there were rooms available to facilitate. Side rooms could be utilised for patients that may need extra privacy or were at risk of infection. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for with mental health needs. We saw examples when staff were caring for vulnerable patients with compassion and kindness, taking care to support those with temporary or long-term mental impairment.

After the inspection, the trust told us that staff in critical care offered a ‘goody bag’ for visitors which included toiletries for when visitors stayed in one of the family rooms available. Trust volunteers were also on hand at main reception to support visitors.

**Emotional support**

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.
Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients and family members told us they felt involved in the care and treatment and staff took time to explain what was happening and why. Staff took care when explaining difficult situations and supported family in coming to terms with bad news. Support was available from the chaplaincy service which was available at any time. Members of different faith groups would attend the unit to support patients and family according to their belief. We saw staff comforting a family member of a patient that was end of life. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a patient being supported when they became distressed. The patient was unable to speak but staff recognised they needed help and intervened. Staff used calm words and hand signals to help reassure the patient. The curtain was pulled around the bed to offer a safer environment.

**Understanding and involvement of patients and those close to them**

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed conversations between staff and patients and noted that technical language was kept to a minimum and patients were invited to ask questions at every opportunity. Patients’ relatives and carers were informed of what was happening to their relatives and involved in their care. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We were told that systems were in place to identify and support the communication needs of patients, which included interpreters, specialist advice or advocates, such as chaplaincy team. We saw a patient communicating with staff by using a note pad, due to being unable to speak. Staff would also use signs or hand signals to help communicate better.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The unit had introduced a method to feedback messages by adding to the pride tree, displayed on a wall. This open to anyone to add a comment to be displayed. These were mostly positive comments; however, patients and families were encouraged to contribute. Concerns were discussed openly with staff and the process to escalate a concern was made clear. Patients gave positive feedback about the service. We saw several cards, comments displayed and gifts that had been given by former patients to the unit. Patients we were able to talk to give positive feedback about their stay in the critical care unit.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Critical care provision on the unit flexed to meet the differing needs of level two and level three patients. The critical care outreach team reviewed all patients on the wards who were discharged from intensive care. Follow up appointments were arranged and post critical care support was available to all patients discharged. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Staff made it a priority to monitor and manage patients to avoid same sex breaches. If they occurred, staff would report them using the electronic reporting system, but they told us that the senior nurses were vigilant and aimed to predict any potential risks, to avoid breaches. Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional
support or specialist intervention. The critical care unit was designed in accordance with the relevant guidelines. Access to the unit was restricted and a reception area was available. There was good access available for wheelchair users and people using walking aids. Areas were available for private conversations to take place between staff and visitors.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community. There were a wide range of leaflets and information available which reflected the community. Patients and families could access interpreter or translation services if required. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreter services were available, and staff could explain the process to request them. Patients were given a choice of food and drink to meet their cultural and religious preferences. Where appropriate, diverse and varied options were given to patients to meet their preferred needs. Dietary needs were discussed as part of the discharge planning for patients.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

The unit had a policy outlining the process to facilitate admissions and transfers. Admissions from emergency departments were prioritised. During the inspection, we observed four patients’ admissions to critical care following arrival to hospital by helicopter transfer. Staff were proactive in ensuring timely admission of patients to receive the best care. This involved the review of patients and appropriate move made to the cardiothoracic critical care ward to create spaces. This flexible approach ensured patients were kept safe and admitted in a timely manner.

Managers monitored waiting times and made sure patients could access appropriate services when needed and received treatment within agreed timeframes and national targets. Patients came straight from theatre to the unit, following surgery, there were no patients being cared for in theatre recovery areas during our inspection. Staff told us that they would review all patients and endeavour not to allow patients to wait in recovery before being admitted to critical care. There was a system where two beds within critical care were kept clear and flexed to ensure that patients could receive the right level of care without delay.

Emergency patients were prioritised for admission, followed by admissions from other wards in the hospital. Managers and staff worked to make sure patients did not stay longer than they needed to. Managers told us that appropriate discharge was a priority but could be delayed due to lack of suitable beds on other areas. During the inspection we saw that flow had been disrupted because the lack of suitable beds, for four patients. These were patients that could not be moved from critical care due to complications with their care. They were continually assessed.
for the level of care required and managed appropriately. This was a difficult area to manage because of the complex care needs, often requiring prolonged critical care, of the patients being admitted through the emergency department. Complications post cardiothoracic surgery, could also result in prolonged stays in critical care and higher bed occupancy rates. The service managed these difficulties well. From July 2018 to June 2019, the trust’s adult critical care bed occupancy was consistently higher than the England average. The occupancy rate varied from 86.5% in August 2018 to 100% in July and November 2018 and January 2019.

Adult critical care bed occupancy rates, University Hospital Coventry and Warwickshire NHS Trust.

Note data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month. 
(Source: NHS England)

The Faculty of Intensive Care Medicine Core Standards state that discharges from a critical care unit should occur within four hours of the decision. Although we saw data which confirmed this did not always occur, the number of patients who were discharged after four hours was low. Critical care managers acknowledged that there were delays, however, priority was given to the patient needs and support for patients, if a step-down bed was not available. We found on inspection that step-down places were managed well and patients were not delayed in discharge from the critical care unit. Priority was given to discharge planning and staff would ensure that three beds were identified and made suitable, each night, to assist in managing the flow of discharged patients. Staff did not move patients between wards at night unless there was an identified clinical need identified following an MDT.

Learning from complaints and concerns
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

We spoke to visitors who told us they felt comfortable in approaching staff to raise any concerns or questions. They knew the procedure for making formal complaints, in writing, but those we talked with said that it would be a rare occurrence. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Patients, relatives and carers knew how to complain or raise concerns. We found information leaflets about raising concerns and complaints available in the reception area. The service clearly displayed information about how to raise concerns. We saw posters displaying information for anyone to complain through the patient liaison services.
Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared appropriately with all staff on the critical care unit. Staff understood the policy on complaints and knew how to handle them. They told us that complaints were discussed in meetings to try and learn from them. We were told by some staff that they could not recall the last complaint made because there seemed to be so few about critical care. Learning from complaints in other areas was sometimes shared with critical care staff at meetings. Patients were involved in any investigations that took place and families notified where appropriate. We saw an example where duty of candour had taken place and the patient and family had been involved in the investigation.

From May 2018 to April 2019, the trust received two complaints about critical care at University Hospital Coventry (0.3% of total complaints received by the hospital). One of the two complaints had already been closed at the time of data submission. The trust took 67 working days to investigate and close this complaint. This was longer than the trust’s target of 25 working days. The other complaint was still open at the time of data submission. This complaint had been open for 65 working days. This was also longer than the trust’s target of 25 working days for general complaints and just over the target of 60 days for complex complaints. At the time of inspection, we saw that there were no complaints related to the critical care and historical ones were completed appropriately. Both complaints concerned the general critical care unit. One related to “patient care” and the other “clinical treatment”.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Critical care managers told us that although complaints were low in number, they had been made a priority and were reviewed weekly along with the unit risk register. This was put in place following delays in closing previous complaints. At the time of inspection there were no complaints open for the critical care unit.

From May 2018 to April 2019, the trust received 235 compliments about its critical care services at University Hospital Coventry. We saw that the team had received several compliment cards and some gifts in appreciation of their care for patients. Individuals had also received thank you cards from families and former patients. Many of the acknowledgements were displayed on the pride tree located near the entrance to the unit. The trust noted that the main theme arising from 1,600 compliments received across the trust over the same 12-month period were how well staff demonstrated the trust’s values, particularly compassion, pride and respect. Recent compliments mentioned the professionalism and responsiveness of their staff. This also applied to compliments for the staff in critical care.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

<table>
<thead>
<tr>
<th>Is the service well-led?</th>
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**Leadership**

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles. They were supportive and demonstrated clear vision for the improvement of the service.

The service was managed locally by a matron, consultants for general critical care and cardiothoracic surgeons that supported with specialist critical care. This leadership team had
formed to cover all critical care as part of the plan to create one service. Historically the cardiothoracic critical care ward had been managed as a separate ward which led to inconsistencies. We found that the team was cohesive and consistent to their approach to critical care. This was an improvement from previous inspections. Staff told us that the senior team visited the unit and were approachable by any member of staff. We saw that local leadership was supportive of all staff and the matron was described as “brilliant”. They had extensive experience within critical care and had developed a cohesive team across the two locations. The matron was knowledgeable about the unit’s performance against the required standards and was proactive in developing actions to improve learning from incident. Consultants were actively involved in discussions about patient care and led daily MDT meetings where all were able to contribute. We observed a positive relationship between the leadership team. Junior doctors told us that the consultants were always available for support and guidance and that they were passionate about providing good care. After the inspection, the trust told us that clinical group senior leadership team which oversaw critical care services had developed, and successfully implemented, a ‘Joint Model of Care’ which was formally approved by the trusts’ chief officer group on the 14th May 2019. The joint model of care formally brought together General Critical Care and Cardio Thoracic Critical Care services to improve the clinical care pathway for cardio thoracic patients where patient care was jointly led by a cardiac surgeon and intensivist. A team of middle grades doctors provided supporting care across both departments on a rotational basis 24 hours a day dependent upon individual competencies. The joint model of care was underpinned by standardised processes and documentation which has been in place since June 2019.

Vision and strategy
The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Staff were aware of the trust values and strategy. The trust vision, mission statement and values were all visible in the unit or reception areas. The vision to become national and international leaders in healthcare was clearly understood by the staff we spoke to. Everyone could describe the mission statement to care, achieve and innovate and clearly demonstrated this in their work on the critical care unit. We saw a motivated and positive team of professionals that were putting patient safety and care at the forefront of their work. We found that the vision to create one supportive critical care unit had been achieved by introducing process to combine staff groups and support them in developing skills across the service. We saw that staff would be versatile in covering different specialities within critical care and open to developing skills to ensure a higher quality of care was achieved. Leaders demonstrated support for this vision and had developed process to aid the transformation. For example, a process to rotate staff across different areas, between the two locations, was in place and overseen by senior staff. Quality improvement initiatives had been set up to support the aim to improve critical care at the hospital.

Culture
Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
There was an open culture and staff could raise concerns to senior management. There were opportunities to make suggestions and to contribute in quality improvement initiatives. Incident reporting systems were used appropriately, and staff received feedback. This helped to create a culture of openness. We observed good interactions between doctors, nurses and other allied health professionals. This extended to patients and family members. The cardio-thoracic critical care ward, although located separately, was managed as part of one critical care service provided by the trust. Staff told us that a positive culture existed and that the combining of two wards had been successful. Staff were supportive of each other regardless of position within the team. We were told by all staff that they were proud to be part of the critical care team. Staff were open and honest during our inspection and spoke freely about the challenges to providing safe and high-quality care and keen to talk about the successes achieved, particularly since the integration of the two wards. A plan had been introduced to rotate staff between the two critical care wards, enabling staff to become familiar with the differences between cardiothoracic and general critical care. This allowed greater opportunity for personal development and assisted in creating a one-unit approach to critical care. The unit celebrated the achievements and hard work of staff and we saw that two of the critical care team had received trust awards. There was a team award given to all staff on the unit. After the inspection, the trust told us it was proud of its’ critical care service’s promotion of a culture of ‘Kaizen’ (Continuous Improvement) and openness. The trust’s Kaizen culture and the ‘pride tree’ system also supported people to express their views and could be actively involved in making decisions about their care, treatment and support.

**Governance**

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

The service contributed to monthly governance and risk meetings that formed part of the overall trust governance report for board. Meetings were used to review incident data, investigations and departmental risks. Actions were developed to support learning and quality improvement, which was communicated to staff by recorded notes from the meetings. Information was shared with critical care staff at regular safety huddles and handover meetings. The unit held daily meetings with the clinical lead, matron, senior staff and MDT team to discuss staffing for the next day and any admission or discharge issues. We saw that several patients had been on the unit for a longer period than expected and these were discussed during the meeting to provide accurate updates. We saw that the service adhered to local policies and national guidelines that would be accessed through the trust intranet. Staff at all levels were clear about their roles and understood what they were accountable for within critical care unit.

**Management of risk, issues and performance**

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

We saw the governance minutes for July, August and September 2019, which noted discussions on serious incidents and risk. We saw a sample of minutes from the critical care pressure ulcer summit, which had been introduced to address historical issues around pressure injuries. Action plans were available from meetings which identified ownership of action and completion dates. The service had an electronic based risk register in place, that detailed the risks to the service,
actions to mitigate risks, a risk level, a risk owner and a review date. Risks were owned by senior staff and the risks we reviewed were managed effectively. The matron reviewed the risks weekly and escalated concerns appropriately. Monthly meetings were held to discuss risk and progress of action plans relating to the unit. We saw minutes from meetings indicating the monitoring of the risks within critical care. The risk register was for the whole of critical care and included the cardio-thoracic critical care unit, which historically had been managed separately. Risks were discussed regularly at daily briefings and all staff were aware of the risks identified within the critical care unit. There were examples of initiatives on the unit to improve patient care, such as the introduction of daily skin assessments for all patients, to manage the risk of pressure injuries. We saw that new types of collars had been introduced to reduce the risk to patients and padding added to equipment such as nasal tubes.

Information management
The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a wide range of information available to enable managers to assess and understand performance in relation to quality, safety, patient experience, human resources, operational performance and finances. Staff had good knowledge of performance and demonstrated enthusiasm in applying techniques to improve the unit’s performance. Information was shared appropriately and securely with electronic systems requiring password access. Sensitive information was only made available to appropriate people and secured when not in use. For example, computers were locked or switched off when unattended. The service used a combination of paper and electronic patient records and written records were being scanned to add to the electronic system. We saw a therapy information notice board that included training compliance as 100% for therapy staff. There was also details of plans for the week ahead and names of nominated staff for trust awards.

Engagement
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Staff said that communication had improved, particularly since the introduction of one matron across the two critical care wards and forming the one critical care unit. There was more engagement and ownership of the issues across all professional groups and the team ethos had developed and strengthened since February 2019. Patients and families said that they were well informed about their care and that communication between staff was appropriate. We saw information being shared through published notes and minutes from meetings were made available to staff on the unit. Staff told us that they felt part of the unit and could contribute to the decisions being made to improve quality of care. Information was appropriately displayed throughout the unit and reception area and visitors could access a receptionist to ask questions. We found appropriate information was shared with patients, to promote services in the community that could benefit recovery. For example, community counselling services and well-being groups. Clinics were facilitated by two specialist nurses to support families with bereavement.

Learning, continuous improvement and innovation
All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in quality improvement.

The service subscribed and took part in the Virginia Mason methodology of quality improvement initiatives which had been developed through a 5-year collaboration between NHS Improvement and the Virginia Mason Institute in Seattle, America, taking the lean improvement method from manufacturing and applying it to healthcare. This was a trust wide asset that supported staff to understand and develop good quality improvement. This was the trust’s UHCWi quality improvement programme.

As part of a quality improvement initiative, the service had introduced several projects. Examples include, staff support meetings which are nurse led and provide the opportunity for any member of the team to discuss difficult and traumatic situations that have occurred.

A manager has been designated to oversee skin integrity daily, for patients across the service. This allowed staff to escalate specific pressure injury concerns to an appropriate person immediately and swift intervention could take place if required. There was a named “Pressure Ulcer Manager of the Day” (PUMOD).

A “pride tree” had been created to decorate a wall within the critical care unit. This had been developed by two nurses and allowed staff, patients and visitors to display comments about what made them proud and to share success.

In all the cases we saw, protected time had been given for staff to develop and facilitate these projects. Senior nurses would allocate cover for clinical duties or stand in, if required, to ensure that the staff had time to complete these tasks.

An intensive training programme that staff affectionately called “boot camp”, had been introduced to enable staff development to be focused on and for the service to attain high standards, by making learning available. This is an intense training session that covers key skills for nurses and allows focus on priority learning. Staff told us that it worked well and benefitted their roles.

We saw a notice board that listed some issues that were described as “rocks in our shoes”. There were four points on the board and each had an action with a staff member named for implementing the change. All the “rocks” or issues were identified by the staff on critical care and discussed at staff huddles and team meetings.

The service had introduced a process for investigating lower grade pressure injuries, to identify risks and prevent escalation of the injury. We saw information relating to increased risks with specific equipment that may cause a pressure injury. A chart is attached to equipment to help promote awareness of the risks. This has been shared through the tissue viability network.

Two members of staff had won awards for services to patients within this core service. The awards were:

- the DAISY award in recognition of outstanding compassionate care by nursing staff to patients, and
- Together Towards World Class Colleague award for Compassionate Care.

After the inspection, the trust told us that the service was part of the “Pathway to Excellence, Ward/department accreditation” work which was focused on delivering the trust strategic objective of safest patient care and excellent patient experience. The pathway to excellence provided staff with more opportunities of leadership, shared decision making, professional development and welfare. In turn, patient standards would be more visible, more often with particular emphasis on excellent safety, care, and dignity.
Facts and data about this service

The maternity service at University Hospital Coventry has 78 inpatient beds (including couches and birthing pools) located across five wards and units:

<table>
<thead>
<tr>
<th>Ward/unit</th>
<th>Inpatient beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foetal well-being unit, Ward 24, West Wing (day case service)</td>
<td>Four couches</td>
</tr>
<tr>
<td>Labour ward</td>
<td>15</td>
</tr>
<tr>
<td>Midwifery led unit</td>
<td>Four static birthing pools and one birthing couch</td>
</tr>
<tr>
<td>Ward 24 – antenatal</td>
<td>20</td>
</tr>
<tr>
<td>Ward 25 – postnatal</td>
<td>34</td>
</tr>
</tbody>
</table>

In addition, there are two maternity outpatient clinics located at the hospital:
- Antenatal and gynaecology.
- Foetal medicine.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

From January 2018 to December 2018 there were 5,591 deliveries at the trust. A comparison from the number of deliveries at the trust and the national totals during this period is shown below.

Number of deliveries at University Hospital Coventry and Warwickshire NHS Trust – Comparison with other trusts in England.

(Source: Hospital Episode Statistics (HES))

A profile of all deliveries and gestation periods from January to December 2018 can be seen in the tables below.
Notes: A single birth includes any delivery where there is no indication of a multiple birth. This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.

At this trust there were no deliveries where gestation periods were unrecorded. This compared with 18.7% nationally.
(Source: Hospital Episodes Statistics (HES))

Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff, and most staff had completed it.

Not all staff always kept up to date with their mandatory training. For example, not all staff were up to date with their neonatal life support training. This meant not all staff had completed the training that the trust determined to be essential for safe and efficient practice, to reduce organisational risks and to ensure staff complied with policies and regulatory requirements.

Mandatory training completion rates

The trust set a target of 95% for completion of mandatory training.

A breakdown of compliance for mandatory training courses as of April 2019 at trust level for qualified nursing and midwifery staff in maternity at University Hospital Coventry is shown below:
In maternity at University Hospital Coventry the 95% target was met for seven of the 17 mandatory training modules for which qualified nursing and midwifery staff were eligible.

A breakdown of compliance for mandatory training courses as of April 2019 for medical staff in maternity and gynaecology at University Hospital Coventry is shown below. It should be noted that medical staff at the trust work across maternity and gynaecology.

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous thromboembolism</td>
<td>Staff trained</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>22</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>24</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>23</td>
</tr>
<tr>
<td>Information governance</td>
<td>19</td>
</tr>
<tr>
<td>Fire safety - annual</td>
<td>19</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>16</td>
</tr>
<tr>
<td>NPSA collection and transportation of blood and blood products</td>
<td>123</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>124</td>
</tr>
<tr>
<td>NPSA obtaining venous blood</td>
<td>151</td>
</tr>
<tr>
<td>Neonatal life support update</td>
<td>151</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>151</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>26</td>
</tr>
<tr>
<td>Neonatal life support update</td>
<td>19</td>
</tr>
<tr>
<td>Manual handling - object</td>
<td>19</td>
</tr>
</tbody>
</table>

In maternity at University Hospital Coventry the 95% target was met for eight of the 12 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)
The mandatory training was comprehensive and met the needs of women and staff. The training included a wide range of modules designed to keep patients and staff safe, as well as making sure staff knew how to use systems within the trust. These included environmental, professional, and legal aspects that impact on the midwife’s role, how to carry out appropriate risk assessments, antenatal screening including foetal/neonatal health assessment, and management of women in crisis.

The midwifery practice facilitator was responsible for co-ordinating staff training. Staff completed their mandatory training through face-to-face sessions and online courses. However, some staff told us they still had to complete elements of mandatory training at home in their own time such as the K2 package. Some staff also said they had to complete training in between patients on quieter shifts. This meant not all staff had protected time to complete their mandatory training.

Midwives completed specialised midwifery training. They completed Practical Obstetric Multi-Professional Training (PROMPT). This was an evidence-based training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve staff knowledge, clinical skills and team working. As of August 2019, the unit had achieved 90% compliance. Action plans were put in place to maintain compliance. For example, in September 2019, extra sessions were planned to train new doctors.

During our previous inspection in 2018, we found effective systems were not in place regarding cardiotocography (CTG) monitoring to ensure it was carried out in line with trust procedures. Cardiotocography is a technical means of recording the foetal heartbeat and the uterine contractions during pregnancy. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic foetal monitor. To achieve compliance with Saving Babies Lives Care Bundle Version 2, the trust was required to provide assurance that staff who attended to women in labour could demonstrate competency in interpretation and escalation of concerns surrounding CTG monitoring. The second version of the Saving Babies’ Lives Care Bundle heralds a significant commitment to meet the national ambition set by the Secretary of State, to achieve a 50% reduction in the rate of pre-term and stillbirths in the UK by 2025. Relevant staff within maternity services could access CTG training and competency assessments through the K2 CTG Perinatal Training Programme. This process enabled staff to complete required training modules that incorporated a competency test. Between April and August 2019, staff compliance with the training ranged from 95% to 99%.

Clinical staff completed training on recognising and responding to women with mental health needs, learning disabilities, autism and dementia. Managers monitored mandatory training and alerted staff when they needed to update their training. For example, areas of non-compliance or concern were escalated to line managers and matrons, training compliance was added to the group risk register and focussed sessions were delivered within the clinical areas by the maternity training team to increase compliance.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had training on how to recognise and report abuse, and they knew how to apply it.

Most staff were up-to-date with safeguarding training. All staff we spoke with had the knowledge and skills to confidently deal with safeguarding issues. Nursing and midwifery staff received training specific for their role on how to recognise and report abuse. The trust has a safeguarding training strategy in place, in accordance with which all new staff received Level 2 safeguarding
training as part of the trust induction programme. All new staff were required to undergo a training needs analysis within eight weeks of appointment to identify the need for Level 2 or 3 Safeguarding training, with refresher training every three years. The trust monitored compliance with these requirements through regular review of training data. The trust set a target of 95% for completion of safeguarding training. The tables below include preventing radicalisation training as a safeguarding course. This training module works to stop individuals from getting involved or supporting terrorism or extremist activity.

A breakdown of compliance for safeguarding training courses as of April 2019 for qualified nursing and midwifery staff in maternity at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>5</td>
<td>5</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>196</td>
<td>197</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>192</td>
<td>193</td>
<td>99.5%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>191</td>
<td>197</td>
<td>97.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>178</td>
<td>192</td>
<td>92.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>12</td>
<td>13</td>
<td>92.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

At University Hospital Coventry, the 95% target was met for four of the six safeguarding training modules for which qualified nursing and midwifery staff were eligible.

Medical staff received training specific for their role on how to recognise and report abuse. This meant they had the competencies to recognise child maltreatment, recognised opportunities to improve childhood wellbeing, and to take effective action as appropriate to their role. A breakdown of compliance for safeguarding training courses as of April 2019 for medical staff in maternity and gynaecology at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th></th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 3</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>8</td>
<td>12</td>
<td>66.7%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In maternity at University Hospital Coventry, the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

As of October 2019, medical staff compliance with safeguarding training was:
Staff could give examples of how to protect women from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff treated all patients the same regardless of different characteristics such as their age, disability, race, religion or belief. We spoke to patients of all ages and ethnicities and all were positive about the care they received. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. For example, they understood that women involved in risk activities such as substance misuse, those with perinatal/mental illness or support needs and victims or perpetrators of domestic abuse may constitute a safeguarding concern for mother and or the unborn baby.

Effective arrangements were in place to safeguard women with or at risk of female genital mutilation (FGM) and these were in line with national guidance including DH Female Genital Mutilation and Safeguarding: guidance for professional's, March 2015. All suspected cases of FGM or concerns whereby the individual was under 18 years of age, were referred to the police or children's social care service according to statutory guidance. This was recorded by the safeguarding team and evidenced through an electronic database. The Department of Health (DoH) database was updated of any identified cases of FGM. Within maternity services where the majority of FGM was diagnosed the DoH risk assessment tool was utilised to assess risk to any female informants / children and there was a well embedded information sharing process between midwives, GPs and health visitors. FGM featured as a regular training topic in the trust and they started using the FGM RIS (Risk Indicator System) in 2018, which was an IT system used to aid information sharing. A risk indicator was placed on a new-born female's records if born to a mother who had been subject to FGM. This was done by a named midwife who supported the specialist FGM antenatal clinic but was supported by the safeguarding team.

The safeguarding midwife worked closely alongside other safeguarding professionals such as the lead professional for safeguarding, the named nurse for safeguarding adults and support nurses for safeguarding adults. The team was co-located, and this allowed for seamless safeguarding advice and support to be available to maternity staff.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff said they would contact the trust safeguarding team if they needed advice or support. They provided a high level of expertise, support and guidance to staff and provided professional leadership for in all matters pertaining to safeguarding children and adults. They supported staff in effective decision making. The named midwife ensured that the trust met its statutory obligation to safeguard and promote the welfare of all pregnant women and the unborn, children and young people who accessed services from within the trust.

The service had appropriate support systems in place for vulnerable patients. For example, specialised midwives provided tailored care, support, and treatment for women such as those with
mental health concerns and teenagers. Staff discussed safeguarding concerns during handovers. Community staff discussed current safeguarding cases at multidisciplinary GP and health visitor meetings to ensure all parties were fully up-to-date. Acute hospital staff said when they raised safeguarding concerns community staff acted promptly and carried out a home visit and referred to partner agencies such as the police or social services when necessary.

Community midwives were provided with regular child protection supervision. This promoted good standards of practice and contributed to improved outcomes for vulnerable children and young people and their families. Staff followed safe procedures for children visiting the ward. Visitors gained access to the delivery suite and the maternity wards via an intercom and buzzer system. Security cameras were in place at the entrance to each area of the department. Patients’ own children could visit; however, no other children were allowed.

Staff followed the baby abduction policy and undertook baby abduction drills. All babies were electronically tagged, and labels and tags were checked daily. Tags were removed as part of the discharge process. All staff were trained and aware of the ‘baby tagging COP’. Risk assessments were in place for babies that had social or safeguarding concerns and babies in cots were always tagged. All areas had restricted access with auditory and visual monitors. However, the trust policy surrounding procedures following baby/child abduction or missing child was now out of date. This was identified on the risk register and was being actioned. Women and babies were protected against inappropriate or unsuitable staff. In accordance with the trust’s criminal records disclosure and pre and post-employment checks policy a criminal records bureau check was carried out for all staff employees prior to their appointment. To ensure maximum security of new born babies and fire safety within the unit, only two members of family or friends were permitted to visit at any one time.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Surfaces and furniture were durable and easily cleaned which minimised the chance of bacteria to thrive and be spread from one person to another. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff using infection prevention control techniques to prevent the spread of infection such as hand-washing, use of antibacterial hand gel and personal protective equipment such as gloves and aprons. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaned equipment was labelled with a green’ I am clean’ stickers. Cleaning wipes were available with all mobile equipment to ensure staff decontaminated equipment after each use. There had been no cases of Clostridium Difficile, MRSA, or MSSA. Selective patients were screened for MRSA dependent upon whether they had been transferred from another healthcare setting and if they were receiving an elective procedure. This was in line with the trust’s guidance for screening of MRSA and national recommendations. Staff flushed out the birthing pools daily. This prevented infection build up. Staff also followed a specific cleaning regime for the pools following each use. The inpatient environment supported staff to minimise the risk of the spread of infection between patients. Isolation rooms were available should they be required for patients with infectious diseases. The service’s infection control scorecard for October 2019 showed good compliance:
Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Women could reach call bells and staff responded quickly when called. Patients and women, we spoke with said staff attended to their needs in a timely way. The design of the environment followed national guidance. Staff ensured both patients and visitors were kept safe on the inpatient and community areas. Visitors gained access to the delivery suite and the maternity wards via an intercom and buzzer system. Staff had swipe card access to gain entry to the department. Security cameras were in place at the entrance to each area of the department. The obstetric theatres and neonatal unit were located close to the delivery suite.

Staff carried out daily safety checks of specialist equipment. Staff checked resuscitation trolleys and defibrillators were safe to use in line with Resuscitation (UK) guidance. Each trolley had a standardised equipment checklist, which was simple, easy to follow and complete. This ensured trolley checks were consistent and easy to audit. This was in line with Resuscitation (UK) guidance which states, ‘All clinical service providers must ensure that their staff have immediate access to appropriate resuscitation equipment and drugs to facilitate rapid resuscitation of the patient in cardiorespiratory arrest’. The service had suitable facilities to meet the needs of women’s families. The day room was well equipped and has facilities for patients and their families to use during their stay. However, the bereavement rooms were not situated separately to the rest of the unit which meant recently bereaved parents might encounter new-born babies. This could prove upsetting for bereaved women and their families. This was recorded on the risk register and there are well developed plans for a new bereavement room to be built. We were advised that to manage the risk in the meantime, bereaved mothers were placed away from new-born babies. A dandelion was placed on the door of the rooms so that staff could bring meals to the women without them having to walk through any ward area. We saw partners and family members provided with chairs at the women’s bedside tables.

The service had enough suitable equipment to help them to safely care for women and babies. Midwives said they had access to the equipment they needed including foetal monitoring.
machines, breast feeding pumps and resuscitators. However, some equipment in the scanning department was out of date. We raised this at the time and staff addressed this immediately. Staff disposed of clinical waste safely. The service had systems for managing waste and clinical specimens across all locations. This included classification, segregation, storage, labelling, handling and, where appropriate, treatment and disposal of waste. The environment supported the timely transfer of patients to emergency units. The delivery suite was located near the obstetric theatres and neonatal unit.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each woman and took action to remove or minimise risks. Staff identified and quickly acted upon women at risk of deterioration.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff knew about the process of dealing with a patient whose condition had deteriorated. The procedure for escalation depended on the level of the problem but varied from seeking advice from managers or facilitating immediate admission to the acute department at the trust. Midwives and support workers monitored vital signs for new-borns and mothers as clinically required and took time-appropriate action(s) to prevent an avoidable deterioration in a patient.

Staff used the modified early obstetric warning (MEOWS) score. These were audited to ensure compliance. As part of the manager’s standard work, record keeping audits were completed regularly. The results of these audits had not identified any themes of concerns or incidents affecting patient care. However, the service recognised the need to move to an electronic method of observation recording to enable more effective and timely recording of observations and calculation of MEOWS Scores improving responsiveness to patients requiring escalation or repeat observations. The department recognised the benefit of VitalPAC across the organisation and have therefore submitted a case for this to be implemented within maternity. It is already in use in gynaecology. (Source DR:67)

Staff knew how to provide airway support to resuscitation to new-born babies and adults. Staff completed annual new-born life support training and adult resuscitation training as part of the specialised midwifery training. Staff completed risk assessments for each woman on admission / arrival and updated them when necessary and used recognised tools. Midwives performed a thorough risk assessment at the booking appointment. The risk assessment informed discussion with the woman regarding her options in relation to her maternity care; including her plan of antenatal care, and appropriate place of birth. Women were risk assessed for issues such as raised body mass index (BMI), gestational diabetes, and smoking in line with national guidelines.

Staff knew about and dealt with any specific risk issues. Staff discussed missed venous thromboembolism incidents during the maternity safety champions meetings. As of September 2019, there were 18 incidents in the previous year. Action plans had been put in place to address this. For example, laminated posters had been posted on walls reminding staff of completing Venous thromboembolism (VTE) assessments and a VTE check had been added to the theatre checklist. VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs. Maternity staff we spoke with were knowledgeable about sepsis. They completed sepsis training as part of the PROMPT skills drills training which they were required to complete annually. Staff could access the trust’s sepsis team for advice and support for additional support. The maternity team also had ‘sepsis heroes’ who conducted additional sepsis training, including sepsis simulation training. All medical records we reviewed contained appropriate actions taken to assess
deterioration of patients in maternity. The unit had systems in place to care for mothers to be with more complex needs. If the woman had a pre-existing medical condition, risk factors, a previous complicated pregnancy or delivery, or there was a recognised risk to their baby, staff booked them under the care of a consultant obstetrician (specialist doctor).

Midwives referred women to the hospital for an antenatal appointment if something in either their or their family history required more monitoring than could be provided in the community. When attending the antenatal clinic staff carried out a range of tests including urine tests, blood pressure checks and an abdominal examination. Staff could offer further tests such as blood tests and ultrasound scans. During this appointment, women were seen and examined by a consultant obstetrician who then become responsible for planning further care.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a woman’s mental health). Staff took patients psychological and emotional needs seriously. Women’s mental health needs were discussed at handovers and pregnancy and delivery plans routinely addressed the mental health and emotional wellbeing of patients and patients who were at risk of perinatal mental health issues. Staff could contact the perinatal mental health lead for advice and support. Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of self-harm or suicide. Staff took a holistic approach to their patients and acknowledged and addressed the physiological, psychological, sociological, developmental and cultural needs of the patient. Risk assessments at booking included a social and medical assessment and referral as well as mental health.

Staff shared key information to keep women safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep women and babies safe. Staff use a written handover sheet to handover to the next staff member. Staff also accessed contemporaneous notes within the patient electronic system for updates. Staff used a structured communication tool called the Situation, Background, Assessment, Recommendation (SBAR) for communication between team members. The antenatal and postnatal wards were separated into two areas and staff in each area handed over to the midwife on the next shift for their specific area. The labour care co-ordinator maintained an overview of all the patients and were the point of contact for all staff if there are any concerns. Shift changes and handovers included all necessary key information to keep women and babies safe. We attended a morning handover. This was attended by a multi-disciplinary team including anaesthetists, obstetric consultants, and midwives. This meeting also included trainees and theatre team representatives.

Staff followed systems to protect women and their babies from avoidable harm. They monitored, recorded and escalated concerns regarding cardiotocography (CTG) reviews. A CTG measures babies' heart rates and monitors the contractions in the uterus. The service followed safety systems to improve CTG compliance. Since our previous inspection in 2018, leaders had reviewed the trust clinical guideline on CTG monitoring, making explicit the ‘fresh eyes’ practice of other clinicians reviewing the CTG. They had embedded the 'fresh eyes' process for all CTG monitoring, documenting consistently and clearly in healthcare records using stickers, ensured CTG interpretation session was delivered in PROMPT training and the competency package was completed by all members of the multi-disciplinary team. They also performed daily and weekly audits to monitor against CTG guideline standards and fed back findings at safety huddles and bi-weekly maternity safety champion huddles. The trust informed us that the chief nursing and medical officers attended the bi-weekly huddles. Leaders reported compliance of CTG monitoring based on bi-weekly audits to group board and QIPS to determine future audit frequency. In the
previous four week reporting period, compliance with one-hour interpretation showed 90% to full compliance with the two-hour fresh eyes checks. The national average number of stillbirths per 1,000 births was 3.93. Between April and August 2019, the trust reported an average of 5.56. This has been superseded by the 2019 MMBRACE report published in October 2019 (which reviewed data from 2017). The trust’s stillbirth mortality rate improved from the previous report to a trust performance of 3.86 adjusted rate. As a result, managers had produced an action plan to address this risk. For example, the Saving Babies Lives Care Bundle (SBLCB) improvement plan was developed, shared and ratified with the patient safety and nursing midwifery committees. Staff and parent guides were produced to ensure all five elements were embedded within the department and patients were aware of the risk of still birth and preventable measures. NHS England and Improvement had sight of the concerns and actions regarding the number of stillbirths. Work continued through the MBRRACE perinatal mortality review tool to review the events leading to a stillbirth and neonatal deaths. The MBRRACE-UK programme of work comprises national surveillance of late foetal losses, stillbirths and infant deaths, confidential enquiries into perinatal mortality and serious infant morbidity and the national Confidential Enquiry into Maternal Deaths.

Staff tested women for carbon monoxide (CO) at booking. Exposure to CO is especially dangerous during pregnancy because it deprives the baby of oxygen, slows its growth and development, and increases the risk of miscarriage, stillbirth and sudden infant death. Between June and August 2019 staff exceeded the 95% compliance target. Referrals to the stop smoking in pregnancy service was an opt out service.

Any cases where the midwives had not referred for ultrasound scan but there was a reduction in the symphysis fungal height were escalated to the appropriate manager for discussion and learning. As part of the SBLCB improvement plan actions were identified for all missed cases and shared with the departmental quality of care meetings. Images for babies not identified during pregnancy were reviewed with the sonography team for quality assurance. Following the introduction of customised birthweight charts in November 2018, the trust was 96% compliant and accurate data could be collected around babies that were small for gestational age (SGA) detection. A total of 242 cases had been audited from November 2018 to May 2019 for learning.

Managers had put action plans in place to prevent cerebral palsy in pre-term labour. Staff took part in the PReCePT (Prevention of Cerebral Palsy in PreTerm Labour) project. This was the first ever perinatal quality improvement (QI) programme delivered at scale across England, bringing together midwives, obstetricians and neonatologists in every maternity unit in the country. This project was designed to help reduce cerebral palsy in babies through the increased antenatal administration of magnesium sulphate to mothers during preterm labour. Actions put in place in the unit included establishing a working party with clinical leads to launch the project, adding the project to the mandatory training study days to increase awareness of it and board magnets had been purchased to identify which patients met the criteria for it.

The department had effective systems in place to care for very ill women. Critically ill women were supported by the critical care outreach team. Staff working on the midwife-led facilities had immediate access to obstetric (doctor-led) care, if this was needed. Women who met the low risk criteria, including those giving birth for the first time could access this service. There has been one transfer to critical care between April and August 2019. There were no maternal deaths in the same reporting period. Managers recorded the number of massive obstetric haemorrhages. These
are a major cause of maternal mortality and morbidity. There had been eight in the year to date. Staff monitored foetal movements and escalated risks in line with guidelines. For example, reduced foetal movements were discussed at every subsequent antenatal appointment and staff used a checklist (Royal College of Obstetricians and Gynaecologists (RCOG) Green-top guideline 57), to manage women with reduced foetal movements. The trust had introduced a variety of ways to raise awareness of reduced foetal movements. For example, a trolley key coin stick and roller banner pens was given to all high risk women in the foetal medicine unit and magnetic shelf wobblers were given to all women who booked at the trust.

The service had pathways in place to look after women from 20 weeks pregnancy to six weeks after birth. The labour ward triage unit provided additional care and assessment. Women could call the unit's emergency telephone number at any time during their pregnancy to discuss any problems or to receive advice. Staff would advise women to attend the unit if they risk assessed they may have a problem which needed attention from a midwife or an obstetrician. The midwife, GP or clinic could also refer women to the triage service. On admission, women were assessed by a midwife or doctor and further care planned as necessary. Staff followed systems when responding to women 26 weeks pregnant or more who had concerns about their baby’s heartbeat. Women were referred to the foetal wellbeing unit for specialised assessment.

Due to the increase in complex pregnancies, there was an increased number of patients requiring foetal medicine clinic appointments resulting in failure to meet guidelines of a minimum of 95% of patients to be seen within three working days of referral. Leaders had identified this on the risk register and had produced an action plan to address this risk. For example, an e-referral service was introduced to ensure patients were triaged and assessed within a specified time.

Processes had been put in place to ensure prevention of retained foreign objects following surgery. Staff were required to complete safety checks prior to, during and after surgical procedures in accordance with best practice principles. Staff completed the World Health Organization’s ‘Five Steps to Safer Surgery’ checklists. We observed staff appropriately used the WHO checklist in the maternity theatres. Spot checks were carried out every two weeks to ensure staff were complying swab check processes in line with policy. Audits showed 80% to full compliance over four audits between July and September 2019.

The department had effective systems in place for the diagnosis and treatment of complications which could occur in unborn babies. The maternity service had a foetal medicine department, with sub-specialty trained consultants and effective systems in place to provide detailed ultrasound scans, amniocentesis, chorionic villus sampling (CVS) and diagnostics. Staff followed processes to identify and treat infectious diseases. They offered a blood test for HIV, Hepatitis B and Syphilis. The tests were recommended to protect women’s health through early treatment and care and reduce any risk of passing on an infection to their baby, partner or other family members. Staff offered women diagnosed with epilepsy specialist care. Women were referred to a consultant with a special interest in epilepsy. Staff provided specialist care for women with more complex labour and delivery needs. The unit offered high dependency rooms for women who required more
intensive care. From April to August 2019, there had been a total of 191 admissions. The neonatal unit had the facilities to provide cooling. This medical intervention reduces brain damage and improves an infant's chance of survival and reduced disability. Staff were able to reduce the risk of permanent brain damage in babies. Managers monitored post-natal readmissions as a quality indicator. Between April and August 2019, the percentage ranged from 9 to 12%. The national average was 6.3%.

**Nurse and midwifery staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and midwifery staff of relevant grades to keep women safe. During our previous inspection, leaders told us staffing levels was their main concern. This had impacted on staff morale and some staff told us they felt vulnerable due to the low staffing levels. Since then, recruitment was robust and by the middle of October 2019 the projected establishment would be filled. The head of midwifery (HOM) met with the chief nursing officer and directly reported to them if there were any changes in this risk. The HOM highlighted any increase in risks in relation to staffing through the group board meeting to the chief nursing officer as required by reporting through the appropriate committee meetings. The ward manager could adjust staffing levels daily according to the needs of patients. Managers responded to midwifery red flag events. These were warning signs that something may be wrong with midwifery staffing. Recommended events for reporting included delayed or cancelled time critical activity and delay of 30 minutes or more in providing pain relief. These were set out in the department's standard operating procedure. Managers would follow the escalation policy on these occasions to ensure patients were provided with safe care which included moving staff around.

However, staffing issues in the scanning department were reported. National protocols such as the ‘Saving Babies Lives’ programme further increased the pressures. These workload pressures meant sonographers were finding it difficult to meet service demand and look after their own safety in the workplace adequately. For example, staff were often over scanning. This meant staff were at risk of muscular-skeletal injury. However, the trust had recognised this issue and it was recorded on the risk register. The trust had said they were going to stop the use of all agency staff. The department relied heavily on agency sonographers to deliver capacity to meet demand. The manager said loss of agency staff would mean around 300 less scans a week to an already overstretched service. The service was achieving their targets; however, this was due to sonographers carrying out more scans than they should. The current level of midwifery sonographers was 3.43 WTE. To supplement current substantive staff, agency cover was agreed to ensure safe staff levels in the department. Steps that had been taken to avoid the need for agency staff and ensure safe staffing included:

- Superintendent midwife sonographer now in post to lead and support the team.
- Lead sonographer working clinically.
- Continued recruitment drive for midwife sonographers.
- Current agency staff backfilling vacancies between them, and demand and capacity models being reviewed.
- Ward clerk support to manage scan requests to free up sonographers from undertaking administrative duties.
- A local university obstetric ultrasound course for two existing members of the team due to complete in March 2020.

(Source: DR 68)

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers used a national tool available for calculating midwifery staffing levels. It is based on data that has been collected over many years and has been used by the Royal College of Midwives (RCM) to argue for adequate national and local midwifery staffing ratios. The intrapartum birth-rate plus tool had been used since April 2019 and one of the red flags within the tool had been addressed and the labour ward co coordinator was now separated on the staff rotas to ensure they were supernumerary. If the workload increased and the red flag triggered there was a clear escalation policy to mitigate this risk. Since April 2019, the department had achieved 98% compliance with supernumerary labour co coordinators. Staff attended a Coventry and Warwickshire daily bed escalation conference call to support local maternity system activity. This ensured women from the area received care at the right place and the right time by the appropriate specialist workforce. The board maintained appropriate oversight of whether the unit had safe, sustainable and productive staffing. For example, in January 2019, it was identified that one standard for Safer Staffing that had not been met. Registered midwife to birth ratio had peaked in July / August 2019 at 1:39. This position was improving month on month to achieve the 1:30 ratio which was agreed for additional recruitment within a business plan. As of October 2019, the ratio was reported by the trust as 1:31. A further cohort of staff was soon to join and are progressing through the supernumerary stage.

The table below shows a summary of the nursing and midwifery staffing metrics in maternity at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Maternity annual staffing metrics</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff group</strong></td>
<td><strong>Annual average</strong></td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
</tr>
<tr>
<td>All staff Qualified Nurses and midwives</td>
<td>394.0</td>
</tr>
<tr>
<td>Qualified Nurses and midwives</td>
<td>209.6</td>
</tr>
</tbody>
</table>

Qualified nursing and midwifery staffing rates within maternity at University Hospital Coventry were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly turnover or sickness rates. In addition, there was not enough agency usage for this staff group to comment on the performance of this metric over time.

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

The ward manager could adjust staffing levels daily according to the needs of women. Managers responded to midwifery red flag events. These were warning signs that something may be wrong...
with midwifery staffing. Recommended events for reporting included delayed or cancelled time critical activity and delay of 30 minutes or more in providing pain relief. Managers would follow the escalation policy on these occasions to ensure patients were provided with safe care which included moving staff around. The number of midwives and healthcare assistants on all shifts on each ward matched the planned numbers. The number of midwives and healthcare assistants mostly matched the planned numbers. On occasions when they did not, managers put actions in place such as moving staff around. This ensured patients were provided with safe care. Staff provided safe one to one care in labour. From April to August 2019, compliance ranged from 99% to full compliance.

**Vacancy rates**

The service had reducing vacancy rates.

![Vacancy rate - qualified nurses, health visitors and midwives](image)

Monthly vacancy rates over the last 12 months for qualified nurses, health visitors and midwives showed a shift from November 2018 to April 2019.  
*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

Leaders had action plans in place to address vacancy rates. For example, new staff were offered a "golden hello". This is an amount paid to an employee as an inducement to take up employment with an employer. Managers discussed vacancies at various governance forums such as the monthly workforce, finance and performance meetings. The service had now implemented successful measures to retain their student midwives to address this issue. showed new staff felt supported and safe in their roles with the support from the specialist midwives. The head of midwifery and trust board had oversight of the staffing challenges and an ongoing recruitment programme was in place to attempt to increase the midwifery establishments. The learning and development team held a midwifery taster days for staff interested in a career within midwifery.

**Bank and agency staff usage**

![Bank hours - qualified nurses, health visitors and midwives](image)

Monthly bank usage over the last 12 months for qualified nurses, health visitors and midwives showed a shift from November 2018 to April 2019.  
*(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)*
Managers limited their use of bank and agency staff and requested staff familiar with the service. Although there was a high proportion of agency sonographers, they were essential to maintaining the service due to high vacancy rates in this area. The manager said the trust was planning to stop using all agency staff soon. After the inspection, the trust said that this would not be the case until more substantive recruitment of sonographers could take place. Staff were concerned about the impact on this on the viability of the service and the effect on patient safety. Managers made sure all bank and agency staff had a full induction and understood the service. To help achieve this, all new starters were asked to take part in the corporate induction programme as an essential requirement for the start of their employment with the trust. It generally took place on the first day of employment and welcomed new starters to the trust to help them get acquainted with the organisation so that they could settle quickly into their new role. It covered key employment-related information, including an overview of the trust and how they worked, as well as the necessary statutory and mandatory training to ensure that they could work safely and effectively. This was followed by the local departmental induction. This was tailored to the employee’s area of work and aimed to help them understand the expectations of their job role. Staff provided a safe maternity service in line with the Royal College of Midwives (RCM) guidance. The midwife to birth ratio target was 1:30. Between April and August 2019 the service achieved 1.28 to 1.34.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep women and babies safe. The service offered 96 hours of obstetric consultant cover on the labour ward each week. This met the recommended hours of cover for the number of deliveries at the trust in accordance with the Safer Childbirth/RCOG: ‘The Future Workforce guidance’. Anaesthetic cover was available 24 hours a day, seven days a week. Obstetric anaesthetists were free from other duties during this time. It should be noted that medical staff at the trust worked across maternity and gynaecology and provided dedicated labour ward cover.

The table below shows a summary of the medical staffing metrics in maternity and gynaecology at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual locum hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>379.2</td>
<td>16%</td>
<td>11%</td>
<td>5.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Staff</td>
<td>54.3</td>
<td>26%</td>
<td>18%</td>
<td>0.4%</td>
<td>0</td>
<td>3,847 (3%)</td>
<td>709 (1%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)
The medical staff matched the planned number on all shifts in each department.

Medical staffing rates within maternity and gynaecology at University Hospital Coventry were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly vacancy or turnover rates, or agency medical staff usage. Over the same period there was no bank medical staff usage reported.

Sickness rates

Sickness rates for medical staff were reducing.

Monthly sickness rates over the last 12 months for medical staff showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Staffing skill mix

The service had a good skill mix of medical staff on each shift and reviewed this regularly. In April 2019, the proportion of consultant staff reported to be working in maternity and gynaecology at the trust was similar to the England average. The proportion of junior (foundation year 1-2) staff was also similar to the England average. There were no or very few middle career medical staff working at the trust. Conversely the proportion of registrars was higher than the England average.

Staffing skill mix for the 40.4 whole time equivalent staff working in maternity at University Hospital Coventry and Warwickshire NHS Trust.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>45%</td>
<td>42%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>0%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>50%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>5%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2
(Source: NHS Digital Workforce Statistics)
The service always had a consultant on call from 22.00 to 08.30 and weekends and a consultant presence from 08.30 to 22.00 seven days per week. This meant all women including those with medical complexity associated with factors such as being older mothers, obesity, multiple pregnancies arising from assisted reproduction were always safely cared for.

**Records**

**Staff kept detailed records of women’s care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Women's notes were comprehensive, and all staff could access them easily. The systems that managed information about patients supported safe care and treatment. Records accurately recorded the patient's choices; risk assessments and care plans were clear and up to date and staff signed and timed documents. Staff complied with antenatal assessment paper documentation. For example, records of foetal movements were recorded. However, there had been considerable delays in procuring an electronic patient record system. This was identified on the risk register and action points put in place to address this included consideration of the option of purchasing a standalone maternity system if delay persists. When women transferred to a new team, there were no delays in staff accessing their records. Mothers to be carried their own notes. Every time they visited their own GP, midwife or the hospital they were required to bring their own notes with them. This minimised the woman experiencing problems if they were outside Coventry and needed to be seen at a local maternity unit. This enabled the doctors and midwives to record any observations or examination in the women’s notes and discuss any concerns or questions they may have. Records were not all always stored securely. Nursing and medical paper records for inpatients were not all stored securely in locked trolleys although they were stored by the nursing station. This meant there was little chance of records being inappropriately accessed and was in line with trust policy.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff secured and checked controlled drugs in line with current national guidance and legislation. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated by law. For example, two registered nurses completed the required daily checks and all medication was in date and matched the controlled drugs register on each ward. This was in line with the Misuse of Drugs legislation. Quarterly CD Audits undertaken by pharmacy ensured processes were being followed. We reviewed the controlled drug audit summary report May 2019. The audit incorporated 17 regulations and legislation standards and 12 best practice standards that apply to controlled drugs storage and practice. Maternity had achieved 94% compliance. Due to a lack of resources a dedicated clinical pharmacy service was not provided, however staff knew how to contact pharmacy for support and advice when needed. It was agreed that there were areas where medicine processes could be improved if there was a pharmacist linked to maternity. For example, to provide advice and support to the team, improve the discharge process, counselling patients as well as ensuring that there were enough supplies of critical medicines.
Staff reviewed women's medicines regularly and provided specific advice to women and carers about their medicines. To take home medicines (TTO's) formed party of the discharge checklist. This prompted staff to review their patients medication and provide advice.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. Medicines for use by community midwives was stored on the acute hospital site until required. Checks were made and recorded to ensure the medicines were within their expiry date until staff needed it. Community staff would then dispose of medication they had not used to ensure the effectiveness of medication was not affected. Newly installed automated electronic medicines storage systems across maternity ensured medicines were available, safe and secure with restricted access to authorised staff. A training programme for staff on using the new system was in place.

The use of Midwives’ Exemptions Guidelines were being reviewed and assessed to ensure that they were the most effective way of providing medicines for patients. At the time of the inspection, a clinical guideline had been submitted for approval to the Trust Medicines Management Committee. The purpose of this was to clarify the guidelines for when midwives could supply or administer medicines to patients directly to a patient with an identified clinical condition without the need for a prescription. The head of midwifery attended a governance meeting to review the guidelines during our inspection.

Medicine fridge temperatures were monitored by ward staff and were within the recommended range. Staff were aware of what action to take if there was a deviation. Medicine fridge temperatures were monitored by ward staff and were within the recommended range. Staff were aware of what action to take if there was a deviation. The trust used electronic medicine cupboards for storing medicines. These cabinets had continuous monitoring of the temperature within the cabinet i.e. the location that the medicines were stored rather than a remote probe in the room. This continuous monitoring temperature was fully recorded, allowed full remote monitoring and supports automated provision of reports to staff. The ward nurses did not need to monitor the temperature as a report was automatically generated and reviewed by senior staff and allowed action to be taken in a timely way. Staff understood how long the medicine has been at any temperature deviation so appropriate action can be taken, and all retrospective data is stored. There was a trust wide clinical operating policy for dealing with elevated temperatures in drug storage. In addition, the medicines stocked on wards in the automated cabinets were determined by the medicines used within the clinical specialty in agreement with ward managers and the specialist pharmacist. Pharmacy teams restocked the automated cabinets either daily or weekly depending on the area.

Medicines required in an emergency including an obstetric haemorrhage trolley were readily available when needed. Regular checks of emergency medicines and equipment were carried out by staff. Tamper evident seals were in place to ensure medicines were fit for use, however intravenous fluids required in an emergency were not stored using tamper evident seals. This posed a potential risk to patients in that they could be tampered with. We raised this with the director of pharmacy who took action to review this trust wide. Following the inspection, the trust informed us that they were fully compliant with the storage of all medicines including IV fluids which were being checked daily by ward staff. IV fluids on resuscitation trollies were being stored in double wrapped bags; with tamperproof seals and expiry dates checked daily in accordance with the management of resuscitation policy.
Allergy statuses or medicine sensitivities of patients were routinely recorded on medicine administration charts. Venous thromboembolism (VTE) risk assessments were routinely recorded for patients on the clinical results reporting system which identified if treatment was required. Staff knew how to contact pharmacy staff and how to access medicines out of hours when pharmacy was closed. Anaesthetists had quick and convenient access to pain relief drugs. On the labour ward, two separate epidural trollies were available. Staff followed current national practice to check women had the correct medicines. For example, staff gave patients enough information about the medicines they proposed to prescribe to allow them to make an informed decision and drug allergy status was documented in medical records.

The service had systems to ensure staff knew about safety alerts and incidents, so women received their medicines safely. Medication incidents were reviewed in the maternity safety champions meetings. There were 51 medication incidents in the year to date as of September 2019. Bi-weekly meetings would discuss any medicine incidents to ensure learning and action was shared. This was particularly useful for the new cohort of midwives to ensure they were kept up to date.

**Incidents**

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff shared several examples of incidents they reported. We also saw several examples of reported incidents in the maternity grand safety huddle meeting minutes. Staff reported all incidents that they should report. We saw several examples of incidents reported appropriately by staff in the maternity grand safety huddle meeting minutes. Staff reported the more serious incidents that occurred but also reported many incidents involving low and no harm to patients. This showed they understood that by reporting even these less serious incidents, the organisation could learn and improve.

**Never Events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There was evidence of strong systemic protective barriers which were successful, reliable and comprehensive safeguards. From July 2018 to June 2019 the trust reported no never events for maternity.

*(Source: Strategic Executive Information System (STEIS))*

Managers shared learning with their staff about never events that happened elsewhere. Never events and incidents were shared across the local maternity system for wider learning.

**Breakdown of serious incidents reported to STEIS**

Staff reported serious incidents clearly and in line with trust policy. They demonstrated knowledge of the process and procedures to help ensure serious incidents were identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar
incidents happening again. In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SI’s) in maternity at University Hospital Coventry which met the reporting criteria set by NHS England from July 2018 to June 2019. A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity/obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant)</td>
<td>9</td>
</tr>
<tr>
<td>Maternity/obstetric incident meeting SI criteria: mother only</td>
<td>2</td>
</tr>
<tr>
<td>Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
</tr>
</tbody>
</table>

Staff received feedback from investigation of incidents, both internal and external to the service. Staff told us managers fed back learning points from incidents to staff through a variety of ways such as safety briefs, team meetings, the trust, and maternity newsletter. This showed the clinical governance systems and processes helped staff achieve their organisational objectives of delivering both safety and quality within the department. Staff met to discuss the feedback and look at improvements to women's care. Staff attended multi-disciplinary huddles daily. Staff reviewed the incidents from the previous day and safety issues for the day ahead. A weekly grand huddle was also held to review themes and risks to encourage safety improvements for the service. The service held grand rounds to share the learning from past incidents. This was an open discussion of all incidents and was attended by a multi-disciplinary team including midwives, anaesthetists and obstetricians. Managers maintained appropriate oversight of incidents and learning from them through effective governance systems. Leaders of the service attended specialty-based quality improvement and patient safety (QIPS) meeting meetings to discuss incident data, serious incidents, and legal cases to share with their teams. Incident data was provided to specialist clinical risk committee meetings (e.g. falls forum) and throughout the committee structure up to trust board. There was evidence that changes had been made as a result of feedback. For example, an issue raised by the perinatal review panel which were of concern but not directly relevant to the issue was that the mother was not appropriately managed given her carbon monoxide level. The service had developed a “Smoking Cessation in Pregnancy and Following Childbirth Guideline” to minimise the chance of this happening again.

Managers investigated incidents thoroughly. Women and their families were involved in these investigations. We reviewed the previous five investigations. Staff conducting investigations found out what happened, got beyond ‘the obvious’ to the bottom of why the incident happened and identified underlying system and process issues that caused or contributed to the incident. The investigations were multi-disciplinary, root causes and contributory factors were identified, there was evidence of learning from incidents and action plans detailed where improvements were needed in response to the incidents. Managers debriefed and supported staff after any serious incident. A patient safety response (PSR) team visit was held immediately following incidents. During these meetings staff were supported by the local maternity team and PSR team. The incident investigation reports included a section to record how staff were involved in the investigation and what support they received. Midwives could contact their professional midwifery advocate for support if required. The bereavement midwife also offered staff, women and their families additional support. Referrals could be made to the trust occupational health as required.
Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if and when things went wrong. All staff we spoke with demonstrated the importance of being open, honest and transparent with their patients. Duty of candour was embedded in the services patient culture. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. There was evidence of investigation followed by action planning and staff told us duty of candour was followed to keep patients and those involved in their care informed with how incidents were managed. All incident reports recorded what the impact was on the patient, and how the patient was involved and supported during the investigation.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, women and visitors.

Safety thermometer data was displayed on wards for staff and women to see. However, the safety thermometer data showed the services did not achieve over 95% harm free care for the last 12 months. Between January and October 2019, the proportion of women that received combined harm free care ranged from 43 % to 83%. Staff used the safety thermometer data to further improve services.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of women subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. For example, policies and procedures reflected relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), and relevant professional bodies. Staff followed Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) (2015) guidelines. For example, staff offered all women with risk factors for gestational diabetes a test and midwives and obstetricians emphasised the importance of foetal movements to women during antenatal appointments. We saw leaflets ‘feeling your baby move is a sign they are well’ detailing what to do if women were worried about their baby’s movements. Staff practiced evidence-based care and treatment. For example, staff monitored foetal growth from 24 weeks and midwives and obstetricians emphasised the importance of foetal movements in antenatal appointments. Staff displayed posters and leaflets about this in the antenatal clinics.

Women with a multiple pregnancy was planned and provided in line with NICE quality standards for management of twin and triplet pregnancies in the antenatal period and all women with risk factors for gestational diabetes were identified and offered glucose tolerance testing as highlighted by MBRRACE-UK (2015) and in line with the current NICE guideline.

Staff followed the National Bereavement Care pathway. This meant staff were offering patients an evidence-based bereavement pathway to improve the overall quality and consistency of
bereavement care for parents and families. The pathway included five pregnancy or baby loss experiences including miscarriage, termination of pregnancy for foetal abnormality, stillbirth, neonatal death and the sudden unexpected death of an infant up to 12 months.

Staff could easily access the maternity policies and guidelines via the trust’s intranet. However, we found many policies were out of date. This was a trust wide issue. Staff could easily access the maternity policies and guidelines via the trust’s intranet. However, we found many were out of date. This was a trust wide issue. We were assured by the trust however that there were mechanisms in place to alert a reader, when opening the guidance, that the guideline was due to be updated. Although staff had access to trust policies and procedures through the intranet, we identified some policies and procedures which were out of date and in need of renewal at the time of the core service inspection. We raised this with the trust who took action to address this by the time of the well led review. The trust informed us that it used an electronic document management system called E-library to enable trust-wide access to clinical guidelines, policies and patient information leaflets. Policies were in place outlining the uploading, review and approval of these documents within the trust. The trust implemented a policy for clinical guidelines to be reviewed and updated, approved at specialty QIPS and uploaded within three years. As guidelines were due for review or expire they were still available on the E-library system for use in an emergency situation (as amber and red rated respectively). However, before the document could be accessed, a visual warning on the system alerted the user that the guideline had expired which they had to acknowledge before the guideline could be accessed. This limited the risk of any out of date care being provided.

National guidance was audited as part of the trust wide audit programme and through completion of national audits. Auditing of national guidance was reported to the Patient Safety and Clinical Effectiveness Committee within the Clinical Audit report bi-monthly. Guidelines were monitored and reviewed through group board meetings. Updated guidelines were highlighted during the maternity grand safety huddles.

Staff protected the rights of women subject to the Mental Health Act and followed the Code of Practice. They knew how to ensure women with mental disorders received the appropriate care and treatment they were legally entitled to. For example, staff said they would refer such women to the mental health liaison team or gain advice from the perinatal mental health or safeguarding lead.

At handover meetings, staff routinely referred to the psychological and emotional needs of women, their relatives and carers. This was made clear at the handover. Handovers were well structured, consistent, concise and effective and the patient board headlines followed the well-established Situation Background Assessment Recommendation (SBAR) method. This format was used to improve communication, ensure effective escalation and increase safety. All staff were compliant with sepsis training and knew the signs and treatment options.

**Nutrition and hydration**

Staff gave women enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for women’s religious, cultural and other needs.

Staff made sure women had enough to eat and drink, including those with specialist nutrition and hydration needs. The service was UNICEF Baby Friendly level two accredited. Stage two accreditation is achieved when a service demonstrates that all staff have been educated according to their role, as described at Stage one, and that this training has prepared staff to care for
mothers and families effectively. All staff who have contact with new mothers and babies will need to be educated to allow them to implement the standards according to their role.

Maternity staff provided specialist feeding support to patients to ensure they could feed their baby using their preferred feeding method. Patients could use one of the day rooms on the unit so they could breastfeed in private. Staff ensured that babies received the colostrum, or “first milk”, which is rich in protective factors. Breastfeeding initiation rates were recorded on the maternity dashboard. Between April and August 2019 compliance ranged from 81 to 83%. This was above the national average of 73.6% and exceeded their internal target of 73.6%. Breast milk was labelled and stored appropriately. Staff had conducted daily temperature checks for the breast milk storage fridge on the postnatal ward. Patients had access to hot and cold drinks and snacks whilst on the maternity unit. The department had a patient allergen file to ensure all staff were aware of patient’s nutritional allergies.

When discharged, staff gave women information about support groups within their area. They were also referred to an infant feeding team, who, along with the community midwifery team could support them with any breastfeeding issues they may experience whilst at home.

Staff fully and accurately completed women's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor women at risk of malnutrition. Specialist support from staff such as dietitians was available for women who needed it. Women with diabetes could see a dietitian as part of their care such as in antenatal diabetes clinics.

Pain relief

Staff assessed and monitored women regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed women’s pain using a recognised tool and gave pain relief in line with individual needs and best practice. Women could choose water as a form of pain relief in a normal labour. Using the birthing pool enabled women to move around freely and maintain an upright position to facilitate normal birth. It helped to prevent the use of drugs during labour to enable women to have a more a natural experience. Women could also choose alternative methods of pain relief. For example, acupuncture, aromatherapy, homeopathy, hypnosis, massage and reflexology. Other forms of pain relief included a mixture of oxygen and nitrous oxide, pethidine as a pain-relieving injection in labour and an epidural which is a special type of local anaesthetic procedure. It numbs the nerves which carry the feeling of pain from the womb and the birth canal to the brain. There were several types of anaesthesia for caesarean section. Women received pain relief soon after requesting it. Staff offered patients effective medical and non-medical pain relief options, 24 hours a day. Staff prescribed, administered and recorded pain relief accurately. The service informed us that there had been no clinical audits undertaken relating to pain or time to epidural within the last three months. (Source DR: 69)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for women.

The service participated in all relevant national clinical audits. The service generally performed well or the same as national averages in national clinical outcome audits and managers used the results to improve services further. The service had a lower than expected risk of readmission for
elective care than the England average. The service had a lower than expected risk of readmission for non-elective care than the England average. Managers monitored post-natal readmissions as a quality indicator. Between April and August 2019, the percentage ranged from 9 to 12%. The national average was 6.3%.

National Neonatal Audit Programme
The table below summarises University Hospital Coventry’s performance in the 2018 National Neonatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>
| Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?  
(Antenatal steroids reliably reduce the chance of babies developing respiratory distress syndrome and other complications of prematurity) | 88.0%                | Within expected range          | Met                      |
| Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?  
(Administering intravenous magnesium to women who are at risk of delivering a preterm baby reduces the chance that the baby will later develop cerebral palsy) | 63.5%                | Within expected range          | No current standard      |

(Source: National Neonatal Audit Programme)

National Maternity and Perinatal Audit Programme
The table below summarises University Hospital Coventry’s performance in the 2018 National Maternity and Perinatal Audit Programme against measures related to maternity care.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
</table>
| Trust-level case ascertainment  
(Proportion of eligible cases included in the audit)                                            | 101.6%               | N/A                            | Met                      |
| Antenatal measures (before birth, during or relating to pregnancy)                                                                 | 53.7%                | Within expected range          | No current standard      |

(Babies who are small for their age at birth are at increased risk of problems before, during and after birth)
<table>
<thead>
<tr>
<th>Metrics</th>
<th>Hospital performance</th>
<th>Comparison to other hospitals</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case-mix adjusted proportion of elective deliveries (caesarean or induction) between 37 and 39 weeks with no documented clinical indication for early delivery (For babies with a planned (or elective) birth, being born before 39 weeks is associated with an increased risk of breathing problems. This can lead to admission to the neonatal unit. There is also an association with long term health and behaviour problems)</td>
<td>37.7%</td>
<td>Higher than expected</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted overall caesarean section rate for single, term babies (The overall caesarean section rate is adjusted to take into account differences which may be related to the profile of women delivering at the hospital)</td>
<td>24.9%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of single, term infants with a five minute Apgar score of less than seven (The Apgar score is used to summarise the condition of a newborn baby; it is not always a direct consequence of care given to the mother during pregnancy and birth, however a 5 minute Apgar score of less than 7 has been associated with an increased risk of problems for the baby)</td>
<td>1.2%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of vaginal births with a 3rd or 4th degree perineal tear (Third or fourth degree tears are a major complication of vaginal birth. Only tears that are recognised are counted therefore a low rate may represent under-recognition as well as possible good practice)</td>
<td>3.4%</td>
<td>Within expected range</td>
<td>No current standard</td>
</tr>
<tr>
<td>Metrics (Audit measures)</td>
<td>Hospital performance</td>
<td>Comparison to other hospitals</td>
<td>Meets national standard?</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>-------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Case-mix adjusted proportion of women with severe post-partum haemorrhage of greater than or equal to 1,500 ml (Haemorrhage after birth is a major source of ill health after childbirth. Blood loss may be estimated by visual recognition or by weighing lost blood. High rates may be due to more accurate estimation and low rates due to under recognition)</td>
<td>N/A</td>
<td>N/A</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

Post-partum measures (following birth)

Proportion of live born babies who received breast milk for the first feed and at discharge from the maternity unit (Breastfeeding is associated with significant benefits for mothers and babies. Higher values represent better performance)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Middle 50%</th>
<th>No current standard</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>73.1%</td>
<td></td>
</tr>
</tbody>
</table>

(Source: National Maternity and Perinatal Audit Programme)

Managers carried out a comprehensive audit programme. Managers used information from the audits to improve care and treatment. There were engagement meetings and/or follow-up of audit outliers. For example, in relation to an outlier for significantly high rates of emergency caesarean sections at the trust, leaders provided case note summaries for the 30 women reviewed and details of actions the trust was taking, including an ongoing audit into the review of category one cases. The trust provided an action plan to the CQC by the due date of 28 October 2019. The service’s audit programme was:

<table>
<thead>
<tr>
<th>OBSTETRICS (MATERNITY) EXTERNAL AND INTERNAL ‘MUST DO’ CLINICAL AUDIT PROGRAMME 2019/20</th>
</tr>
</thead>
</table>

Clinical Audit Programme Summary

<table>
<thead>
<tr>
<th>Total number of audits on programme</th>
<th>External ‘Must Do’ audits</th>
<th>Internal ‘Must Do’ audits</th>
<th>No. audits registered pre-2019/20</th>
<th>No. new audits for 2019/20</th>
<th>Number of Quality Account audits</th>
<th>Number of CDC Audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

The service provided an overview of the specialty clinical audit programmes for 2019/20. The programme incorporated all clinical audit activity considered to be an organisational priority. In addition to reporting new audits registered for 2019/20, the programme also contained all current open activity regardless of the financial year the audits were registered in. This provided an accurate and transparent illustration of all new and existing audit activity. A column was included in the table titled ‘Financial Year’; this identified in which financial year the audits took place and thus gives an indication of the age of each audit. The clinical audit programme was developed on
Recording the audit project number, the status of the project and the financial year in which it was registered enables differentiation between re-audits of the same topic, which were undertaken in successive years and were running concurrently, but at different stages of the audit cycle. Recording this additional information also allows for progress made towards completing audits to be easily tracked as the programme is updated during the year. The programme identified which audits were external 'Must Do's' i.e. national audits, and those which were internal 'Must Do's' such as those undertaken locally in response to the trust's organisational priorities were:

**External 'Must Do' Clinical Audits (Priority Level 1)** - Mandated national clinical audits, relevant to the services provided at UHCW, including:

- National Clinical Audit & Patient Outcomes Programme (NCAPOP) (including National Confidential Enquiries into Patient Outcome & Death (NCEPOD) studies).
- National audits where participation must be reported in the annual Quality Accounts.
- National audits included in the Clinical Outcomes Review Programme.
- Commissioner priorities including national and regional Commissioning for Quality and Innovation (CQUIN) Schemes and NHS Standard Contract requirements.
- National audits mandated by NHS England and NHS Improvement including Getting it Right First Time (GIRFT) audits and Audits of Seven Day Services.

**Internal 'Must Do' Clinical Audits (Priority Level 2)** - Audits undertaken locally to demonstrate compliance with regulatory requirements, including:

- To meet Care Quality Commission (CQC) requirements.
- To support internal assurance programmes.
- To provide evidence of implementation of National Institute for Health & Care Excellence (NICE) guidance.
- To support the internal mortality review process.
- To meet requirements set out within the Information Governance Toolkit.
- Local clinical risk management issues.
- Audits undertaken in response to serious incidents / clinical adverse events / complaints / patient and public involvement initiatives
- Patient Safety Alerts
- Route Cause Analysis Outcomes
- Organisational clinical priorities e.g. Board Assurance Framework
- Audits identified to address outputs from participation in national clinical activity.

(Source DR:70)

Managers shared and made sure staff understood information from the audits. For example, audit results from the ‘Saving Babies Lives Care Bundle’ were shared through a local maternity system newsletter. This meant staff could compare their results to the other maternity units in the area. Results of audits were shared with staff the chief nursing officer and chief medical officer through the bi weekly production board. Improvement was checked and monitored. Audits were continual to confirm that improvements had been effective. The service was accredited by UNICEF. They awarded baby friendly accreditation based on a set of interlinking evidence-based standards for maternity, health visiting, neonatal and children’s centres services.

The percentage of women receiving induction of labour ranged from 37% to 43% between April and August 2019. This was higher than the national average of 28.8% and higher than the trust target of 28.5%. Twenty-three women suffered with third and fourth degree tears between April
and August 2019. The target goal was less than six a month. This meant they achieved their goal in three of five months and two months were rated as ‘areas of concern’.

Standardised caesarean section rates and modes of delivery
From January to December 2018, the total number of caesarean sections was similar to expected for both elective and emergency sections.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>University Hospital Coventry and Warwickshire NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.8%</td>
<td>629</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>16.5%</td>
<td>1,139</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>29.3%</td>
<td>1,768</td>
</tr>
</tbody>
</table>

Notes: Standardisation is carried out to adjust for the age profile of women delivering at the trust and for the proportion of privately funded deliveries. Delivery methods are derived from the primary procedure code within a delivery episode. This table includes all deliveries, including where the delivery method is ‘other’ or ‘unrecorded’.

In relation to other modes of delivery from January to December 2018, the table below shows the proportions of deliveries recorded by method in comparison to the England average. Over these 12 months the trust’s caesarean section rate and instrumental delivery rate were both similar to the England averages.

Proportions of deliveries by recorded delivery method (January to December 2018)

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>University Hospital Coventry and Warwickshire NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections¹</td>
<td>1,768</td>
<td>31.6%</td>
</tr>
<tr>
<td>Instrumental deliveries²</td>
<td>565</td>
<td>10.1%</td>
</tr>
<tr>
<td>Non-interventional deliveries³</td>
<td>3,258</td>
<td>58.3%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>5,591</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes: This table does not include deliveries where delivery method is ‘other’ or ‘unrecorded’.
1 Includes elective and emergency caesareans
2 Includes forceps and ventouse (vacuum) deliveries
3 Includes breech and vaginal (non-assisted) deliveries
(Source: Hospital Episodes Statistics (HES))

The unit ensured antenatal care was readily and easily accessible and encouraged pregnant women to access and maintain contact with antenatal care services. Staff achieved the target goal for the number of women booked by 12 weeks and six days. This was in line with NICE QS22 Statement 1 guidance.

Maternity active outlier alerts
As of August 2019, the trust reported nine active maternity outliers. These were as follows:
- Four alerts for neonatal readmissions.
- Two alerts for puerperal sepsis and other puerperal infections.
- Two alerts for emergency caesarean section.
- One alert for puerperal sepsis (not including other infection).
(Source: Hospital Evidence Statistics (HES))

The trust actively addressed all notified outlier alerts from the CQC. We saw copies of completed actions regarding puerperal sepsis and emergency caesarean section. This resulted in the alerts being closed. The CQC and the trust worked together regarding any outlier alerts.

MBRRACE-UK Perinatal Mortality Surveillance Report
Staff were committed to reducing the number of stillbirth, new-born and women deaths. The trust took part in the 2018 MBRRACE audit. The table below summarises the trust’s performance in the 2018 MBRRACE-UK Perinatal Mortality Surveillance Report for births from January to December 2016.

<table>
<thead>
<tr>
<th>Metrics (Audit measures)</th>
<th>Trust performance</th>
<th>Comparison to other trusts with similar service provision</th>
<th>Meets national standard?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stabilised and risk-adjusted perinatal mortality rate (The death of a baby in the time period before, during or shortly after birth is a devastating outcome for families. There is evidence that the UK’s death rate varies across regions, even after taking into account differences in poverty, ethnicity and the age of the mother.)</td>
<td>6.61</td>
<td>Up to 10% higher than the average for the comparator group</td>
<td>No current standard</td>
</tr>
</tbody>
</table>

(Source: MBRRACE-UK)

The service ensured a post-mortem examination was offered to families who had experienced a still birth or neonatal death from 16-week gestation in order to improve future pregnancy outcomes for parents. In addition, all patients’ placentas were sent for histology testing.

At this trust there were no deliveries where gestation periods were unrecorded. This compared with 18.7% nationally.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of women. Hospital based staff rotated between all sections of the maternity department to ensure they maintained their competencies in all areas. This also enabled senior staff to deploy staff to the areas of the maternity department where they were most needed. The clinical preceptor
support midwife (CPSM) was a relatively new role, at Band 7, designed to support newly qualified midwives, provide a high level of leadership and maintain good working relationships within the maternity unit. The clinical preceptor support midwives were expert practitioner / role models, providing professional leadership and support to junior midwives during their preceptorship period to develop and maintain clinical practice knowledge and skills. The CPSM’s carried bleeps so that midwives in preceptorship could access them promptly to help or guide them with competencies such as cannulation. The CPSM’s also supported band 6 and band 7 staff who needed support refreshing skills and competencies. The CPSM’s gathered and responded to new starters feedback and made changes to address this. For example, new staff fed back they weren’t always given their supernumerary periods. The CPSM’s responded by building the supernumerary period into the induction programme. The CPSM’s had also reviewed the competency programme content based on feedback. For example, they added a theatre competency. They had also introduced a buddy system so all new starters had peer support.

In addition to mandatory training and in response to learning from incidents and complaints, additional education and training was offered. For example, two in house Perinatal Institute GAP study days was attended by around 100 staff. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. A midwife became the first non-medical member of staff to get an externally funded PhD in 2018. Managers gave all new staff a full induction tailored to their role before they started work. Student midwives conducted a comprehensive induction programme when starting their role on the unit and followed a detailed preceptorship programme. The Bereavement Support Service at University Hospitals Coventry and Warwickshire NHS Trust was run by three specialist midwives. One midwife had a diploma in bereavement counselling and was a member of the British Association for Counselling and Psychotherapy. A large part of the role involved training and educating all grades of staff in best practice in bereavement care and highlighting the importance of effective and sensitive communication.

The maternity service worked alongside the local university to provide continual professional development opportunities in programmes such as the New born Initial Physical Examination (NIPE) programme, Mentors and Assessors module and Return to Midwifery Practice. There were also opportunities to work alongside the maternity risk manager, bereavement midwife, infant feeding specialist, screening midwife and maternity specific practice facilitator. The service offered staff opportunities to develop and encouraged skills exchange between different staff roles. For example, midwives were offered secondment opportunities such as the patient experience midwife role. Managers made sure staff received any specialist training for their role. Patients had access to specialist teams and specialist midwives with specialised training and backgrounds. Managers ensured staff were competent to care for critically ill patients. All enhanced maternity care (EMC) midwives completed an EMC competency framework. Staff had to evidence they were competent before being supported to progress. Band five midwives had to complete preceptorship competency frameworks before progressing.

Appraisal rates
Managers supported staff to develop through yearly, constructive appraisals of their work. The service had effective systems in place to support and develop staff. Staff said the appraisal system supported them and their managers in setting clear objectives and recognised their performance as well as the behaviours they had exhibited in their roles. Staff said they found the process personal and valuable. From May 2018 to April 2019, 93.8% of staff in maternity at University Hospital Coventry received an appraisal compared to a trust target of 90%. The breakdown by staff group is shown in the table below.
### May 2018 to April 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Appraisals received</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes / No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional professional, scientific and technical</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>187</td>
<td>197</td>
<td>94.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Additional clinical services</td>
<td>80</td>
<td>85</td>
<td>94.1%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical staff</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>26</td>
<td>29</td>
<td>89.7%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Estates and ancillary</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>317</strong></td>
<td><strong>338</strong></td>
<td><strong>93.8%</strong></td>
<td><strong>90%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

The 90% completion target was met for all staff groups except administrative and clerical staff, and estates and ancillary staff.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision. In addition to CPSM’s, the service also had professional midwifery advocates (PMA’s) to support staff. This provided midwives with practical and theoretical support. The service also had a supervision advocate system where staff were allocated a supervisor from another trust site. This offered staff the opportunity to share learning and good practice between trusts. There were enough clinical educators to support staff learning and development. The service ensured student midwives practiced safely and within their competence. Student midwives were supervised always throughout their training and colleagues and managers were supportive and approachable. Student midwives conducted a comprehensive four-week induction programme when starting their role on the unit. In addition, student midwives followed a detailed preceptorship programme. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff could always contact a clinical preceptor support midwife (CPSM) for support during their preceptorship period to develop and maintain clinical practice knowledge and skills. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Midwives attended a variety of forums for their continued professional development including academic courses, in-house training programmes, clinical skills training and forums. For example, PMA’s attended forums to share best practice and to network with each other. Managers made sure staff received any specialist training for their role. For example, midwives, obstetricians, anaesthetics and theatre teams completed specialised midwife training such as PROMPT which was a multi-professional training programme which has been shown to improve outcomes for real women and their babies. Managers identified poor staff performance promptly and supported staff to improve. Processes were in place to provide midwives with restorative, personal action for quality improvement and education and development. The unit had professional midwifery advocates to facilitate this.

### Multidisciplinary working

**Doctors, midwives and other healthcare professionals worked together as a team to benefit women. They supported each other to provide good care.**

Staff held regular multidisciplinary meetings to discuss patients and improve their care. We observed effective communication between staff at all levels. For example, consultants, junior
doctors and midwives shared patient information in handovers. Staff worked across health care disciplines and with other agencies when required to care for patients. There were good examples of multidisciplinary working throughout all services. Patients had access to specialist teams and specialist midwives across all areas who supported patients. They provided specific support, training and development to staff to improve their skills and patient care. Staff worked collaboratively with external local providers to ensure patients received person-centred care based on their personal needs and preferences. Staff worked positively with clinical commissioning groups (CCGs), local authority social workers and third sector organisations to support patients. Social workers, GPs, and other healthcare staff worked together to enable appropriate support upon discharge. There were positive and collaborative relationships with external partners including CCG's and the local maternity system to build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs. Maternity and neonatal staff jointly attended MatNeoQI West Midlands maternal & neonatal safety local learning system meetings. This work is part of the NHS Improvement's National Maternal and Neonatal Health Safety Collaborative. The learning System aims to create a safe space for local learning and sharing. Staff referred women for mental health assessments when they showed signs of mental ill health, depression. Specialist midwives provides continuity of care to women with mental health issues and they could access the perinatal mental health lead for advice and support.

Seven-day services

Key services were available seven days a week to support timely care.

Consultants led daily ward rounds on all wards, including weekends. Women are reviewed by consultants depending on the care pathway. The department ran a full consultant-led, centralised obstetrics unit, with an alongside midwife-led unit (the Midwife-led Birth Centre or MBC). Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Staff said they could access support and advice from support services, diagnostics and consultants anytime easily.

Health Promotion

Staff gave women practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on every ward/unit. There were information leaflets available which included information on areas such as smoking cessation and breast feeding. Staff assessed each woman’s health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, staff completed carbon monoxide testing of all pregnant women at booking. Staff could refer women to the stop smoking services aimed to minimise the chance of problems during pregnancy such as miscarriage, low birth weight and premature delivery. The unit supported national and local health promotion initiatives. Patients were offered the influenza and whooping cough vaccine at the antenatal clinic.

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

Staff supported women to make informed decisions about their care and treatment. They followed national guidance to gain women’s consent. They knew how to support women who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit women’s liberty.
Staff understood how and when to assess whether a woman had the capacity to make decisions about their care. Staff said they would refer patients to the safeguarding midwife and/or perinatal mental health lead if they had concerns around capacity. Staff gained consent from women for their care and treatment in line with legislation and guidance. Staff gave patients all the information about what their options were and what treatments involved if needed, including the benefits and risks, and what might happen if treatment did not go ahead. For example, for home birth and freestanding midwifery led birth units the process of transfer to the obstetric unit, should it be required, was fully explained to women by their midwife when they completed the birth plan appointment. When women could not give consent, staff made decisions in their best interest, taking into account the woman’s wishes, culture and traditions. Staff made sure women consented to treatment based on all the information available. For, example, the named midwife, explained to women the range of choice of birthplaces. They had the opportunity to consider four options which complied with Maternity Matters - Choice, access and continuity of care in a safe service (2007). This included home births and in-patient obstetric unit. Staff clearly recorded consent in the woman’s records. Midwives took time to discuss and inform patients of the choices offered throughout the antenatal, intra natal and postnatal period. Staff clearly recorded consent in the patients’ records. Patient choices were recorded in their notes.

Mental Capacity Act and Deprivation of Liberty training completion

Nursing and midwifery staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards. The trust reported that from January 2018, MCA and DoLS training was part of the trust induction. A separate MCA e-learning package was available on the trust’s website although this was not mandatory. Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust’s target. Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not currently included in the trust’s mandatory training. The trust reported that it was planning to introduce mandatory training in MCA and DoLS for registered practitioners and medical staff by September 2020. This will be included in a new mandatory safeguarding adults level 3 training module. The trust also reported that in the meantime the trust’s safeguarding team had been providing MCA training to priority staff groups since September 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff were knowledgeable about the basic principles of consent and Mental Capacity Act 2005. We saw staff appropriately gained patient consent for treatment in accordance with legislation and guidance. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Deprivation of Liberty Safeguards were monitored trust wide on a weekly basis and discussed at the safeguarding team safety huddle. There was a bi-monthly report that was shared through the safeguarding committee in relation to the number of applications the trust had made. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff could access policies on the trust intranet and said they would approach the safeguarding team and the perinatal mental health nurse for advice and support. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Staff implemented DoLS safeguards in line with approved documentation.
Is the service caring?

Compassionate care

Staff treated women with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for women. For example, staff closed doors and curtains when providing care to protect the women’s modesty. Staff took time to interact with women and those close to them in a respectful and considerate way. Staff listened to their concerns and involved them in as many decisions as possible. Women said staff treated them well and with kindness. All staff interactions with patients were supportive, reassuring and caring. We observed all staff in theatre and recovery were caring and attentive towards a patient who had a caesarean section. Staff regularly checked the wellbeing of this patient during and following the procedure. All feedback received from patients and those close to them was consistently positive.

Staff followed policy to keep women’s care and treatment confidential. Staff followed the General Data Protection Regulation. This is a regulation in EU law on data protection and privacy for all individual citizens of the European Union and the European Economic Area. It also addresses the export of personal data outside the EU and EEA areas. Staff understood and respected the individual needs of each woman and showed understanding and a non-judgmental attitude when caring for or discussing women with mental health needs. (AMSAT). Staff provided care and offered care to patients regardless of their experiences, statuses and characteristics. One patient said staff were non-judgemental and fully supported her with her choice to bottle feed her baby. Staff understood and respected the personal, cultural, social and religious needs of women and how they may relate to care needs. Staff treated patients with dignity and respect always. For example, they pulled curtains around patients when carrying out intimate examinations. Staff provided support to bereaved patients in a separate and private ‘quiet’ room. They could refer patients to a specialist bereavement midwife for further support and advice. Staff could refer women and their families for religious care and support.

Friends and family test performance (antenatal), University Hospital Coventry and Warwickshire NHS Trust

From July 2018 to June 2019, the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was consistently similar to the England average. There was a considerable drop in the trust’s score from 93% in August 2018 to 78% in September 2018. This was followed by an improvement to 93% in October 2018. In June 2019 the trust’s performance was 96% compared to the England average of 95%.

Friends and family test performance (birth), University Hospital Coventry and Warwickshire NHS Trust
From July 2018 to June 2019, the trust’s maternity Friends and Family Test (birth) performance (% recommended) was consistently lower than England average. There was a drop in the trust’s score from 95% in August 2018 to 79% in September 2018. Starting from February 2019 there was a gradual improvement in the trust’s performance. In June 2019, the trust’s performance was 94% compared to the England average of 97%.

Friends and family test performance (postnatal ward), University Hospital Coventry and Warwickshire NHS Trust

From July 2018 to June 2019 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was consistently similar to the England average. There was a considerable drop in the trust’s score from 96% in July 2018 to 81% in October 2018. This was followed by an improvement in November and December (93%). In June 2019, the trust’s performance was 94% compared to the England average of 95%.

Friends and family test performance (postnatal community), University Hospital Coventry and Warwickshire NHS Trust

From July 2018 to June 2019, the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was consistently similar to the England average. In June 2019 the trust’s performance of 98% was the same as the England average.

(Source: Friends and Family Test – NHS England)

CQC Survey of women’s experiences of maternity services 2018

The trust performed worse than other trusts for two out of 19 questions in the CQC maternity survey 2018, and about the same for the remaining 17 questions.
<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>9.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>7.9</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.5</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>7.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>8.0</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If attention was needed during labour and birth, did a staff member help you within a reasonable amount of time?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.4</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.8</td>
<td>About the same</td>
</tr>
<tr>
<td>Care in hospital after the birth</td>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>7.2</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Looking back, was there a delay in being discharged from hospital?</td>
<td>4.3</td>
<td>Worse</td>
</tr>
<tr>
<td></td>
<td>Thinking about response time, if attention was needed after the birth, did a member of staff help within a reasonable amount of time?</td>
<td>7.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>8.1</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.9</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, was your partner who was involved in your care able to stay with you as much as you wanted?</td>
<td>9.3</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>9.0</td>
<td>About the same</td>
</tr>
</tbody>
</table>
(Source: CQC Survey of Women’s Experiences of Maternity Services 2018)

**Emotional support**

Staff provided emotional support to women, families and carers to minimise their distress. They understood women's personal, cultural and religious needs.

Staff gave women and those close to them help, emotional support and advice when they needed it. Staff provided emotional support to bereaved parents. The bereavement midwives had close links with a bereavement charity. The service offered maternity staff debrief sessions following neonatal and maternal deaths. Staff said the service kept the bereaved parents updated of investigation findings and offered them support throughout the process. The bereavement midwives also offered staff, women and their families additional support. Staff spoke to patients and their loved ones in a calm, reassuring and professional manner always. Numerous thank you cards were displayed across the department which supported the positive feedback women and their families gave us about the level of emotional support they received from staff.

Staff supported women who became distressed in an open environment and helped them maintain their privacy and dignity. However, leaders had identified on the risk register the lack of a separate bereavement facility for parents experiencing pregnancy loss of the death of their baby had a negative impact on the immediate and long-term mental health of women and their families. Leaders had action plans in place to address this. For example, they had identified space near to the women’s and children’s entrance and there was support at executive level on progressing plans for an identified space. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The role of the bereavement midwife was to provide immediate and long-term sensitive care and support for families in Coventry and Rugby, following late foetal loss, stillbirth and neonatal death. Although the role of the bereavement midwife was hospital based, they saw families at home giving help and guidance with the necessary practical requirements such as registering the death and the funeral arrangements as well as supporting families emotional needs and helping to create positive memories of their baby. They provided advice and support in subsequent pregnancies where required. A large part of the role involves training and educating all grades of staff in best practice in bereavement care and highlighting the importance of effective and sensitive communication.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Anyone who had experienced or been affected in any way by pregnancy loss or the death of a baby was invited to attend a special service at Coventry Cathedral. Bereaved parents, family members and friends commemorated the all too brief lives of their babies on October 13. This came as part of Baby Loss Awareness week which encouraged people to talk openly and raise awareness of baby loss. University Hospitals Coventry and Warwickshire (UHCW) NHS Trust, along with a neighbouring trust and support of local partner organisations, organised the service.

**Understanding and involvement of patients and those close to them**

Staff supported and involved women, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure women and those close to them understood their care and treatment. Visiting was available to partners 24 hours a day as part of the trust’s ‘Mum + 1’ policy, this was to help facilitate bonding and to support the mother. Other visitors are allowed between 7.00pm and 8.00pm. During the induction of labour process, women were asked to bring only one birth partner.
This ensured privacy of other women in the ward area. Women could nominate two birthing partners to support them during their labour. They were permitted to remain with women during their time on the labour ward. Staff signposted women to a variety of mobile phone applications. For example, an application offering a personal baby expert and virtual friend to support them through their emotional, physical and social journey through pregnancy and becoming a new parent. Staff talked with women, families and carers in a way they could understand, using communication aids where necessary. For example, staff could use adapted tools to screen for mental health problems; or to assess for signs of pain or distress

Women and their families could give feedback on the service and their treatment and staff supported them to do this. The Women’s Experience of Maternity Care Survey was undertaken by Quality Health between April and August 2018. The survey provided information on women’s experiences during all aspects of their maternity care, including ante natal and postnatal care and care received during labour and birth. Recommendations were produced to address areas needing improvement. For example, ‘ensure that adequate time is given during appointments’ and ‘remind staff the importance of introducing themselves’. Staff supported women to make informed and advanced decisions about their care. A high proportion of women gave positive feedback about the service in the Friends and Family Test survey. The feedback from the Friends and Family Test was positive for all wards. The trust performed similarly to or better than other trusts for all 19 questions in the CQC maternity survey (2018)

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. Managers planned and organised services, so they met the needs of the local population.

The service met the needs of the diverse local population. The service employed specialist midwives and offered specialist services such as the diabetes clinic, teenage pregnancy support, anal sphincter injury clinic and mental health clinics. Managers told us due to the increase in referrals and complexity of women being referred to antenatal clinics this was impacting on patient waiting times. Managers had conducted a variety reviews and changes to the service to address this. For example, an additional senor registrar clinic was set up on Friday afternoons to support overflow on ante natal appointments for women requiring scan reviews and regular reviews and backfill of clinics was put in place where possible to maximise appointments by review of rota.

Women were offered choices of care. Home Births were arranged through the community midwife and a supervisor of midwives. The community midwife carried out antenatal care at the women’s GP’s surgery or in their home. If complications arose in labour they could be transferred in to hospital. Low risk care women could choose to spend the early part of labour at home.

The Lucina birth centre offered women a safe place to give birth if they were assessed as ‘low-risk.’ The midwife risk assessed the progress of the woman’s pregnancy at each visit and confirm that your pregnancy was uneventful at their 36-week appointment. At this time, they provided the woman with the contact details of birth centre. There was a birth pool on the labour ward. The midwives on the labour ward assisted and advised them regarding the use of the pool during their labour and birth. High risk women were offered consultant/shared care. This was where antenatal care was shared between the hospital obstetrician, the community midwife and the GP. These women gave birth on the labour ward at University Hospital. The antenatal care was provided in the maternity unit, in the community or at the Hospital of St Cross. The unit was accessible to
wheelchair users and patients with limited mobility. Staff provided specialist equipment for heavier patients. For example, the antenatal ward had a large accessible bathroom with a large bath and hand rails. Facilities and premises were appropriate for the services being delivered. Staff could access emergency mental health support 24 hours a day 7 days a week for women with mental health problems, learning disabilities and dementia.

The service had systems to help care for women in need of additional support or specialist intervention. The department had some specialist midwives to provide dedicated support to patients. These roles included midwives involved in the teenage pregnancy midwifery project, an infant feeding midwife, risk midwives, safeguarding children’s midwife, bereavement midwives, and an infectious diseases midwife (high population of HIV patients). Managers monitored and took action to minimise missed appointments. For example, the ante natal department had recently set up a text message appointment reminder service. Managers ensured that women who did not attend appointments were contacted. Ante-natal staff followed a DNA policy. For example, if a women did not attend two consecutive appointments staff would contact the community midwife to visit the women at home.

The service relieved pressure on other departments when they could treat patients in a day. Women benefited from the convenience of one stop shop style ante-natal appointments. This was where staff offered all ante-natal appointments in one place and on the same day such as consultant appointments, blood tests and scans. Ensuring women received their induction of labour in a timely manner was a challenge for the service in relation to capacity issues. The service addressed through via their service improvement learning in conjunction with their partnership with the Virginia Mason Institute. For example, the service had staggered admissions throughout the day with the aim of improving care for patients as staff had more time to spend with each patient when being induced. Induction of labour patient leaflets now provided patients with information regarding induction process. Service improvement plans such as offering low risk patients the choice to have their inductions at home were in place.

**Bed Occupancy**

From quarter 4 of 2017/18 to quarter 1 of 2019/20 the bed occupancy level for the trust’s maternity service was consistently much lower than the England average. In quarter 1 of 2019/20 the trust’s bed occupancy level was 9.4% compared to the England average of 58.4%. The chart below shows the occupancy levels compared to the England average over the period.

(Source: NHS England)

**Meeting people’s individual needs**
The service was inclusive and took account of women’s individual needs and preferences. Staff made reasonable adjustments to help women access services. They coordinated care with other services and providers.

Staff made sure women living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Specialist midwives provided care and support to women with complex needs including mental health. They attempted to provide vulnerable women with a holistic sense of safety through continuity models of care. Staff supported women living with learning disabilities by using ‘This is me’ documents and patient passports. Staff understood and applied the policy on meeting the information and communication needs of women with a disability or sensory loss. Pathways of care for people with learning disabilities, were concordant with all current and contemporary guidance. The service had information leaflets available in languages spoken by the women and local community. Patient information leaflets were readily available in languages other than English. Staff had access to translation services for patients whose first language was not English. Women could access the hospitals maternity leaflets in a mobile phone application. This included day to day practical advice and fun facts and a baby growth and development trackers. Managers made sure staff, women and their loved ones and carers could get help from interpreters or signers when needed. A face to face and telephone interpreting service was available and staff could provide written translations. This included people who used British Sign Language (BSL) or those who required written information in Braille. There were also a number of staff who were able to interpret a variety of languages. Women were given a choice of food and drink to meet their cultural and religious preferences. The trust provided a range of cultural and ethnic meals including certified halal, vegetarian, vegan, Asian vegetarian and Caribbean. The trust provided a range of meals for patients with special dietary needs including certified gluten free and texture modified consistencies. Staff had access to communication aids to help women become partners in their care and treatment. Patient communication books (Hello, how may I help you?) were available for patients to complete. This was for women and their relatives to make a note of anything that they would like staff caring for them to answer or address, or for staff to give them handy information or reminders about their ongoing care and recovery.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge women were in line with national standards.

Managers monitored waiting times and made sure women could access services when needed and received treatment within agreed timeframes and national targets. Managers had oversight of ante-natal appointment waiting times. Managers monitored waiting times and made sure women could access emergency services when needed and received treatment within agreed timeframes and national targets. Staff transferred women with medical emergencies to the obstetric high dependency unit (HDU) where they provided a caring environment for pregnant women who became acutely (severely) ill either during or after giving birth. Managers and staff worked to make sure women did not stay longer than they needed to. Women with low risk pregnancies were supported to spend the early part of labour at home and home births could be arranged through community midwives and a supervisor of midwives. The community midwife carries out antenatal
care at women’s GP’s surgery or in the woman’s home. Only if complications arose in labour would the woman be transferred in to hospital.

Managers worked to keep the number of cancelled appointments to a minimum. When women had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers monitored that moves between wards/services were kept to a minimum. Women were kept in wards appropriate to their needs. For example, women admitted to hospital during their pregnancy because of problems or complications were cared for on the ante natal ward. The service moved women only when there was a clear medical reason or in their best interest. For example, staff would move women to the high dependency unit (HDU) if they become acutely (severely) ill either during or after giving birth. Staff did not move HDU patients to postnatal ward at night.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff followed a maternity care pathway. This described the care women could expect during their journey through pregnancy, labour and childbirth, and the postnatal period until they were discharged to primary care services. Staff planned women’s discharge carefully, particularly for those with complex mental health and social care needs. For example, support was offered to women with mental health issues by GPs, counsellors, midwives, health visitors and liaison mental health practitioners. Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. Staff supported women and babies when they were referred or transferred between services. The transitional care nursery was a low dependency ward which provided support in a comfortable and vibrant environment for babies who were born prematurely. This nursery did not only benefit the babies, but it also aimed to instil confidence in sometimes nervous parents. The unit was opened to help support parents through the transition of their baby being cared for in an acute medical area to a less clinical nursery setting. Managers monitored transfers and followed national standards.

(Source: DR 71)

It was easy for people to give feedback and raise concerns about care received. The
service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included women in the investigation of their complaint. Women, relatives and carers knew how to complain or raise concerns. People who used the services were encouraged to raise concerns and make complaints. The service clearly displayed information about how to raise a concern in patient areas. Patients and carers were advised how they could make a complaint or raise a concern on a leaflet or feedback form. They could also complain using the trust’s internet site. Information about how to feedback a concern, complaint, comment or compliment was displayed clearly in all the wards we visited. Staff understood the policy on complaints and knew how to handle them. Staff tried to resolve complaints locally and informally before proceeding to formal processes such as referring to PALS. A patient experience midwife attempted to speak to all women on daily basis to identify any issues they might have.

Managers investigated complaints and identified themes. Issues raised were investigated and lessons learned were shared with all staff to improve the quality of care. Since introducing the role of the patient experience midwife no formal complaints had been made since 6 June 2019. Prior to this the service was averaging around three a month. This showed this specialist midwife role had a positive effect on patient experience and therefore decreased the number of complaints about the service.

From May 2018 to April 2019, the trust received 34 complaints about maternity at University Hospital Coventry (5.3% of total complaints received by the hospital). Managers dealt with complaints thoroughly, appropriately and proportionately and ensured patients were not caused unnecessary distress waiting for updates, and for confirmation that their concerns had been addressed. For the 33 complaints that had been closed at the time of data submission, the trust took an average (mean) of 23.1 working days to investigate and close these complaints. This was within the trust’s target of 25 working days. The one complaint that was open at the time of data submission had been open for 55.3 working days. This was longer than the trust’s target of 25 working days. A breakdown of complaints by department is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour ward</td>
<td>10</td>
<td>29.4%</td>
</tr>
<tr>
<td>Ward 25 - postnatal</td>
<td>5</td>
<td>14.7%</td>
</tr>
<tr>
<td>Ward 24 - antenatal</td>
<td>4</td>
<td>11.8%</td>
</tr>
<tr>
<td>Operating theatres</td>
<td>3</td>
<td>8.8%</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>3</td>
<td>8.8%</td>
</tr>
<tr>
<td>Community midwifery</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Lucina birth centre (midwifery led unit)</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Foetal well-being unit</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Ultrasound - obstetrics</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Booking office</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Foetal medicine unit</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Labour ward triage</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

A breakdown of complaints by subject is shown in the table below.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>22</td>
<td>64.7%</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>5</td>
<td>14.7%</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>---------------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Communications</td>
<td>2</td>
<td>5.9%</td>
</tr>
<tr>
<td>Appointments</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Trust admin / policies / procedures including pt record management</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Patient care including nutrition / hydration</td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From May 2018 to April 2019, the trust received 156 compliments about its maternity services. All of these concerned the maternity service at University Hospital Coventry. All of these compliments concerned the reporting unit obstetrics. The trust noted that the main theme arising from 1,600 compliments received across the trust over the same 12-month period were how well staff demonstrated the trust’s values, particularly compassion, pride and respect. Recent compliments mentioned the professionalism and responsiveness of their staff.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and recommendations resulting from investigation outcomes were shared with all staff through a variety of forums such as team meetings and huddles.

Is the service well-led?

Leadership
The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. The service had effective leadership structures which provided direction and support to staff.

The maternity unit was part of the women’s and children’s clinical group. The Women’s And Children’s Group had an experienced leadership team, comprising of a group clinical director, head of midwifery, group director of operations (GDO) and group director of nursing and allied health professionals (GDNA). The Women’s And Children’s clinical group CD was a member of Trust Delivery Group, the trust’s senior decision making group, which ensured that the maternity service was recognised and included in appropriate service and trust wide developments. There were clear lines of accountability at all levels. Ward managers reported to the modern matron and the modern matrons directly to the head of midwifery. Aligned with improvement methodology, senior management were now more visible within the clinical areas. For example, they attended the bi weekly maternity safety champion production board. The head of midwifery had weekly one to one meetings with the chief nursing officer. Leaders had introduced a maternity safety improvement plan. This was shared at group quality improvement performance meetings, patient safety executive committee and trust/public board and included NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Safety Standards and MBRACE gap analysis. Leaders had recently introduced successful initiatives such as the daily brief, effective handover and the daily huddle on labour ward involving all of the multidisciplinary team. Leaders benchmarked their data as a way of ensuring they were providing their patients with safe and effective care. Leaders viewed data collected from providers in England and regularly compared their own clinical outcomes to identify areas for quality improvement. The maternity dashboard enabled maternity
clinical staff to regularly compare total deliveries, C-sections, induction of labour and third- and fourth-degree tears.

All staff we spoke with said the leaders such as the head of midwifery and matrons were visible and approachable. Staff felt leaders appreciated the day-to-day pressures they experienced. They felt supported to develop in their roles. For example, there was a preceptorship programme for band five midwives to progress to band six positions. They received additional support from the clinical support preceptorship midwives. Leaders and senior staff had oversight of the challenges the maternity service was facing and had actions in place to address them. Senior staff were all knowledgeable about the CQC action plan resulting from the previous inspection. Leaders engaged with and empowered staff at all levels to implement the changes needed. This was supported by the evidence of positive changes that had been made since our last inspection such as the increase in staff.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The unit’s maternity pledge was “Working to support healthy babies and new mothers”. As part of University Hospitals Coventry and Warwickshire NHS Trust’s continued commitment to providing the best possible maternity services to the people of Coventry and Warwickshire staff had set out five pledges to ensure that every expectant mother and new baby was given support throughout their pregnancy journey to try and achieve the best possible outcomes. Through this they aimed to ensure every expectant mother was supported - from pregnancy, to birth, to those critical first months of parenthood - with a comprehensive package of personalised, high quality support:

1. ‘During your pregnancy we will help you make informed choices about your own care. This includes giving you open and honest information about your own health, your pregnancy and birth options and support available to you.
2. During birth we will actively listen to you to ensure we have the opportunity to give you the personalised birth experience you would prefer and answer any questions that you may have.
3. If there are any difficulties encountered during the birth, we will communicate what is going on with you in order for us to provide the correct support to achieve the best possible outcome.
4. After the birth of your baby we will provide care which is tailored specifically to you and your baby. We will ensure that you have the support and foundations in place before you go home in order to give you both the best possible start to life together.
5. When you go home we will offer you a comprehensive package, involving your GP and health visitor, incorporating high quality personalised support to give you and your baby the best possible start. This offering will include an offer of ongoing mental health support and health support when needed.’

Senior leaders of the service said their vision was to have a dedicated bereavement facility, shared guidelines across the local maternity system (LMS), a hub and spoke model, and a decrease in perinatal death.
Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We found a supportive and enthusiastic culture in teams we inspected. Staff were proud of the quality of service they delivered and spoke positively about the organisation. There was constructive engagement with staff; staff at all levels were encouraged to raise concerns. Staff felt well supported by their line managers and they promoted a culture of openness and inclusivity amongst all levels of staff. This was an improvement since our previous inspection. All staff we spoke with at all levels told us the culture had shifted and was more positive. Staff felt supported, respected and valued. They described a no blame culture.

We found the culture centred around the needs and experiences of the patients. Staff felt they were offered more development opportunities and felt managers valued their safety and wellbeing. We found staff and teams working effectively and supporting each other. The huddles created an environment where staff regularly communicate and feel safe to raise concerns about patient safety. A culture of speaking up being business as usual was promoted Maternity staff could contact the trust’s freedom to speak up guardians. The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in “Freedom to Speak Up” in 2015. This ensured that the needs of staff were met and that Freedom to Speak Up developed in a way that responds to local circumstances, were fundamental principles of the role.

Community midwifery staff were part of the strong teamwork. Were an important part of the overall maternity service at the trust and staff told us they all supported each other, particularly in response to increased activity on the unit. The department had several new recruits in post. This supported safe staffing of the unit and meant staff no longer felt burnt out and overworked.

Staff displayed the trust values. The trust had developed a set of values to reflect how they expected their staff to treat patients, visitors and each other. These were:

- “Compassion. We treat everyone with courtesy and compassion,
- Openness. We act with openness, honesty and integrity in all we do.
- Pride. We take pride in all we do and aspire to do.
- Learn. We see education, research and learning as central to improvement.
- Partnership.
- Improve.
- Respect.”

All staff were polite, courteous and respectful when interacting with patients and visitors.

Governance

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.

Managers had a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom. There were clear departmental governance arrangements and there were teams and accountable personnel to oversee governance. There were clear and effective processes for
managing risks, issues and performance. This was in seen in their evidence-based practice, competency and skills mix of staff and in their documentation and minutes from meetings such as the grand safety huddle meetings. The head of midwifery and other leaders maintained appropriate oversight of governance in the maternity department. They attended a variety of governance meetings such as the huddles, and grand safety rounds. They could escalate directly to the trust management board. These were well attended by staff from many disciplines, including obstetricians, anaesthetists and midwifery staff. This demonstrated staff interacted effectively and held useful discussions concerning areas such as incidents, patient experience, complaints and compliments. Staff conducted team meetings in a consistent manner. Team meeting minutes across the department followed the same format and actions from the meeting were allocated to staff to be responsible for the actions. The board had appropriate oversight of the challenges the maternity department faced and were responsive in addressing these. For example, the unit had recently conducted a recruitment drive to staffing issues which posed a threat to the patient safety. After the inspection, the trust told us that group leadership team also attended monthly multidisciplinary Quality Improvement Patient Safety (QIPS) meetings. These meetings reviewed patient safety, clinical effectiveness and patient experience in line with the trust strategy. Outcomes of the Group QIPS meetings were submitted to the Group Management Board to provide assurance that actions arising were being undertaken in a timely way. The Women and Children’s group were accountable to Chief Officers for the delivery of performance through quarterly performance reviews. Clinical groups met regularly with chief officers and corporate directors to review performance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

A specialist risk management midwife managed both clinical and non-clinical risks with the overall aim to facilitate the provision of a safe maternity service, based on best practice which was achieved by the reduction of risk and subsequent harm to mothers and babies. Leaders had now introduced a local maternity system (LMS) dashboard to enable clinical teams to view data across the LMS and identify areas for quality improvement. It allowed the LMS to act on areas requiring improvement before it reached the national dashboard. The dashboard was streamlined to reflect the clinical improvement metrics and national maternity indicators from the recently published national maternity dashboard. Indicators were selected to cover five themed domains. These were mortality and morbidity, choice, clinical care and health promotion, organisational culture and user experience. Data was captured from various sources from the organisation’s maternity dashboards, CQC style in house surveys and support services such as the stop smoking services. Action plans were produced to address red flagged areas on the LMS dashboard. For example, each trust was required to develop an action plan to improve the percentage of women that were not left alone by midwives or doctors at a time when it worried them.

Clear arrangements were in place for managers to identify, record, manage risks and provide actions plans to address them. The group maintained a group risk register, which was discussed at group board monthly and presented to the Trust Risk Committee twice per year. The risk register represented the current risks to the maternity service. We found the risk register reflected the scope of what staff and managers identified as risks during our visit, such as, the lack of bereavement facilities. Mitigation strategies were put in place to address the risks identified and to attain optimal results. The head of midwifery used a maternity dashboard and clinical audits to
continuously monitor quality, operational and financial outcomes. They took actions to address areas of concerns. There was maternity representation at board level. This was in line with national guidelines.

The service took potential risks into account when planning services such as the winter season and unexpected fluctuations in demand. The service had winter plans in place and managers could follow escalation procedures to keep women safe if they were up to full capacity and couldn’t accept any more patients. The trust board had full assurance regarding patient safety in the maternity unit. The service collected, monitored and audited all metrics such as induction of labour delays and transfer of babies to other units. This meant the service could always drive improvement in response to this information. This was an improvement since our last inspection.

The trust was compliant with the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. This meant they were compliant with the following safety actions:

- ‘Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
- Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?
- Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?
- Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?
- Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?
- Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies’ Lives care bundle?
- Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?
- Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an ‘in-house’ multi-professional maternity emergencies training session within the last training year?
- Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?
- Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution’s Early Notification scheme?’

**Information management**

The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Data or notifications were consistently submitted to external organisations as required.

Staff currently used paper based records system. The service was planning to change to an electronic maternity records system and was in the processing of choosing a new system. The service mostly had effective arrangements in place to ensure records were available when required. Managers demonstrated a holistic understanding of performance which looked at people’s views with information on quality, operations and finance. Managers had a framework to
oversee the quality and safety of patient care. They reported a range of service performance measures and discussed quality and sustainability in all governance meetings.

Arrangements ensured availability, integrity and confidentiality of identifiable data, records and data management systems in line with data security standards. Staff followed the General Data Protection Regulation (GDPR) which came into force on May 25, 2018 and was designed to modernise laws that protect the personal information of individuals. Although patient records were not stored securely in a locked cabinet the cabinet was placed at the midwives’ station which meant there was always a member of staff around. At no time did we see patient’s files left out when not in use.

Engagement
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Staff gathered insight into how women felt about their experience of staying in the unit to help staff understand what they did well and what they could do better. Leaders gathered patients and staff views and experiences and acted on them to improve their services. Staff used a feedback tool that supported the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This showed staff listened to the views of patients and staff to help identify what was working well, what could be improved and how. The new role of the specialist patient experience midwife now managed the FFT. In the previous two months compliance with the response rate had increased and reached the target response of 15% in all areas of the unit. Staff were trialling the use of IPads to increase compliance. Staff were asking patients to complete the test immediately following completion of the NIPE tests. The patient experience midwife had recently introduced a QR code on the front of all discharge packs. This meant that if women had not already had the chance to complete the survey, they could do so from home at a later stage through a smartphone or tablet. Staff asked women to complete the maternity satisfaction survey and the feedback was analysed on a quarterly basis and action plans were put in place to address areas needing improvement. This showed staff felt believed acting on patient feedback was an important way to improve the quality of their services and the experience of patients. ‘Ask the midwife’ midwives took over the UHCW social media page to answer any questions women had about their pregnancies and/or giving birth.

Staff were actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. For example, bi weekly maternity safety champions meetings and a safety production board on labour ward with fortnightly executive level rounding took place. A survey was completed to explore safety culture, local leadership, learning systems, resilience / burnout and work-life balance. This SCORE Culture Survey had 72% of all maternity and neonatal staff respond. Outcomes form this were:

• ‘SCORE Debriefing Sessions – 14 debriefing sessions had been held (120 staff had been debriefed).
• Quality of Care – a Weekly Learning Forum was established.
• Clinical preceptor support midwives supported newly qualified midwives.

After the inspection, the trust told us that It should be noted the response rate was significantly higher than the 60% required response rate indicating excellent staff engagement.
A ‘Whose Shoes’ event brought together midwifery and multiagency partners and service users and families. People’s views and experiences were gathered and acted upon to shape and improve the services and culture. For example, a ‘Whose Shoes’ event was attended by many service users and 86% of attendees rated the event as “excellent”. Women could attend the maternity engagement group. This gave them the opportunity to meet and discuss, shape and comment on maternity services in the area. There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population and to deliver services to meet those needs. A ‘Maternity Voices Partnership’ (MVP) for Coventry and Warwickshire wide role had been appointed to, who was a board member on the LMS. The Head of Midwifery also attended these meetings to further support collaborative working.

The patient experience midwife was appointed in February 2019. Their role included managing the Friends and Family results by managing any feedback during admission and monitoring the gap analysis for quality report produced in February 2019. For local complaints management, face to face meetings offered with every complainant with matron(s)/consultants/Head of Midwifery prior to written response being sent. For the NHS Long Term Plan, a Complex High Risk Continuity Team was introduced in March 2019. A patient was invited to attend the maternity safety champions meetings. This enabled staff to showcase their approach to safety. Staff showed the experiences of patients, carers or family members was important to them. Staff displayed ‘You said we did’ information in the department’s waiting areas. The service encouraged the involvement of patients in the shaping of their service through feedback and also through encouraging the participation of previous patients in safety huddles.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff had made many service improvements since our previous inspection in 2018, such as increase in staffing, compliance with foetal monitoring and a positive change in the culture. Leaders put quality improvement plans in place to progress the service. We noted many areas of innovation. A smoking in pregnancy video was produced to increase the awareness of the dangers in smoking in pregnancy. It was shared on the trust’s social media pages and inpatient waiting areas and used as part of the risk perception pathway. The video was shared with all obstetric staff and were encouraged to share it with women and their families. The head of midwifery held a community midwives learning event to update staff on progress staff had filmed two videos surrounding the topic of reduced foetal movements. They were aiming to share this on social media and had re-filmed in several other languages. One video was by a midwife discussing reduced foetal movements (RFM) myths and the second by a midwife reminding patients to monitor and report in RFM within the department and areas of improvement required. The department held multi-disciplinary meetings to reflect on cardiotocography (CTG) cases. Staff voted what option they would have taken though an interactive anonymous voting button. This meant staff were supported to be honest and transparent in their feedback and opinions.

Maternity staff were presented with a baby feeding award by the Lord Mayor in January 2019.

The department had received innovation funding for a research midwife to trial the placental growth factor, or PGIF. This test measures the blood levels of a protein released by the placenta (placental growth factor, or PGIF) that is found in abnormally low levels in women with the condition. The test was found to be highly accurate in detecting pre-eclampsia for women who were below 35 weeks of pregnancy.
The service had opened a Tommy's National Centre for Miscarriage Research in April 2016. This was the first world-class research centre to be opened dedicated to researching the causes of early miscarriage. The service worked in collaboration with the Tommy's National Early Miscarriage Centre which was a partnership of three universities. Each site ran specialist clinics enabling 24,000 women per year to access treatment and support and participate in Tommy’s research studies. Staff working for this service were extremely proud of the research they undertook. The centre had a biomedical research unit with dedicated research midwives who recruited patients to National Institute for Health Research (NIHR) studies.

The maternity team were crowned as the Midwifery Service of the Year by the Royal College of Midwives.

The service subscribed and took part in the Virginia Mason methodology of quality improvement initiatives which had been developed through a 5-year collaboration between NHS Improvement and the Virginia Mason Institute in Seattle, America, taking the lean improvement method from manufacturing and applying it to healthcare. This was a trust wide asset that supported staff to understand and develop good quality improvement. This was the trust’s UHCWI quality improvement programme.

The maternity service had systems for continuous improvement using UHCWI methodology as its foundation. Leaders encouraged all staff to participate and follow the methods of improvement. Leaders told us of initiatives that have resulted from the programme included:

- GEMBA rounding - observing the work where it takes place.
- Daily safety and operational huddles.
- Production boards - to monitor key indicators of performance and address risks early.
- Improvement boards - a visual display to look-back on progress against goals and objectives.
- Passport sessions to introduce the UHCWI method to staff at all levels and its improvement tools and offer the opportunity to undertake a waste walk, to apply tools to eliminate waste and to share learning and improvements.
- Standardised work to reduce the amount of unwarranted variation in practice
- Stand up presentations - provides a weekly opportunity for individuals or teams to share their improvement projects with staff and patients from across the organisation and always attended by the Trust executive team
- Kaizen events - areas of focussed improvement work using a range of improvement tools.

The department was accredited by UNICEF for the International Baby Friendly Initiative in 2019. The service was the first in region to be awarded this accreditation.

The OASIS (Obstetric anal sphincter injury clinic) was for women who suffer 3rd or 4th degree tears and was the only such clinic in the region with a multi-professional one-stop clinic where patient sees a consultant for an endoanal scan, a specialist midwife and a physiotherapist during the same appointment avoiding the need for three separate visits.

The INSPIRE clinic was for women who have suffered female genital mutilation (FGM). INSPIRE is a consultant-led service supported by specialist midwives who assessed and support patients in deciding on their preferred mode of delivery and making suitable adjustments, for example preparing de-infibulation.
One stop shop style ante-natal appointments had been introduced. This was where staff offered all ante natal appointment in one place and on the same day, such as consultant appointments, blood tests and scans.

After the inspection, the trust told us that the service was part of the “Pathway to Excellence, Ward/department accreditation” work which was focused on delivering the trust strategic objective of safest patient care and excellent patient experience. The pathway to excellence provided staff with more opportunities of leadership, shared decision making, professional development and welfare. In turn, patient standards would be more visible, more often with particular emphasis on excellent safety, care, and dignity.

Neurosurgery

Facts and data about this service

Ward 43 at University Hospital Coventry is the trust’s neurosurgery ward. The ward has 46 inpatient beds. The ward includes a step down unit for patients post-surgery or transferred from the intensive care unit.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The neurosurgical service is a tertiary service covering a population of 1.5 million across Coventry, Warwickshire and Worcestershire. The trust holds neurosurgery outpatient clinics at five hospitals in the region that are managed by other trusts. The trust carries out over 3,000 neurosurgical procedures each year.

(Source: Trust website)

The trust had 2,006 neurosurgery admissions from March 2018 to February 2019. Emergency admissions accounted for 620 (30.9%), 733 (36.5%) were elective, and the remaining 653 (32.6%) were day case.

(Source: Hospital Episode Statistics)

We inspected neurosurgery at University Hospital from 8 to 10 October; and during the evening of the 4 November 2019. During our time on site we spoke with 45 staff across ward 43, ward 42, within theatres and from other areas within the trust. These staff included doctors, nurses, health care professionals, senior management and support staff. We spoke with seven patients and six relatives. We reviewed 17 patient records and observed numerous episodes of care. We also attended meetings relevant to neurosurgery services.

Ward 43 had capacity for 46 patients. During our inspection 12 beds on Ward 43 were closed for refurbishment under fire regulations. Therefore 12 patients were located in a satellite area on ward 42 to enable to same number of patients to be cared for if necessary. The ward was staffed to four areas. Area one contained the main reception area for the ward and had two six-bedded bays. These two bays were those temporarily closed at the time of inspection. Area three had two four-bedded bays and two side rooms. Area four had two four-bedded bays with four side rooms. Area two was the neuro-enhanced care unit located within ward 43. This area provided care for patients with a higher acuity; for example, who required ongoing cardiac monitoring, but could be ‘stepped down’ from critical care. This area consisted of two four-bedded bays and four side rooms.

Is the service safe?

Mandatory training
The service provided mandatory training in key skills to all staff and made sure most nursing staff completed it. However, not all medical staff were compliant with mandatory training requirements.

**Mandatory training completion rates**

Nursing staff received and mostly kept up-to-date with their mandatory training. The trust set a target of 95% for completion of mandatory training. A breakdown of compliance for mandatory training courses as of April 2019 at trust level for qualified nursing staff in neurosurgery at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire safety – annual</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>22</td>
<td>24</td>
<td>91.7%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>NPSA preparing and administering a transfusion of blood or blood products</td>
<td>21</td>
<td>24</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>21</td>
<td>24</td>
<td>87.5%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>20</td>
<td>24</td>
<td>83.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>19</td>
<td>24</td>
<td>79.2%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In neurosurgery at University Hospital Coventry the 95% target was met for six of the 11 mandatory training modules for which qualified nursing staff were eligible. As of August 2019, mandatory training compliance for nursing staff was 92% although still did not meet the trust target of 95%.

Medical staff did not all keep up-to-date with their mandatory training. A breakdown of compliance for mandatory training courses as of April 2019 for medical staff in neurosurgery at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th></th>
<th></th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>20</td>
<td>20</td>
<td>100.0%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information governance</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>18</td>
<td>20</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Fire safety – annual</td>
<td>20</td>
<td>23</td>
<td>87.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>17</td>
<td>21</td>
<td>81.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Moving &amp; handling - medical and dental</td>
<td>18</td>
<td>23</td>
<td>78.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>18</td>
<td>23</td>
<td>78.3%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>
The group directors for neurosurgery told us they had taken actions to improve the compliance rate for medical staff, including ensuring mandatory training discussions formed part of appraisals and revalidation conversations. The mandatory training was comprehensive and met the needs of patients and staff. Staff told us mandatory training modules, which were delivered both via e-learning and face to face, were of a good quality and met their needs. Staff told us they mostly had time in the working day to complete required training. During our inspection we observed staff complete this during their shift. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Managers monitored mandatory training and alerted staff when they needed to update their training. Monthly mandatory training compliance was monitored and displayed on the ward for staff to view. We saw staff completing their training during their inspection; and they told us managers reminded them if training was due to renewal.

**Safeguarding**

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Nursing staff had training on how to recognise and report abuse and they knew how to apply it. Not all medical staff were fully compliant with safeguarding training requirements.

Nursing staff received training specific for their role on how to recognise and report abuse. The trust set a target of 95% for completion of safeguarding training. The tables below include preventing radicalisation training as a safeguarding course. This training module works to stop individuals from getting involved or supporting terrorism or extremist activity. A breakdown of compliance for safeguarding training courses as of April 2019 for qualified nursing staff in neurosurgery at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>24 24 100.0% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>24 24 100.0% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>2 2 100.0% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>23 24 95.8% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>23 24 95.8% 95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

At University Hospital Coventry the 95% target was met for all five safeguarding training modules for which qualified nursing staff were eligible.

Medical staff did not all achieve compliance targets for training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as of April 2019 for medical staff in neurosurgery at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>24 24 100.0% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>24 24 100.0% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>2 2 100.0% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>23 24 95.8% 95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>23 24 95.8% 95%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Medical staff did not all achieve compliance targets for training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as of April 2019 for medical staff in neurosurgery at University Hospital Coventry is shown below:
<table>
<thead>
<tr>
<th>Module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>22</td>
<td>23</td>
<td>95.7%</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>21</td>
<td>23</td>
<td>91.3%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>9</td>
<td>10</td>
<td>90.0%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>19</td>
<td>23</td>
<td>82.6%</td>
<td>95%</td>
<td>No</td>
</tr>
</tbody>
</table>

In neurosurgery at University Hospital Coventry the 95% target was met for two of the five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. We saw staff were supportive to patients with protected characteristics; and sought to enable an equitable and safe level of care. For example, during our inspection we saw a patient with physical and learning disabilities was well supported. Although this patient was an adult (over 18) it was recognised that due to their additional needs; they required significant parental support. Therefore, the patient was in a side room and provision was made to enable a parent to remain with the patient throughout the entire duration of the hospital stay to promote their safety and wellbeing.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A trust wide lead nurse for safeguarding attended board rounds to learn about ongoing risk of harm or neglect to patients and act where necessary. Staff gave us examples of situations where they would have concerns about a risk of harm.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with had a clear understanding of how a vulnerable adult may present; and were aware of the need of such patients. Patients requiring neurosurgery often had vulnerabilities due to the nature of their condition or an injury and staff understood how this could impact patient decision making and behaviour. We saw examples of three safeguarding referrals made and noted these were appropriate and thorough, and protected the needs of the patient. Where appropriate, staff discussed the referral with patients or their relatives. Where appropriate referrals to specialist support agencies were made following assessments. For example, a referral to a hoarding therapy service had been made for one patient where it was identified that this was a need.

Staff followed safe procedures for children on the ward. The ward took patients aged 16 and 17 years old who required specific neuro-surgical care. These patients were in side rooms to promote their safety where possible; and relocated to an adolescent ward when their acuity had reduced. During our additional inspection visit on the 4 November we saw that a 17 year old patient had been admitted. They were in a side room as per trust policy, and their parent had been enabled to remain with them for the duration of their stay. Routine safeguarding referrals had been made to the local authority due to the nature of the patient’s condition and age.

Data from the trust showed that from November 2018 to October 2019, three 16 year old and five 17 year old patients had been on the ward. At the time of the inspection there was no specific standard operating procedure in place to manage patients under 18 on the ward. However, the trust reported that in recognition of the need to provide optimal care to young persons in an adult
ward setting, a policy for the admission of Young People 14-18 years to an acute care adult ward had been drafted and was going through the process for approval. Adolescents are supported on ward 43 by the trust paediatric services accessed via the bleep system.

**Cleanliness, infection control and hygiene**

The service did not consistently control infection risk well. Not all the equipment and the premises were visibly clean. However, staff used protective equipment and control measures to protect patients, themselves and others from infection. The service used systems to identify and prevent surgical site infections.

Not all of the ward areas were clean or had suitable furnishings which were clean and well-maintained. Two communal sink and bathroom areas were, at times dirty, although we did observe cleaning staff to regularly work across the ward. The day room used by patients waiting for surgery, and by other patients and visitors was carpeted and looked unclean on the day of inspection; for example, rubbish was on the floor. We observed soiled bedding had been left on the chair next to a patient bed. The patient was in the bed with clean linen at the time. What looked like faeces had dripped from the bedding onto the chair. The bedding was on the seat for over 30 minutes despite two staff attending to the patient to take vital signs observations and to administer medicines. We asked a healthcare assistant what the process for removing soiled bedding was and they told us that when beds are changed soiled bedding should be immediately bagged up and removed; they immediately attended the bay to remove this.

On the final day of our inspection, we found the sink in the male patient’s bay within the neuro-enhanced care unit (NECU) was unclean. This was also highlighted by a relative. We raised this with staff who told us it had already been reported as the drainage was faulty. A senior nurse shortly after asked this to be reported, at which point a different staff member contacted facilities. Therefore, we were not sure if this had been initially reported. A short while after, a relative came out and informed staff that the sink was now overflowing onto the bay floor. During our additional inspection visit on 4 November 2019, staff told us this issue was now rectified and commented that on this occasion; the facilities staff had taken longer than usual to respond to the request for support. After the inspection, the trust told us the sink was replaced on the same day. The delay was due to it being reported incorrectly.

We found a chair in a side room used by visitors had ripped arms; duct tape had been used to seal these on both arms. This was not in line with infection prevention and control best practice.

Other areas of the ward, such as side rooms generally appeared visibly clean during our inspection. Privacy curtains used were reusable. Those checked during inspected appeared visibly clean. Data from the trust reported that bed curtains were cleaned or replaced in line with National Cleaning Standards 2004.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning audit data was displayed monthly on the ward for staff, patients and visitors to view. We saw for August 2019 this was at 93% which was an improvement on preceding months. Staff worked effectively to prevent, identify and treat surgical site infections. Staff used records to identify how well the service prevented infections. Medical staff completed an audit into the incidence of post-operative infection following extra ventricular drain insertion in 2019.
The neurosurgery participated in the National Getting It Right First Time (GIRFT) Surgical Site Infection Audit in 2019. The audit criteria included patients who had Extra Ventricular Drain (EVD) insertion; however, there were no cases of surgical site infection within the sample audited. Data was due to be submitted to this national audit in December 2019; the national report had not been published. (Source: DR 57)

Managers monitored compliance to MRSA testing of eligible patients. Band three healthcare assistants (more senior healthcare assistants) had been provided with access to an online electronic system so they could check if appropriate screenings had been carried out. Staff reported this had led to an improvement in screening for elective patients with 95% of eligible patients being screened in August 2019.

Staff did not always follow infection control principles; although they did use personal protective equipment (PPE). We found staff theatre shoes were not cleaned in line with Health Building Notice (HBN) 26: ‘Facilities for surgical procedures; Volume 1’. This guidance states shoes should be cleaned daily; and also, when contaminated. During our inspection we observed four theatre staff to have visibly blood stained and dirty theatre shoes. We raised this at the time of inspection and staff acknowledged this was not acceptable.

Staff missed seven opportunities to demonstrate effective hand hygiene out of approximately 25 opportunities observed on the ward, such as before and after patient contact. The majority of these seven were missed by one staff member. We also saw missed opportunities within theatre and occasions when staff did not follow infection control principles when entering or exiting an operating theatre. Ward and theatre managers acknowledged this was an area which required improvement and reported that an increased rate of hand hygiene audits had driven some improvement. This was a regularly discussed at safety huddles to remind staff to follow good practice; and a member of the trust wide infection prevention and control team had attended the ward and safety huddles to reinforce good practice.

During our additional inspection visit on the 4 November 2019, we observed staff to wash their hands when leaving patient bays. Staff consistently used appropriate personal protective equipment (PPE) when required included gloves, aprons and visors. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We randomly checked pieces of equipment on the ward and found all to be appropriately labelled with ‘I am clean’ stickers which were dated. We found one commode in a sluice room which looked damaged; however, this was not labelled and did not appear to be in patient use at the time of the inspection. During our inspection we found hand gel was plentiful, apart from one occasion in a patient bay where it had run out.

Environment and equipment
The design, maintenance and use of facilities, premises and equipment was not always in line with national guidance. However, staff managed clinical waste well.

Patients could reach call bells however sometimes had to wait some time before staff were free to attend. Patients and/or relatives could reach call bells. We observed staff on the ward to make sure patients could access these. Patients we spoke with told us the timescales varied between less than a minute and over 20 minutes. We saw one call bell to be ringing for over 27 minutes on the last day of our inspection. Staff told us the reason for these delays was due to lack of staff which resulted in them already being with other patients when call bells were pushed. We saw
this to be the case during our inspection. The matron for the ward undertook monthly audits which included call bell audits. The trust standard was to answer call bells within two minutes. However, the maximum time to answer call bells was not monitored. Data from the trust showed September and October 2019 audit results. In September 2019, two call bells were activated during the audit period. One of these was answered within two minutes. In October 2019, two call bells were activated; staff answered both within two minutes.

The design of the environment did not always follow national guidance. During our last inspection, we found the neurosurgery service had two dedicated theatres for neurosurgery but no dedicated emergency theatre. This was still the case during this inspection and therefore the environment was still not fully compliant with the NHS standard contract for neurosurgery specifications which state “all units require a minimum of two fully resourced dedicated operating theatres and immediate access to an emergency National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) theatre”. During both the previous inspection and this inspection, we found that elective procedures were being cancelled to accommodate emergency cases; although where possible emergency patients were operated on in an alternative general emergency theatre between the hours of 8am and 6.30pm if that theatre and a neurosurgeon were available. Senior managers told us they were proactively seeking a dedicated theatre; however, they were constrained at this time by financial limits and capacity of the existing theatres.

Within theatres, we found that the environment was not consistently in line with Health Building Notice (HBN) 26: ‘Facilities for surgical procedures; Volume 1’. For example, there was not enough space within staff changing areas to securely store all staff belongings. We found there was not adequate space to store theatre shoes. We found the theatre manager’s office was used as a changing room due to a lack of adequate space. Both areas were untidy and cluttered. We found the main theatre area was cluttered in part, such as the main entrance where a bed had been left in the corridor along with other equipment, and blue fabric and ‘caution’ yellow signs had been left on a windowsill. This was in view of ambulatory patients awaiting eye theatres. The specialist lead nurse for neurosurgery theatres told us of plans to improve the theatre environment including staff areas.

However, the design and layout of the ward area met requirements contained within HBN 04-01; ‘Adult in-patient facilities’. HBN: 04 (1997) recommended that in new hospital projects, a minimum of 50% of in-patient beds should be in single rooms. The University Hospital was built before this date and finished in 2006; ten side rooms were available on the ward which equated to just under 25% of the neurosurgery inpatient beds. Staff told us that if a side room was required for an infectious patient, young adults, patients at the end of life or patients with very particular care needs they could usually provide this.

The two dedicated neurosurgery theatres had laminar flow air ventilation. Laminar flow theatres work to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments, surgeons and the patient’s own skin therefore are recommended for operating theatres conducting significant procedures. Staff carried out daily safety checks of specialist equipment. Two resuscitation trollies were kept on the ward. Staff knew these were located. We checked these and found them to be appropriately stocked. Emergency medicine packs were in date; and consumable products were in sealed packaging. We did find forceps in both trolleys which were reusable but unsealed therefore we were not assured if these had been cleaned since last used. We raised this ward
managers who told us they would rectify this. The automatic external defibrillator (AED) on each trolley was maintained within required timescales. We saw checks on both trolleys were carried out daily within trust given timescales and where any actions identified because of these checks, these were undertaken. Similarly, resuscitation equipment within theatres was sample checked and found to meet national requirements.

Anaesthetic machines within the neurosurgery dedicated theatres were checked daily in line with national theatre practice standards. However, we noted one machine log book record not have the front cover filled out detailing which machine it was linked to. This meant if the book became detached from the machine staff would not be able to identify which machine to return it to. This was escalated to local theatre management at the time of inspection.

We checked various pieces of equipment on the ward and found these to be well maintained within trust wide timescales, except for one stand containing monitoring equipment. This had been due to an electrical safety test on the 4 October 2019; therefore, was just out of date at the time of our inspection. We discussed this with the ward managers who told us maintenance and safety testing were managed by a central facilities team. However, they assured us they would check all equipment to ensure routine maintenance was completed after this finding. We saw one patient to have a portable fan which was their own property. This had not been tested for electrical safety.

We saw one cardiac monitor which was being used to monitor a patient had the wrong name inputted into it. It appeared this monitor had been relocated from another bedside and still contained the previous patient’s details. However, the vital signs being monitored were from the right patient; therefore, there was no risk to the patient directly from this. We spoke to staff about this and saw the incorrect patient name was removed; although the actual patient's name was not inputted.

The service had enough suitable equipment to help them to safely care for patients. During our inspection we saw that staff had access to the equipment they needed to care for patients. In the main, this was well maintained and clean. We saw some equipment required repair such as a trolley located in the sluice room with a damaged leg. However, this was not in use at the time of the inspection.

Staff disposed of clinical waste safely. The service had recently changed the way clinical waste was managed on the ward to ensure better compliance. Rather than leaving clinical waste in bins in bedded areas; staff now took clinical waste bags with them to attend to patients; and removed these straight to larger clinical waste bins in the sluice room following patient contact. All but one sharps boxes we saw were appropriately labelled, in a good state of repair and not overfull. We observed one full box in a sluice room to have a blank label.

Assessing and responding to patient risk
Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration; however, not all patients were reviewed in line with required timescales.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately; however, they did not review all patients within required timescales. Staff used the National Early Warning Score (NEWS2) to monitor patients’ vital signs which indicated any
deterioration in patients’ condition. Alongside NEWS, staff also undertook neurological observations which included assessing patients’ motor functions, orientation to time and place, and sensory functions. Medical staff assessed patients’ state of consciousness using the Glasgow Coma Scale.

During our inspection, we saw staff to undertake the observations competently, including agency staff. Staff used an electronic device to record observations. This automatically calculated a score and alerted to staff if deterioration was present. Where patients were showing an elevated score; if appropriate, staff were promoted to follow specific pathways such as the sepsis screening tool. Staff told us about the escalation process and how they would undertake this.

We saw that some patient observations were not always taken in line with required timescales. For example, at 11.43am on our last day of inspection, we found that one patient was due to have had their observations taken at 10.43am. In addition; their pain assessment had been due at 5.43am but had not been recorded. We saw three other patients whose observations had not been conducted in line with timescales on this same occasion. This left patients at risk of any deterioration not being recognised in a timely manner, and therefore interventions not being administered in line with best practice to promote recovery and treatment.

During our additional announced inspection visit on the 4 November 2019, we saw observations for all patients were well monitored and all patients were stable.

The trust policy expected staff to use the sepsis screening tool documentation to record findings, decisions and actions to ensure patients received care in line with best practice. During our patient record checks we found where appropriate; these documents were used; although not always fully filled out. In one record the documentation was not used; but the doctor following the pathway clearly recorded all decisions within the patient record; including actions taken around the ‘sepsis six’ (six actions to take within one hour of identifying a patient is at risk of sepsis). In this particular case we found the antibiotics had not been administered within one hour; although all other five steps were taken. The reason for this was documented and was due to the patient having numerous allergies which meant a pharmacist opinion was requested before administering a new drug. The patient improved following interventions.

Staff performed ‘intentional rounding’ checks for each patient on an hourly basis. This enabled staff to check the comfort and wellbeing of patients and was recorded in patient records. Records we checked showed that in the main, these checks were done consistently.

Patients being admitted for elective surgery were asked to wait in the ward day room. A band three health care assistant was responsible for checking on these patients periodically and reporting any concerns in deterioration to the nurse in charge or the relevant consultant. Patients who had communication problems or had co-morbidities were admitted straight into the ward, rather than being asked to wait in the day room, therefore enabling closer monitoring.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. Nursing staff undertook risk assessments with patients; and where necessary devised care plans to reduce the risk. These included falls assessments, skin assessments, malnutrition risk assessments and mobility.

Staff knew about and dealt with any specific risk issues. Staff followed care plans to prevent
harm; including hospital acquired harm. Where patients were harmed whilst in hospital, for example having a fall or developing tissue damage; this was reported as an incident and plans were created to reduce the re-occurrence. During the inspection; we observed actions to be implemented to prevent serious tissue damage which included ensuring that all skin assessments completed by health care assistants had a registered nurse oversight at least once per 24 hours. This was actioned following a serious incident involving a patient acquiring a category three pressure ulcer. This implemented process was to be overseen by the band six (senior nurse) working as the ward coordinator each shift.

Audits of cannula care showed that certain standards were not being met which included cannula sites being checked at least every eight hours. An investigation identified this was linked to documentation not being updated rather than the sites not being actively checked. Actions had been set to ensure compliance to reduce the risk of patients being at risk of harm; such as ensuring each new cannula was recorded in the patient record. Data from the service showed a varied performance in this area from June to August 2019. In June 2019, compliance was 70%, in July 2019 it was 86% and in August 2019 it was 57%. During our inspection, we saw that a cannula check for one patient was overdue by nine hours and 10 minutes according the electronic patient record recording observations.

We saw staff had made an effort to improve catheter care on the ward. Audit results showed an improvement in compliance from 20% in July 2019 to 90% in August 2019.

Following several patient falls, actions were put into place to reduce this risk. These included placing sticker in patient records to remind staff of what actions to take if a patient was identified as at risk. Each nurse re-completed their competency training on managing the risk of falls. Data from the trust showed that staff had commenced with bedside handovers (conducting handovers in patient areas rather than at nurses’ stations or other desks) which enabled greater visibility of patients. The data reported that this resulted in a ‘significant reduction’ in patient falls.

The neurosurgical enhanced care unit (NECU) housed patients with more acute care needs. Each patient bed had an allocated heart monitor; and patients with additional medical needs such as tracheostomies were cared for. Patients were accepted directly onto this area following emergency surgery, or as a ‘step down’ patient from the critical care unit. The critical care outreach team attended daily to support patients on the NECU. They monitored and managed patients with tracheostomies and/ or patients with external brain drains.

Where patients had specific needs, we saw information was displayed by their bed, so staff could quickly identify this. For example, symbols indicating patients were at risk of a fall, or required a diet such as soft food only.

Theatre staff did not always adhere to national requirements around safer surgery. For example, during our inspection we observed a member of staff to pre-populate a surgical instrument checklist before the procedure had commenced. We spoke to two members of staff about this, one told us it was common practice to do this within the hospital. The other told us this was an error and this checklist was not normally pre-populated. Despite this, we saw some good practice with the completion of other aspects of the safer surgery checklist based on the World Health Organisation’s Surgical Safety Checklist. This a tool designed to improve communication and teamwork by bringing together the surgeons, anaesthesia providers and nurses involved in care to confirm that critical safety measures are performed before, during and after an operation. A
neurosurgery specific checklist had been devised by a consultant and was in use at the time of our inspection, this demonstrated adaptations based on best practice. We also observed that imaging was displayed during procedures which was checked by the surgeon and verified by a specialist registrar to reduce the risk of operating on the wrong area or part. This was an improvement following two serious incidents over the last 18 months involving wrong site spinal surgery.

Data from the trust reported that no audits of the safer surgery checklist had been conducted for neurosurgery during 2019/2020 due to significant changes to the checklist in this time. However, the trust told us they monitored compliance during this time period for different surgical specialities and compliance was 100% for all checklists which were examined.

Staff undertook training in managing aggression which enabled them to de-escalate situations in which patients or visitors became aggressive or violent. Security staff were also able to attend to support with individuals if necessary. We observed occasions where patients were aggressive, staff recognised that on these occasions it was due to cognitive impairment; and handled the situations calmly and appropriately.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient’s mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

Staff shared key information to keep patients safe when handing over their care to others. Nursing staff handovers took place within patient bays or at the side room and involved a full discussion of each patient. We observed part of a handover and found the information shared to be comprehensive. Handovers were completed in patient areas to create greater visibility of patients, particularly those at higher risk of falls. However, we did notice that this meant the information shared was not confidential and could potentially be overheard by other patients and/or visitors.

The service used a handover document when sending patients for diagnostic imaging. This contained a checklist of information for the imaging department to be aware of such as if cannulas or catheters were in situ, if the patient had any particular needs, if the patient was subject to a ‘do not resuscitate’ order and any required medicine charts.

Shift changes and handovers included all necessary key information to keep patients safe. The ward had a safety huddle board and a production board co-located. A safety huddle was conducted at each nursing staff shift changeover. This promoted staff to share information about each patient and to hand over important information. A production board meeting was held once daily and any ward based staff could attend. Staff at this meeting discussed ward targets and tasks; and enabled sharing of workload and expectations.

Ward managers and matrons held a weekly production meeting which followed a similar format to the ward based event; and included the quality and safety manager for the area. During the inspection we observed a meeting; and saw patient harm was discussed, such as pressure ulcers, falls and cannulation care. Any themes identified through incident reporting were highlighted and plans were created where specific patient risk was identified. Medical staff also held a production board meeting every week.
A board round was held daily at an electronic whiteboard displaying patient names and details such as discharge dates, interventions required and any risk factors. Attendees included ward medical staff, nursing staff and others involved in the patient care. Ward staff told us, and we saw, that allied health professionals (AHPs) often arrived late to this meeting which meant they sometimes missed vital information. This was in part due to a lower staffing level of AHPs resulting in a lesser availability at times.

**Nurse staffing**

The service did not have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service did not have enough nursing staff and support staff to keep patients safe. At the time of inspection, the service was running on a 54% vacancy rate for registered nurses within the neurosurgery ward. An action plan had been approved including recruitment from overseas. At the time of the inspection; several overseas nurses were being considered for a position. In addition, senior staff and a clinical educator were undertaking clinical shifts. More detail over longer time period can be viewed in the below table. Agency and bank staff mostly covered unfilled shifts as described below. Staff told us that the ward felt ‘safe’ in terms of providing care and treatment to patients in line with documented medical need. However, they acknowledged that patient harm was happening such as falls and pressure ulcers; staff attributed this to a lack of substantive staff on the ward.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward managers could adjust staffing levels daily according to the needs of patients. Ward managers used a patient acuity tool to adjust staffing requirements daily and met twice a day to explore planned versus actual staff in order to mitigate patient risk of harm. The ward managers planned the rota well in advance; and the matrons for the area had authorised the recruitment of agency staff to fill rota gaps six weeks in advance. These shifts were advertised to both bank staff and agency staff to increase the likelihood of them being filled. Ward managers told us that by doing this, they generally achieved a 90% fill rate of planned versus actual staffing numbers per shift.

The staffing requirements for registered nurses was nine across ward 43 during the day and six overnight to cover four areas of the ward. Three of these staff were allocated to the NECU to cover a ratio of one nurse to four patients. When compiling the rota; at least two of these nurses working in NECU were required to be substantive and having undertaken neurosurgery competency training. This was to support the care and safety of the higher acuity patients located in NECU. This left six nurses during the day to cover the other three areas of the ward; and three nurses to cover the ward at night. Managers located staff in patient areas based on daily need and patient acuity. However; often the ward did not have the full nine nurses during the day shifts, or six to cover the night shifts. In these instances, if it was identified that this lack of staffing would compromise patient care, the ward managers would attempt to gain cover from the neighbouring neurology ward, would ask trust wide or would work clinically themselves.

Staff told us they could be asked to cover unfilled shifts on neighbouring wards to support there
which further depleted the resources on ward 43. As mentioned above, despite staff presenting as motivated to providing the best level of patient care, we found that patient harm and a lesser standard of care was evident on ward 43. This could be attributed the reduced staffing availability. For example, we described in ‘cleanliness, infection prevention and hygiene’ above how standards were not consistency high. In addition, serious incidents for hospital acquired harm were reported such as category three pressure ulcers. See ‘incidents’ for more details on this. When we noticed specific areas of improvement; such as cleanliness we also noticed all staff were busy attending to patient needs such as checking vital signs or delivering medicines. Therefore, staff may have felt they did not have time to deliver other aspects of care quickly. In addition; patients reported that at times they had to wait for someone to answer their call bell. During the inspection we observed this to happen; however, we noted that all staff were busy with other tasks or patients hence not responding immediately.

Healthcare assistants worked on the ward to support nursing staff. Band two healthcare assistants worked with patients to support basic care needs. Band three healthcare assistants also undertook additional tasks following competency training including taking blood and undertaking pre-operative assessments. Where patients were identified as requiring 1-1 nursing care, a referral could be made to a trust wide enhanced care team to provide staff to support this.

The number of nurses and healthcare assistants did not always meet the planned numbers. During our inspection, we saw that the actual staff rate was below the planned rate on ward 43. Staff told us, as described above, that this was a regular occurrence.

The service had high vacancy rates as discussed above and as can be seen in the below table. The service had a lower turnover rate than the trust average; although nurse transfers from ward 43 to other areas within the trust were on hold at the time of our inspection. The service had sickness rates below both the trust target and the trust average.

The table below shows a summary of the nursing staffing metrics in neurosurgery at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff</td>
<td>125.3</td>
<td>26%</td>
<td>10%</td>
<td>7.1%</td>
<td>4,961 (5%)</td>
<td>24,026 (26%)</td>
<td>3,472 (4%)</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>46.5</td>
<td>50%</td>
<td>5%</td>
<td>3.4%</td>
<td>4,961 (5%)</td>
<td>24,026 (26%)</td>
<td>3,472 (4%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Qualified nursing and midwifery staffing rates within neurosurgery at University Hospital Coventry were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly vacancy, turnover or sickness rates, or agency staff usage.

The service had high rates of bank and agency nurses used as discussed above and as can be
seen in the below table. This was to promote patient safety.

Agency staff usage

![Bank hours - qualified nurses, health visitors and midwives](image)

Monthly agency usage over the last 12 months for qualified nurses showed a shift from November 2018 to April 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers were not able to limit their use of bank and agency staff however they requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The ward managers had a process for inducting temporary staff to the ward. Where agency staff were regularly used; managers ensured they were trained in competencies and requirements required of permanent staff such as how to access the electronic devices used to record patient vital signs.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Nine consultants worked across neurosurgery. A consultant of the day was allocated each morning. This person was responsible for running the board round (a meeting where each patient on the ward is discussed) and ensuring all required tasks were allocated; such as patients reviews. A specialist registrar doctor (a junior doctor undergoing advanced training in a specialist field) was based on the ward daily until 5pm. Out of hours, a registrar was always on call. Junior doctors were also allocated to each area of the ward (four areas in total) each day where staffing permitted. If medical staffing was reduced; managers explored the best way to use medical staff resources on a day to day basis, including working across the medical ward for neurology patients. When outliers were located on different wards throughout the hospital, a member of the medical team was allocated to review these patients daily.

Medical staff reviewed patients twice daily to make decisions about treatment needs, and to plan discharges. The consultant of the day’s role was to cover emergency referrals or admissions; and to cover the emergency theatres. Ideally this person would have no other clinical requirements on these days enabling a faster overview of emergency patients. The service had a part time specialist radiologist dedicated to neurosurgery. On days this service wasn’t available on site, an
agreement was in place to send patients to an NHS hospital in Stoke for specific emergency procedures.

Medical staffing was on the trust risk register for neurosurgery; we saw that over the preceding 12 months newly employed consultants were in place. Recruitment to boost this was ongoing.

The medical staff did not always match the planned number on all shifts in each department. Consultant cover was in place each day. However, junior doctor cover was not always up to required levels. As described above, four junior doctors were planned to cover the four areas of ward 43 daily. However, data from the trust showed that planned numbers did not always match actual numbers. The service had slightly higher vacancy rates for medical staff than the trust target. This can be viewed in the below table; where vacancy rates were 11% from May 2018 to April 2019 as compared to a trust target of 10%. However, it is noted that the neurosurgery medical staff vacancy rate was significantly better than the trust wide medical vacancy rate which was at 26% for the same time period. The service had high turnover rates for medical staff. These again can be viewed in the below table. For neurosurgery, turnover rates for medical staff were 19% compared to the trust target of 10% from May 2018 to April 2019. Sickness rates for medical staff were low; these were below the trust target. See the table below for more data. Medical staffing rates within neurosurgery at University Hospital Coventry were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly vacancy or turnover rates, or agency staff usage. Over this period there was no bank medical staff usage reported.

The service had no bank staff usage but did use locum medical staff. As can be seen in the table below; locum staff coverage was 15% of all medical shifts from May 2018 to April 2019. Managers could access locums when they needed additional medical staff. Less than 1% of shifts went unfilled by either substantive staff or locum staff from May 2018 to April 2019. Managers made sure locums had a full induction to the service before they started work. A trust wide expectation was that information would be sent to locum agencies who supplied medical staff. This was to provide a basic overview and induction to the area the doctor would be covering. The table below shows a summary of the medical staffing metrics in neurosurgery at University Hospital Coventry compared to the trust’s targets, where applicable:

<table>
<thead>
<tr>
<th>Neurosurgery annual staffing metrics</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Annual average establishment</td>
</tr>
<tr>
<td>Target</td>
<td>10%</td>
</tr>
<tr>
<td>All staff</td>
<td>125.3</td>
</tr>
<tr>
<td>Medical staff</td>
<td>29.8</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Sickness rates
Monthly sickness rates over the last 12 months for medical staff showed an upward trend from July 2018 to December 2018, followed by a downward trend from December 2018 to April 2019. (Source: Routine Provider Information Request (RPIR) – Sickness tab)

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Managers monitored medical staffing and where shortages were identified; patient acuity was reviewed to ensure staff were best placed to ensure patient safety.

The service always had a consultant on call during evenings and weekends. Consultant cover was provided physically on site from 7.45am and 6.30pm Monday to Friday. Outside of these hours; the allocated consultant on call covered via telephone for advice; or to attend the hospital if necessary. On Saturday and Sundays, between 8.30am and 5.30pm a consultant was available on call however did attend the ward round for any newly admitted patients, urgent referrals, or serious cases. Between 5.30pm to 8.30am on Saturday and Sunday; a specialist registrar was on call and available to attend the hospital as required in addition to consultant on call cover.

Records
Staff kept detailed records of patients’ care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and most were maintained in line with national guidance. Patient medical and nursing records were mainly paper based. However, some details were recorded and stored electronically such as vital signs observation scores, pain scores, cannular checks, some medical notes and venous thromboembolism (VTE) risk assessments. During our inspection, we reviewed 17 paper-based patient records. We found records contained enough information to keep patients safe. We saw relevant information such as reasons for attendance at hospital, investigations completed and the results, changes to medication, discharge details, and rehabilitation plans were detailed in the notes.

Evidence of post-admission consultant rounds was in the records, although in one case we saw this was over 24 hours after admission rather than within the recommended 12 hours. In all records, we saw daily consultant reviews and diagnosis and management plans were recorded and signed. Records contained entries from multidisciplinary teams such as rehabilitation allied health professionals, and critical care outreach team members. Record entries appeared to be written contemporaneously and were, in the main, legible. All entries were signed, and most had the person making the entry’s name and designation either stamped or written legibly. Some record entries did not contain a legible name which meant it may have been difficult to ascertain who made those entries.
Comprehensive nursing risk assessments and care plans were in the records; and these were reviewed at appropriate intervals. Actions taken by staff; such as skin checks or monitoring fluid intake were documented clearly. We found that some patient records were not filed tidily. For example, it was not always immediately obvious which records were from a previous hospital and which were from the University Hospital.

We viewed VTE assessments on electronic medical records and found these were complete. Where appropriate patients had ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form in place; and stored in their records which told staff if a patient was not to be resuscitated by cardiopulmonary resuscitation. Staff told us of improvements that had been made to the quality of patient documentation through supporting staff to develop their skills in completing risk assessments and ensuring these were recorded properly. Medical staff had undertaken an audit into medical documentation in January and February 2019.

The trust’s audit from June 2019 showed the following findings:

<table>
<thead>
<tr>
<th>Audit type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria based</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Methodology – including data collection methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prospective audit over a period: June 2019. This is a re-audit of the work completed in March/April 2019 on Daily ward round sheets.</td>
</tr>
<tr>
<td>• Set of data collected: 34 case notes were checked for the expected standard of documentation on the neurosurgical daily ward rounds - ITU, Ward 43 &amp; 53 MTECU and outliers.</td>
</tr>
<tr>
<td>• Accepted good practice if the compliance percentage is 80% or more.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Findings</th>
</tr>
</thead>
</table>

### Areas of good practice (≥80%):
- Consultant Name : 91%
- Diagnosis 94%
- GCS 92%
- Neurology 92%
- Vitals 94%
- Plan 100%
- GMC 97%
- Signature 97%
- Name 100%
- Date 100%
- ABG 86%

### AREA requiring improvement : Date of admission

### Comparison from Last cycle :

### Area(s) of continued good practice (≥80% -100%)
- Consultant name, diagnosis, GCS, neurological signs, GMC number, Signature, name and date of admission.

### Area(s) of improved practice
- Observations/Vitals (94% vs 50% previously)

<table>
<thead>
<tr>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Legibility</td>
</tr>
<tr>
<td>• Accurate and factual documentation</td>
</tr>
<tr>
<td>• Signature, date and written name and plan</td>
</tr>
<tr>
<td>• Timing documentation with 24hr clock</td>
</tr>
<tr>
<td>• GMC number to accompany each doctor entry</td>
</tr>
<tr>
<td>• Documenting date of admission</td>
</tr>
<tr>
<td>• Documenting chronologically</td>
</tr>
</tbody>
</table>

(Source: DR 58)

When patients were moved from or to ward 43, staff had access to a ward transfer handover document to share information quickly and easily. Records were stored securely, and all staff could access them easily. When not in use, staff stored records in specific record trolleys behind nurses’ stations. We did not see any patient records left out and not in use. Staff told us they had been encouraged to only update one record at a time and then to return this before updating the
next record, rather than collecting several at a time. This promoted better record security and meant other staff could access records more easily. We found an instance where by two sheets of patient identifiable stickers (one each for two separate individuals) were located in a third patient's medical record. We escalated this immediately to ward based staff who removed these.

An electronic whiteboard system was used to contain all patients on one viewable page. This was used for board rounds and for staff to quickly get information about a patient; such as their current National Early Warning Score, any areas of risk such as pressure ulcers or falls, referrals made, acuity and mobility. When not in use a screen saver covered these details.

**Medicines**

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. A newly installed automated electronic medicines' storage system ensured medicines were available, safe and secure with restricted access to authorised staff. A training programme for staff on using the new system was in place.

Medicine fridge temperatures were monitored by ward staff and were within the recommended range. Staff were aware of what action to take if there was a deviation. Medicine fridge temperatures were monitored by ward staff and were within the recommended range. Staff were aware of what action to take if there was a deviation. The trust used electronic medicine cupboards for storing medicines. These cabinets had continuous monitoring of the temperature within the cabinet i.e. the location that the medicines were stored rather than a remote probe in the room. This continuous monitoring temperature was fully recorded, allowed full remote monitoring and supports automated provision of reports to staff. The ward nurses did not need to monitor the temperature as a report was automatically generated and reviewed by senior staff and allowed action to be taken in a timely way. Staff understood how long the medicine has been at any temperature deviation so appropriate action can be taken, and all retrospective data is stored. There was a trust wide clinical operating policy for dealing with elevated temperatures in drug storage. In addition, the medicines stocked on wards in the automated cabinets were determined by the medicines used within the clinical specialty in agreement with ward managers and the specialist pharmacist. Pharmacy teams restocked the automated cabinets either daily or weekly depending on the area.

Medicines required in an emergency were readily available when needed. Regular checks of emergency medicines and equipment were carried out by staff. Tamper evident seals were in place to ensure medicines were fit for use, however intravenous fluids required in an emergency were not stored using tamper evident seals. We raised this the trust's director of pharmacy who was to review this process. Following the inspection, the trust informed us that they were fully compliant with the storage of all medicines including IV fluids which were being checked daily by ward staff. IV fluids on resuscitation trollies were being stored in double wrapped bags; with tamperproof seals and expiry dates checked daily in accordance with the management of resuscitation policy.

Allergy statuses or medicine sensitivities of patients were routinely recorded on medicine administration charts. Venous Thromboembolism (VTE) risk assessments were routinely recorded for patients on the Clinical Results Reporting System which identified if treatment was
required. Prescribers did not always write separate prescriptions for medicines that could be given by either the oral or intravenous route. It was therefore not always possible to determine what route a medicine had been given to a patient. Making separate entries for each route is good practice to ensure clarity in the medicine administration record.

Staff knew how to contact pharmacy staff and how to access medicines out of hours when pharmacy was closed. A prescription tracker system also ensured that ward staff could check where patients’ medicines were in pharmacy. We directly observed medicines being administered, including controlled drugs. We saw that best practice guidelines were followed, and patients’ identification and allergy status was checked appropriately before administration. Patients told us that due to reduced staff on some shifts, they did not always receive their medicines on time. We observed ward managers to undertake drugs round to ensure patients received medicines as quickly as possible in these situations.

Staff reviewed patients’ medicines regularly and provided specific advice to patients and carers about their medicines. Clinical pharmacists and pharmacy technicians provided regular ward visits for support and guidance with medicines particularly for high risk medicines. The clinical pharmacists regularly reviewed patients’ prescriptions and administration records and recorded any interventions for follow up. There were guidelines on the choice of antibiotic therapy with evidence of reason for choice recorded. Clear review dates of treatment were in place and evidence of advice from pharmacy documented onto medicine administration charts. Patients were supported to take their medicines as intended. Pharmacy staff ensured that where possible patients were counselled and involved in understanding information about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. However, we did find some out of date products. Controlled drugs (CD) and controlled stationary were managed effectively on the ward. Quarterly CD Audits undertaken by pharmacy ensured processes were being followed. CD medicines were handled in line with CD legislation. Although we saw one instance within theatres where there was a gap in signatures for a CD anaesthetic. Also, there was insufficient storage space within the CD cabinet on the ward for patients own CD supplies. This should be further assessed to ensure all CDs are stored in line with policy.

Portable oxygen was securely stored in all but one instance, including on resuscitation trolleys. In one instance we saw a cannister was in a secure wall mounted device, along with other cannisters. However, the additional strap ensuring this was secure was broken. All oxygen cannisters checked were in date and were at least half full.

We checked the food used for special medical purposes for patients who required extra nutritional support to prevent malnutrition in the form of juices and milkshake style drinks. We found three packs of food designed for enteral tube feeding (such as through the nose or directly through the stomach) to be out of date, and one drink to be out of date. The oldest date was August 2019. We handed these to a member of staff who disposed of them. Ward managers told us these should be checked nightly; and assured us they would review this process.

Staff followed current national practice to check patients had the correct medicines. A process of medicine reconciliation was in place to facilitate the review of patient’s current medicines including non-prescribed medicines when admitted to hospital. Any areas of discrepancy were identified, highlighted and actioned. Discharge medicine summaries were screened by a pharmacist before they were forwarded to other healthcare settings.
The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Following concerns that medicine administration was not always being recorded the ward had undertaken a review. Medicine omissions were now checked daily by ward managers and highlighted to staff to ensure doses were not missed.

**Incidents**
The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff gave us examples of incidents they had reported and used an electronic reporting system to do so. Staff told us themes included patient falls, tissue damage and incidences of aggression. Staff reported serious incidents clearly and in line with trust policy.

**Breakdown of serious incidents reported to STEIS**
In accordance with the Serious Incident Framework 2015, the trust reported four serious incidents (SI’s) in neurosurgery at University Hospital Coventry which met the reporting criteria set by NHS England from July 2018 to June 2019. A breakdown of the incident types reported is in the table below:

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical/invasive procedure incident meeting SI criteria</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Medication incident meeting SI criteria</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Pressure ulcer meeting SI criteria</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td>Slips/trips/falls meeting SI criteria</td>
<td>1</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

**Never Events**
The service had no never events on any wards. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2018 to June 2019 the trust reported no never events for neurosurgery.

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff we spoke with had a clear understanding of the duty of candour and were able to articulate when they had been open and honest with patients; and about their own practice. Managers debriefed and supported staff after any serious incident. Staff were kept informed about actions and ongoing investigations. Updates were shared at regular interviews, such as during daily safety huddles. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. When any incident was reported by staff using the electronic reporting system, local managers reviewed these and triaged them. Where any moderate or higher harm was identified; this was escalated to the patient safety team and the relevant matron who organised a review. The quality and safety
manager oversaw all reported incidents and ensured these were reviewed. Where incidents were identified as being less than moderate harm, these were investigated locally, and immediate learning was identified and shared. Ward managers shared learning with the whole team at safety huddles and production boards. They also ensured band six (senior nurses) were aware of any learning as to share with any staff not present at the meetings. Shared learning was also sent out from the medical team; who sent out a weekly safety message. This was displayed in the staff room for all staff to view.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff received feedback through a variety of sources. This included individual email responses directly after submitting an incident from the relevant manager; feedback during safety huddles and production boards, weekly trust wide safety updates, through team meetings and through 1-1 conversations.

Staff met to discuss the feedback and look at improvements to patient care. Ward and directorate management met to discuss serious incidents in a timely manner. We observed a patient safety response meeting after a patient with a category three pressure ulcer had been identified. This was appropriately categorised as a serious incident; incidents leading up to this were discussed and learning identified. Specific information to feedback to staff on the ward was agreed including to ask ward staff for their ideas to prevent recurrence. We later saw evidence that staff on the ward had been involved in this discussion; and had the opportunity to make suggestions and reflect upon the care given to patients.

Morbidity and mortality was discussed daily at ward board rounds. In addition; this was discussed at set morbidity and mortality meetings to determine outcomes and learning. A specialist review template was used to record information making this easier to share with a wider audience quickly. Data from the trust showed that between January and June 2018 all cases of morality were reviewed within 30 days of the notes being received by the medical team and 50% were completed within seven days of the notes arrival. We saw reviewers were not medics who had been directly involved in a patient’s care to avoid bias.

There was evidence that changes had been made as a result of feedback. We observed a laminated poster was displayed in neurosurgery theatres to promote safer surgery following two serious incidents in the previous 18 months. We also saw imaging was displayed on screen within theatres and double checked by the medical team prior to commencing to ensure the correct area had been identified.

**Safety Thermometer**

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date. Safety thermometer data was displayed on wards for staff and patients to see. This was on large colourful posters which clearly highlighted safety thermometer performance. The safety thermometer showed a varied performance in the number of incidences
of harm within the reporting period. Data from the Patient Safety Thermometer showed that the trust reported eight new pressure ulcers and one fall with harm from July 2018 to July 2019 for neurosurgery. Over the same period the trust reported no new urinary tract infections in patients with a catheter\(^1\) in neurosurgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and urinary tract infections patients with a catheter in neurosurgery at University Hospital Coventry and Warwickshire NHS Trust

Staff used the safety thermometer data to further improve services. Managers regularly reviewed the data and used this alongside local safety monitoring data collected alongside the safety thermometer data. Falls and pressure ulcers had been identified as areas that required improvement prior to our inspection; and as such several actions were in place to promote a harm free environment.

**Is the service effective?**

**Evidence-based care and treatment**

The service mostly provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients’ subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Medical staff undertook audits within neurosurgery to ensure compliance to both trust policies and national best practice. For example, a third cycle of an audit into antibiotic prophylaxis was completed in December 2018. An updated set of clinical guidelines for prevention of wrong level spinal surgery were ratified and disseminated in July 2019, although we noticed the expiry of these guidelines was written as the same date. These guidelines followed two incidents whereby wrong level surgery had been performed in the preceding 18

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\(^1\) Urinary tract infections in patients with a catheter level 3 only

\(^2\) Pressure ulcers levels 2, 3 and 4

\(^3\) Falls with harm levels 3 to 6

(Source: NHS Digital - Safety Thermometer)
months. Following a management and departmental re-structure in February 2019, along with the appointment of several new consultants over the preceding year, several processes and protocols were being reviewed. One recent change was a change to the safer surgery checklist to make this specifically in line with neurosurgery. Some staff had raised concerns about in use pathways for the management of spinal injuries. This had been escalated to clinical leads.

Staff from the critical care outreach team conducted an audit to monitor compliance against national and trust standards for tracheostomy care and management. We reviewed audit figures for February to March 2019 and found the neuro-enhanced care unit complied with all 13 standards 100%. This demonstrated that staff were following national guidelines.

Staff protected the rights of patients’ subject to the Mental Health Act and followed the Code of Practice. Staff told us that they did accept patients onto the ward who were detained under the Mental Health Act. Staff showed an understanding of patients who were detained; and for what purpose. Where patients were detained at a mental health unit prior to coming to the acute hospital; mental health staff from the relevant sending establishment attended to provide oversight and support of this.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Input from multidisciplinary teams was made and discussed during handover meetings and board rounds; which included information about patients’ mental wellbeing. Patients who required this had access to neuropsychologists, and the trust wide mental health team.

**Nutrition and hydration**

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Most patients waiting to have surgery were not left nil by mouth for long periods. For elective surgery, ward staff liaised with the theatre team to identify how long patients would be required to wait for surgery; for example, if an operation overran. This enabled staff to offer drinks to patients if appropriate. However, one patient told us they had been without food for approximately 20 hours, and without liquid for approximately 12 hours on the day of their surgery due to this being delayed until late afternoon. The patient reported the written instructions given to them about fasting had not been clear; and had resulted in them not taking usual medication for several days prior to their operation. Staff told us that this had been raised with medical secretaries to potentially reword instructions sent. We reviewed the leaflet that staff gave to patients and found that information about medicines stated that most medicines could be taken up until the day of surgery. Any exceptions to this would be explained individually by a healthcare professional at the pre-operative appointment. We asked the trust about the fasting instructions. Data from the trust sent in reply reported that audits of the pre-operative process showed that 85% of elective neurosurgical patients attended a pre-operative appointment during which the patient received written documentation. This written documentation contained information about fasting. The trust confirmed that the pre-operative team were in the process of updating and improving the instructions given to patients. This was to include new fasting guidance implemented in 2018 which stated that water could be freely drunk until arrival at the hospital at 7.30am. We reviewed
the trust policy about pre-operative fasting and found it reflected up to date guidance. In particular that patients could drink water up to an hour before the induction of general anaesthesia. Whilst we saw one occasion where this was explained to a patient; as above not all patients were aware of this information.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The general menu for patients contained a varied choice and included menus for patients with specific dietary requirements such as soft food only, halal, vegetarian and vegan.

On the neurosurgery ward, a ‘hydration station’ had been created which consisted of a water cooler, plastic cups, fruit squash and a fridge to keep other drinks. This was for patients, visitors and staff and staff promoted the use of this to maintain good health. Specialist food was available on the ward for patients who required extra nutritional support to prevent malnutrition in the form of juices and milkshake style drinks. This also included feeds to be given enterally such as through the nose or directly into the stomach.

Staff fully and accurately completed patients’ fluid and nutrition charts where needed. We saw that fluid and food charts were updated. In addition, staff completed fluid output charts to ensure that metabolic functions were monitored. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the malnutrition universal screening tool (MUST) to assess patients and identify patients that may be at risk of malnutrition. Due to the nature of many patients on the neurosurgery ward, particularly those in the neurosurgical enhanced care unit (NECU) who were mostly unable to independently eat or drink, this was closely monitored.

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Clear entries were made in patient records detailing dietary prescriptions and requirements for patients with specialist needs. We saw in one record; a dietician identified a patient was being given an incorrect feed at the incorrect rate. We saw this was clearly and quickly addressed, and staff commenced with the correct prescription at that point.

**Pain relief**

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients and relatives, we spoke with reported that staff regularly assessed pain levels; and quickly brought pain relief when needed. We observed this happening in practices during our inspection. Staff used different ways to assess patients’ pain levels dependant on how responsive or able to communicate a patient was. For example, where patients were alert and aware of their personal pain levels; staff had open conversations and asked patients to describe their pain on a scale rating. Staff also asked these patients to describe what the pain felt like and how it affected them. For patients who were less able to communicate pain levels; such as patients with reduced capacity to understand questions being asked or non-verbal patients; staff assessed by examining changes in behaviour, body language, input from family and observations. Patients received pain relief soon after it was identified they needed it or they requested it. During our inspection; we saw that staff sourced pain relief quickly after
identifying a patient needed this. Where staff asked other staff to bring the medicines; the first staff member kept the patient informed. Staff prescribed, administered and recorded pain relief accurately. During our inspection we directly observed pain relief medicine to be administered to one patient. Staff did this as per national guidance, following requirements for administering controlled drugs.

**Patient outcomes**

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements.**

The service participated in relevant national clinical audits. The service took part in Getting it Right First Time (GIRFT) reviews which aim to enhance operational efficiency and improve patients care, treatment and experience across NHS hospitals. During our inspection, staff told us that all consultants who were eligible now participated in the British Spinal Registry (BSR). This was an improvement from our previous inspection. Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients’ outcomes. Spinal consultants began the process of inputting data into the BSR database from March 2019. As a result, there was a limited amount of data which had so far been captured. The service had a detailed action plan to ensure the service was maximising the use of the BSR database. Some of the outcomes captured were:

(Source DR: 60 and 62)

The service used a number of internal outcome measures identified and monitored across the trust using a morbidity scorecard and locally determined measures specific to neurosurgery. These internal measures were used:
In addition, external outcome measures were reported into national audit programmes including, the British Spinal Registry, NNAP audit and Shunt Registry. All of the outcome measures both internal and external were reviewed and discussed at monthly Mortality and Morbidity meetings within neurosurgery for data validation and learning and was also being presented to the regional spinal network in order for comparisons to be made.

Patient reported outcomes measures (PROMS) were used on a patient by patient basis and are individual to the patient being treated, rather than use of a specific validated tool.

(Source DR 61)

Relative risk of readmission
The service had a lower than expected risk of readmission for elective care than the England average. From February 2018 to January 2019, neurosurgery patients at University Hospital Coventry had a lower than expected risk of readmission for elective admissions compared to the England average. University Hospital Coventry’s readmission rate was 57, where the expected rate based on the England average would be 100.

The service had a similar risk of readmission for non-elective care than the England average. Over the same period, neurosurgery patients at University Hospital Coventry had a similar to expected risk of readmission for non-elective admissions compared to the England average. University Hospital Coventry’s readmission rate was 102.4, where the expected rate based on the England average would be 100.

(Source: Hospital Episode Statistics - Readmissions)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff told us that information was collected for the British Association of Spine Surgeons; however, that this was not routine and not all eligible patients were included. Managers used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

Competent staff
The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and
development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. A competency booklet was provided to all band five nurses commencing within the neurosciences group including neurosurgery. This included training on recognising deteriorating patients, the Glasgow Coma Scale and collar and brace training. Staff had 12 months in which to complete the booklet with support from colleagues, managers and clinical educators. Additional competencies for the neuro enhanced care unit (NECU) were available. Student nurses also undertook competency training during placements. We saw a letter expressing thanks to the ward staff for facilitating a positive learning environment for student nurses.

Managers made sure staff received any specialist training for their role. Clinical educators planned study days each month; there were five different days in total therefore staff could attend when suitable to complete all five. Managers were reviewing this as to how to deliver this more effectively. At the time of the inspection, it took at least five months if not longer for staff to attend all required days. Consideration was being given as to how to restructure this to ensure staff received the most vital training and information in a timely manner. Nurses rotated between NECU and the other three areas of ward 43 to develop and maintain competencies.

Managers gave all new staff a full induction tailored to their role before they started work. Staff undertook a four week period of working as supernumerary when they started in neurosurgery. They also received a preceptorship for 12 months where staff received ongoing support from a more experienced member of the team. Staff were trained in ward specific competencies as required including tracheostomy care and managing wound drains. Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that the appraisal process was used to identify development and progression. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

**Appraisal rates**
From May 2018 to April 2019, 82.7% of staff in neurosurgery at University Hospital Coventry received an appraisal compared to a trust target of 90%. The breakdown by staff group is shown in the table below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
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<tbody>
<tr>
<td></td>
<td>Appraisals received</td>
<td>Eligible staff</td>
<td>Completion rate</td>
<td>Trust target</td>
<td>Met (Yes / No)</td>
</tr>
<tr>
<td>Medical staff</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>23</td>
<td>25</td>
<td>92.0%</td>
<td>90%</td>
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<tr>
<td>Additional clinical services</td>
<td>31</td>
<td>36</td>
<td>86.1%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>4</td>
<td>10</td>
<td>40.0%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
<td><strong>75</strong></td>
<td><strong>82.7%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Managers held supervisor days where staff could receive specific support and development. These were flexed to meet the needs of staff. The clinical educators supported the learning and development needs of staff. A named clinical educator was allocated to neuro services including neurosurgery. All staff were able to attend a monthly clinical trauma and neuro group. In these group meetings, different topics were discussed in small groups, so staff could circulate, learn and engage with different staff members and learning topics.
Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers on the ward reported that general ward team meetings were held but had been sporadic prior to the inspection. However, they reported that monthly meetings were held with band six nurses. Minutes from meetings were kept in the ward staff room. Updates and information was also shared during twice daily safety huddles, and daily ward production boards.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We observed ward based training events during our inspection; such as training to nurses, occupational therapists and physios about a new neck brace, and how to fit this properly. Medical staff had organised ‘boot camps’ which aimed to provide five days of high quality simulation training for junior doctors nationally. This had been running for three years at the time of inspection; with the most recent one being held in December 2018. Pre and post training questionnaires showed a 100% agreement for those doctors who responded confirming they felt the bootcamp better prepared them for an independent registrar role (senior junior doctor), and improved knowledge and skills for those junior doctors who were at an earlier stage in their post graduate training.

Managers identified poor staff performance promptly and supported staff to improve. Managers worked to identify poor performance through ongoing reviews and audits. Where this was found, managers had a set procedure to follow to be used in line with reflective practice and for nurses, in line with the revalidation process. Where poor performance was identified in agency staff; this was escalated and dealt with quickly. Managers told us of specific examples of when this had happened.

**Multidisciplinary working**

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. This occurred daily during board round meetings where a range of different staff attended to discuss patient needs. This included the consultant of the day, other medical staff, ward managers and the ward coordinator, and the discharge coordinator. Allied health professionals attended this meeting; however often arrived late due to low staffing figures.

Staff worked across health care disciplines and with other agencies when required to care for patients. The neurosurgery service worked closely with a charity who supported people with head injuries. Representatives from the charity regularly attended the ward to support patients and their relatives who were from Coventry. They had created a pack of information to give to patients and families to take away. For patients outside of Coventry, the charity had provided a list of other more local agencies who could provide support. Psychological input was provided by neuropsychologists from within in the trust. These were based within the major trauma team and worked across neurosurgery as well as other neuro departments.

The critical care outreach team worked closely with patients located on the neurosurgical enhanced care unit (NECU). They attended daily to provide support and care and worked well with ward based staff. The ward manager for the NECU also attending the critical care unit each week to see patients who would be ‘stepped down’ to NECU; and to discuss this with the patient
and their families. Families were invited to visit NECU prior to the transfer to understand the new environment. A radiology multidisciplinary team meeting was scheduled to be held every day in the morning. The allocated neurosurgery consultant of the day was expected to attend this along with the consultant radiologist. This meeting occurred prior to the ward board round.

Seven-day services
Key services were not always available seven days a week to support timely patient care.

Two dedicated neurosurgery operating theatres were used for elective and emergency procedures. One theatre (theatre 14) was open Monday to Friday between 8am to 6.30pm. The second theatre (theatre 15) was open Monday to Thursday between 8am and 6.30pm; and also opened two times a month on a Sunday. As described above, there was no dedicated emergency theatre for neurosurgery which affected some elective patients.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. This was evidenced in patient records. During our inspection we saw that consultants were available to undertake their clinical duties. However, we received some information that at times; some consultants would not review other consultants’ patients; or make decisions about patient care needs. We spoke to other staff about this who reported this was not a regular occurrence and that all patients received appropriate review and decisions about care.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. As discussed in ‘medical staffing’ under ‘safe’, consultant cover was provided physically on site from 7.45am and 6.30pm Monday to Friday. Outside of these hours, the allocated consultant on call covered via telephone for advice; or to attend the hospital if necessary. On Saturday and Sundays, between 8.30am and 5.30pm a consultant was available on call however did not attend the ward round for any newly admitted patients, urgent referrals, or serious cases. Between 5.30pm to 8.30am on Saturday and Sunday, a specialist registrar was on call and available to attend the hospital as required in addition to consultant on call cover.

Medical staff had access to an out of hours imaging reporting service for emergency patients; for example, who had undergone a computed (axial) tomography (CT) scan. This was provided from 5pm to 11pm seven days per week by a third party provider. Allied health professional support was in place five days per week for routine patient interactions. Physiotherapists and speech and language therapists (SALT) covered Monday to Friday from 8am until 4pm. Out of hours physiotherapy services were available but this was for urgent requirements such as respiratory support.

Health Promotion
Staff mostly gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Leaflets were available to support knowledge and awareness of a range of medical conditions within neurosurgery. These including information leaflets; and advice upon discharge leaflets. Staff assessed each patient’s health when admitted and provided support for any individual needs to
live a healthier lifestyle. However, two patients told us this was not consistent. During the
inspection we saw that some patients had therapy plans displayed next to their bed, with charts
indicating what should be done when. We asked patients about this. They told us the plans were
displayed next to their bed, but they were rarely updated or referred to in routine interactions with
allied health professionals (AHPs). However, we saw evidence in the patient records reviewed
that therapy prescriptions and activities with AHPs were undertaken regularly.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
Non-medical staff did not always apply the Mental Capacity Act effectively prior to
undertaking routine care and treatment where applicable to support patient show lacked
capacity to make their own decisions. Staff understanding about when to assess capacity
was varied. However, medical staff supported patients to make informed decisions about
their treatment. They followed national guidance to gain patients’ consent.

Not all nursing staff understood the relevant consent and decision-making requirements of
legislation and guidance, including the Mental Health Act, Mental Capacity Act (MCA) 2005 and
the Children Acts 1989 and 2004. Not all staff understood how and when to assess whether a
patient had the capacity to make decisions about their day to day care. During our inspection, we
reviewed 17 patient records and observed direct care and treatment being delivered to patients.
We found that medical staff sought consent for surgical procedures, and where patients may not
have had capacity to decide themselves, full assessments were carried out prior to recording
consent.

However, we found that non-medical staff did not assess patients’ capacity before undertaking
care and or treatment with patients who may lack capacity, although we noted all care and
treatment was given in line with the patients’ best interests. Under the Mental Capacity Act
(MCA), staff are required to assess capacity before carrying out any care or treatment if there is
reasonable belief someone lacks capacity. We spoke with staff about this and identified that
although all staff had recently undergone training on the MCA, this training was not embedded
and staff understanding of their legal requirements was not adequate. Non-medical staff we
asked told us it was the responsibility of doctors to complete MCA assessments. However, for
routine care and treatment as delivered by nurses, allied healthcare professionals and support
staff it may not be appropriate to ask a doctor to undertake an assessment for each new
intervention.

Furthermore, we found that some patients were actively being deprived of their liberty or had
restrictive measures in place (for example mittens to prevent removal of medical equipment, or
bed rails to prevent a patient from getting out of bed) without either an assessment of capacity as
to whether the patient could consent to these measures or any application for Deprivation of
Liberty Safeguards (DoLS). We spoke to staff about this and staff demonstrated a better
awareness of the legal requirement to apply for DoLS than they did for the MCA. However, it was
evident that the legal process was not consistently undertaken or carried out in a timely manner.
We saw one patient record where a DoLS had been appropriately applied for, granted and used
to support a patients’ safety; however, the preceding mental capacity assessment form was
poorly completed and did not reflect any adequate reasoning to determine a lack of capacity.

We raised the above findings with local and senior management at the time of the inspection. We
also attended the ward on the 4 November 2019 for a further announced inspection visit to
review patient records. On this occasion we found some improvements. In three cases where
patients lacked capacity, we saw a capacity assessment had been conducted for routine care and treatment and that DoLS had been applied for as in all cases the patients were being restricted from leaving the ward or removing medical supporting devices. However, two other patients demonstrated fluctuating capacity but there was no evidence of a capacity assessment being completed for routine care and treatment. This included care being given by allied health professionals such as physiotherapists.

In one case we saw the DoLS had expired. A temporary seven-day DoLS was applied for and granted which expired on the 1 November 2019. On 4 November when we reviewed this record, some restrictive measures were still in place however an extension had not been requested. We spoke to ward staff about this who requested advice from the trust wide advanced care team who provide 1-1 nursing support on referral. This team inaccurately advised the ward staff that the DoLS had no expiry and therefore there was no need to renew or reapply the request to deprive the patient of their liberty. This showed a lack of understanding of DoLS requirements from the enhanced care team. However, ward staff understood that an expiry was clearly annotated in the notes and provided assurances that they would re-apply to the local authority.

We did also see that a capacity assessment had been completed and a subsequent DoLS had been applied for a 17-year-old patient. Under the Mental Capacity Act, DoLS can only be applied for over people aged over 18. We did note that staff completing this had queried whether this needed to be done, however, the paperwork was still completed. This again showed a lack of understanding of this area of consent and a potential lack of support to ward staff managing children and young people who required restrictive measures in their best interests. After the inspection, the trust told us that staff had contacted the safeguarding team via email to seek advice as to whether a DoLS was required for this patient. This was documented in the healthcare record and the email evidence was included in the healthcare record. The staff were advised that a Mental Capacity Assessment was required, but not a DoLS and therefore the patient did not have a DoLS in place as per advice.

We also found that in three of three relevant records checked, where patients lacked capacity to consent to clinical photography, no formal assessment of capacity to consent was undertaken. Instead the referring medic had signed to consent on behalf of the patient.

Medical staff gained consent from patients for their medical treatment in line with legislation and guidance. Staff clearly recorded consent for surgical procedures and interventions in the patients’ records. Appropriate consent forms were used with patients to obtain consent to surgery and other medical procedures. Staff used different forms dependant on the needs of the patients. For example, if consultants identified a patient may lack capacity to consent to a surgical procedure they used this paperwork, and clearly documented their reasons and assessments for doing so.

When patients could not give consent, medical staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. We saw that where appropriate and credible assessments had been undertaken to assess patient capacity, if it was deemed the patient did not have capacity, staff sought to understand from relatives and previous knowledge what the patient would wish to do.

Where appropriate patients had ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form in place; and stored in their records which told staff if a patient was not to be resuscitated by cardiopulmonary resuscitation. We saw that a range of people had input to this
decision, including family and the person concerned. If the patient did not have capacity to make such a decision, family wishes were clearly recorded.

Mental Capacity Act and Deprivation of Liberty training completion
Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not included in the trust’s mandatory training during the reporting period. The trust reported that it was planning to introduce mandatory training in MCA and DoLS for registered practitioners and medical staff by September 2020. This will be included in a new mandatory safeguarding adults’ level 3 training module. The trust also reported that in the meantime the trust’s safeguarding team had been providing MCA training to priority staff groups since September 2018.
(Source: Routine Provider Information Request (RPIR) – Training tab)

During our inspection we saw that this training had been introduced. Ward 43 had a certificate demonstrating 100% compliance to the training requirements and had been recognised as having the highest compliance rate across the trust at this point. Managers did not monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary. Post inspection, we requested information about audits and checks on MCA assessments. The trust told us that they have not yet audited capacity assessments on ward 43. An audit programme was initiated following the last CQC inspection, but so far has concentrated on medical wards rather than surgical wards. Surgical wards were to be audited post the current inspection. Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. Where staff had applied for a DoLS to the local authority, we saw these were comprehensive and well completed. This was based on examples of both long term and short term DoLS applications.

Is the service caring?

Compassionate care
Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. However, there were occasions in which patient dignity was compromised.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. However, there were occasions when patient dignity was compromised. We observed one patient to be sitting out in a bay with no clothes on their bottom half, instead they were wearing an incontinence pad. A senior staff nurse observed this and asked staff working in that bay to get the patient dressed as to protect their dignity.

During our additional inspection visit on 4 November 2019, we observed part of a nurse handover being conducted. This was done within patient bays, or outside of patient side rooms for safety reasons and to protect patients from harm such as falls. However, we did notice that despite some efforts to be discreet, this was still not confidential. Details being discussed could be heard by other patients in the bay, and by visitors walking past or nearby to bays or side rooms. Personal and sensitive details being discussed could be overheard.

We saw the trust had addressed some concerns raised at our last inspection with regards to maintaining patient privacy and dignity. However, not all had been resolved. For example, during our last inspection we found the room on ward 43 used for pre-operative assessments was not suitable for private consultations with patients and their families. Whilst some changes had been made at this inspection in 2019; such as providing a separate room for consultants to work from,
staff were still not able to provide a high level of privacy and dignity due to these facilities.

We observed staff to be very kind and caring and display genuine empathy when talking to patients. All staff we spoke with spoke compassionately about patients; and gave us specific examples which illustrated the staff had taken time and care to get to know the patients well. Patients said staff treated them well and with kindness. Patients and relatives told us staff had been ‘brilliant’, citing caring staff who made an effort to provide a good level of quality care. Patients and their relatives told us staff spoke to them in a respectful and considerate way; and that staff responded appropriately when patients demonstrated discomfort or pain.

Staff followed policy to keep patient care and treatment confidential. Staff pulled curtains round patients prior to undertaking any intimate patient care. Patients told us that this was done consistently, and they felt staff treated them in a dignified manner. During the inspection, we saw conversations about patients to be confidential, discreet and professional. Staff spoke respectfully to and about patients; and responded well to requests and queries.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff we spoke with demonstrated a genuine empathy towards patients’ needs, including patients with mental health needs, learning disabilities, and cognitive impairment. Staff worked with such patients daily and presented as non-judgemental and open to delivering a caring service to all. It was clear that staff sought to understand the patients and their lives in order to provide compassionate care. Staff told us, and we saw, that they often cared for patients with severe and enduring substance misuse problems. Staff again remained non-judgemental when describing the care, they provided, and how they supported these patients. We spoke with relatives of a patient who was a substance user; they told us they thought the care offered to the patient was to a high standard and they were happy with the staff approach to working in a respectful and non-discriminatory way.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. On admission staff gathered information about patients personal lives and sought to incorporate this into care needs. For example, staff ensured they asked patients what they preferred to be called and used this name. Staff placed family pictures where patients could see these and referred to these in interactions. The service promoted equality and diversity in its daily work.

Friends and Family test performance
Patients gave varied feedback about the service via the friends and family test. From July 2018 to June 2019 the Friends and Family Test response rate for ward 43 at University Hospital Coventry was 24%. This was based on 290 responses. Ward 43’s annual Friends and Family Test score for this period was 73%. Monthly performance is shown in the table below. The ward scored below 80% in all but two months. There were four months where the score was below 70%.

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<tbody>
<tr>
<td>Ward 43</td>
<td>290</td>
<td>24%</td>
<td>57%</td>
<td>68%</td>
<td>77%</td>
<td>73%</td>
<td>63%</td>
<td>67%</td>
<td>75%</td>
<td>87%</td>
<td>61%</td>
<td>71%</td>
<td>73%</td>
<td></td>
</tr>
</tbody>
</table>

Key

- Highest score to lowest score

1. 100%
2. 50%
3. 0%

4. The total responses exclude all responses in months where there were less than five responses at a particular
ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.

5. Sorted by total response.

6. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff were confident to speak to patients and relatives when they were upset. Staff knew who to contact in the trust to gain additional support if it was needed. A third party charity who worked with people with head injuries also provided support to patients and their families within the Coventry area. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. During our inspection we observed staff to try and comfort patients who were emotionally distressed. Staff used patients’ names to engage with them more effectively and made effort to explain their actions. We observed a patient who had become distressed and wished to leave the ward. A security guard and a nurse attempted to talk to the patient to ascertain why they felt this way. Staff asked the patient about their thoughts and feelings; the patient made it clear she was not happy with the nurse and wished for the nurse to leave. We saw the nurse did leave at this point in accordance with the patients’ wishes which enabled the situation to be very quickly de-escalated.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Many of the patients within the neurosurgery service had impaired cognitive functioning as linked to their medical condition. All staff we spoke with showed a good understanding of this; and understood how this may affect emotions and behaviour. Staff understood the need to work with patients as individuals to provide the best care and emotional support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed staff involve patients in decisions and options about their care. For example, whether patients wanted to self-administer certain medicines. Interactions between staff and patients were patient centred with staff seeking to understand the view of the patient. Staff clearly explained care and treatment to patients; and talked about what they were doing whilst performing care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff modulated their voices to adapt to the needs of different patients and presented as curious about what patients had to say. Staff allowed time to hold conversations with patients; and spoke kindly to all patients; including those that were none responsive. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff and managers were open to conversations with family and patients about the service. Staff supported patients to make advanced decisions about their care. As discussed in ‘consent’ under ‘effective’, where appropriate patients had ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form in place which told
staff if a patient was not to be resuscitated by cardiopulmonary resuscitation. We saw that a range of people had input to this decision, including family. If the patient did not have capacity to make such a decision, then family wishes were clearly recorded.

<table>
<thead>
<tr>
<th>Is the service responsive?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service delivery to meet the needs of local people</strong></td>
</tr>
<tr>
<td>Not all facilities and premises were appropriate for the services being delivered. However, the service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.</td>
</tr>
</tbody>
</table>

Managers planned and organised services, so they met the changing needs of the local population. The service formed part of the major trauma centre provision; and as such could receive referrals across the West Midlands and from further away. Group directors told us of future plans to develop the service, including the site in which it was delivered, to offer a more streamlined service. We spoke to several elective patients and relatives who told us they lived out of area but had chosen to come to this hospital due to the service and quality treatment provided. Due to this relevant staff in the service regularly liaised with, and build relationships and service level agreements with, out of area hospitals such as inpatient rehabilitation hospitals in order to support patients post discharge.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During our inspection there were no mixed sex breaches. Separate bays were allocated for male and female patients. Transgender patients chose which gender bay they wished to be placed in; this enabled patients to make a decision based on their personal identification and how they wished to be treated and cared for. This was in line with trust policy and national guidance.

Not all facilities and premises were appropriate for the services being delivered. As referenced within ‘caring’; some areas of ward 43 were not appropriate for services being delivered. For example, the day room used by ambulatory patients awaiting surgery was drab, messy and uninviting. This was also a room used by inpatients and relatives during visiting hours; as such some people would bring food and drink into this room; patients told us this was difficult to see and smell when fasting for many hours prior to surgery. However, staff on the ward had achieved a charitable grant to upgrade the day room following our inspection. Another area that we found not fit for purpose on our previous inspection was the pre-operative assessment room. This was much the same on this inspection. There was a lack of space or lockers for patients to store their belongings whilst in surgery which meant these were stored in the pre-operative room which was accessed by many different people; including other patients and relatives. Despite this we saw some improvements had been made including a reconfiguration of the reception area enabling a large ‘hydration station’ for staff, patients and visitors. A large bathroom had been split into separate changing facilities and a wet room to enable more patients to use these. As described in ‘safe’ under the heading ‘environment and equipment’ the service was not compliant with national standards with regards to not having a dedicated emergency theatre for neurosurgery. See ‘access and flow’ for detail of impact including cancelled elective procedures.

At the time of our inspection two six-bedded bays were being upgraded to comply with fire safety regulations. Patients, visitors and staff with restricted mobility could access all areas of the trust. Wheelchairs were provided for patients that needed these. All patient areas were accessible by lifts as well as stairs. The corridors and door entrances were wide. The trust had a ‘ring and ride’

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service where patients could ring and request a wheelchair or transport within the hospital. This was delivered by volunteers.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems. Specialist teams were available for patients with learning disabilities and dementia. Staff could make electronic or direct referrals to the relevant teams to access support for patients with specific needs.

Meeting people’s individual needs
Not all patients were provided with an interpreter in a timely manner. However, the service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Data from the trust reported, and staff told us, that a trust wide dementia nursing team was available to support patients who were diagnosed with, or exhibiting symptoms of, dementia. A trust wide learning disabilities team was also in place. Relatives and staff told us of examples of when this team had attended the ward to support patients interact with staff.

Wards met the needs of patients. Photos of ward based staff were displayed so patients and relatives could familiarise themselves with who would be caring for them. ‘Named nurses’ for patient areas were displayed so patients. Patients told us there were limited activities to engage them whilst on the ward. Patient could use individual pre-payment televisions; and volunteers attended the ward on some days who could talk to patients. Staff displayed clear information to patients and relatives both on the entry to ward 43, and also, throughout the ward. This included details on visiting hours, different types of staff working on the ward, and infection prevention and control expectations. Signs on patient accessible areas such as toilets and the ‘hydration station’ had pictures as well as words to indicate the purpose of the area. This supported patients and visitors who were not able to read or understand the signs.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to a communications book which used pictures and words to describe commonly used phrases and questions. This book also contained a list of commonly used words in different languages to enable translation for day to day care requirements. Communication boards used on the stroke ward to communicate with patients who were not able to speak could be used by staff on ward 43. We observed a member of staff to support a visitor who was deaf. The member of staff responded positively to support alternative communication methods (such as providing a pad and pen) to manage requests made. Data from the trust reported that volunteer deaf befrienders had recently been recruited who were available to provide deaf patients with support and act a communication conduit for non-medical purposes such as informal conversations with patients and staff where British Sign Language (BSL) was the patients’ first language. Staff described how they supported communication with patients who were unable to communicate verbally; such as using pen and paper, basic signs and body language.

The service did not have information leaflets available in languages spoken by the patients and
local community on the ward. However, staff could request these from the online trust library service. Staff mostly ensured patients, relatives and carers could get help from interpreters or signers when needed. Whilst interpreters were available, and staff could request these either face to face or over the telephone; we observed one instance when this had not been done. A patient had been admitted to the ward the previous night and spoke no English. We spoke with relatives who told us that they had interpreted between medical and nursing staff since the patient had been admitted until when we spoke to them at 10.50am. No provision for interpretation had been made up to that point, including for any medical conversations. This is not in line with best practice which states family or friends should not be used as interpreters for medical interventions. We raised this with a senior nurse who told us they had been communicating via the family, but an interpreter would be booked. However, during our additional inspection visit on the 4 November 2019, we saw that two patients who did not speak English had both had interpreters arranged for relevant interactions and this was recorded in their notes. Data from the trust showed from November 2018 and October 2019 the neurosurgery service had 196 face to face interpreter appointments booked for patients, and eight telephone appointments. Sixty-nine appointments were booked which did not take place due to cancellation or non-attendance. The service monitored the use of interpreters on a quarterly basis. The trust had an in date interpreting and translation policy to use when working with patients whose first language was not English, including BSL. This was in alignment with the Equality Act 2010; and clearly outlined that friends, family or carers were not to be used as interpreters. Guidance for staff on how to manage patients who refused the use of interpreters was included.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patient menus reflected different choices of food and drink; including halal, vegan, and vegetarian. Patients told us that spiritual support on the ward had been limited. We saw bibles were available for patients who requested this. However, patients and visitors we spoke with told us they had not been approached by chaplaincy services to offer any religious or spiritual support. Data from the trust confirmed that religious and spiritual support was available. In particular chaplains from Christian, Sikh, Hindu and Islam faiths were available within the hospital to visit patients on request.

**Access and flow**

Patients could not all access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in not line with national standards; although improvements were noted.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for admitted pathways for neurosurgery was consistently worse than the England average. For the 12-month period overall the trust’s performance was 42.3% compared to the England average of 69.8%.
During our inspection, senior managers told us although RTT figures were still below the England average, improvements had been made and as of the end of October 2019; no patients would have waited over 45 weeks. The RTT was 76.1% for August 2019 against a target of 92%.

Despite referral to treatment targets not being met, patients we spoke with during the inspection told us they perceived they had received their operations within a good timeframe.

Neurosurgery theatre utilisation was not maximised within this service. This meant that some patients were not receiving their procedures as quickly as they might have done. We spoke to staff who told us reasons for this included not having a dedicated emergency theatre, a lack of intensive care beds and surgical ward beds which also led to elective operations being cancelled on the day. At the time of inspection theatre utilisation was approximately 70% which was an improvement; work had been undertaken to drive improvement by monitoring consultants’ actual theatre use compared to predicted theatre use. The trust target was 80%. The trust policy around emergency admissions was that if any emergency patients were waiting at another hospital; they would be admitted first each day prior to elective patients being admitted. These emergency admissions were discussed with the consultant of the day and ward managers in order to plan the day.

Managers and staff worked to make sure patients did not stay longer than they needed to. Each morning a board round was held which included representation from consultants, junior doctors, nurses, allied health professionals, the discharge coordinator who supported the ward and other relevant personnel. During this meeting; staff discussed each patient’s anticipated date of discharge and identified actions required to achieve this. Managers worked to keep the number of cancelled operations to a minimum. When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. For the six months between 1 July 2019 and 31 December 2019, a total of 146 patients were cancelled on the day. This was made up of 18 patient initiated cancellations, 48 hospital initiated cancellations for clinical reasons and 80 hospital initiated cancellations for non-clinical reasons. Of these cancellation 94.5% were booked back in within 28 days as per the non-clinical cancellation standard. This is an improvement from the previous six months between 1 January 2019 and 31 June 2019 when 172 patients were cancelled and 86% were booked back in within 28 days as per the non-clinical cancellation standard.
Staff moved patients between wards, including at night. Data from the trust showed that the number of ward moves from May 2018 to April 2019 equated to 13% of patients (204 patients out of a total of 1530). Of these, two patients were at the end of their life and 14 were identified as ‘vulnerable’. This was a similar figure to the previous year.

For the same time period, the number of ward moves at night for ward 43 (between 10pm and 8am) totalled 81 patients. Where patients were moved; staff had access to a ward transfer handover document to share information quickly and easily.

The process for managing neurosurgical patients in outlier wards was

- All outliers reviewed at the morning board round by consultant, registrar, SHO and nursing staff.
- There was one designated SHO for all neurosurgical outliers.
- All neurosurgical outliers were reviewed by a senior registrar on a daily basis.
- Consultant review of outliers happened as clinically necessary as discussed in the morning board round and following senior registrar review.

Below is a table demonstrating the average number of outlying patients per day between July 2019 and the end of October 2019. This figure has been further broken down to demonstrate the number of patients who were outside of ward 43 but in an appropriate area, or patients who are outside of ward 43 and who should be inpatients on ward 43. The service grouped these into the following definitions:

<table>
<thead>
<tr>
<th>Month</th>
<th>Average Outliers on Group Wards (Patients per day)</th>
<th>Genuine Outliers (Patients per day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-19</td>
<td>5.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Aug-19</td>
<td>2.6</td>
<td>0.4</td>
</tr>
<tr>
<td>Sep-19</td>
<td>6</td>
<td>0.3</td>
</tr>
<tr>
<td>Oct-19</td>
<td>11.8</td>
<td>0.06</td>
</tr>
<tr>
<td>Nov-19</td>
<td>5.6</td>
<td>0.1</td>
</tr>
<tr>
<td>Dec-19</td>
<td>4.1</td>
<td>0.09</td>
</tr>
</tbody>
</table>

Definitions

Outliers on Group Wards:
These are patients who are under the care of a Neurosurgeon, however they may be on ward 42 (Neurology), 41 (stroke) or 53 (Major Trauma). This cohort of patients may need to be under the care of a Neurosurgeon for operative management of their condition. However their condition may mean that they are best cared for in another ward setting which is outside of ward 43 (Neurosurgery).

Genuine Outliers:
These are patients who are under the care of a Neurosurgeon and are outlying on a ward outside of the Neurosurgical ward, but who should be cared for on a Neurosurgical ward.

(Source DR:64)

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. A trust wide discharge co-ordinator was allocated to ward 43 and 42 and worked with patients with complex needs. They worked across a multidisciplinary team including social services, other hospitals, care home settings to promote a safe discharge. An example was provided of a foreign national patient who sustained a head injury whilst at work in the UK and was treated at University Hospital. The discharge coordinator liaised with the Home Office, numerous interpreters to locate next of kin, and relevant consulates to ensure appropriate support was in place for a lengthy stay in the UK, including rehabilitation and eventual repatriation. In addition; the next of kin was supported financially to come to the hospital from abroad in order to facilitate family connections.
Rehabilitation beds for patients who were medically fit; but required additional support before going home were available both within the same hospital and in local community hospital beds. Where patients were not local to Coventry, the discharge co-ordinator worked to enable a bed in a more appropriate location if required.

**Average length of stay**
From March 2018 to February 2019 the average length of stay for elective neurosurgery patients at University Hospital Coventry was 6.5 days compared to the England average of 4.6 days. Over the same time period, the average length of stay for non-elective patients in neurosurgery at University Hospital Coventry was 13.1 days. This was similar to the England average of 12.8 days.

*(Source: Hospital Episode Statistics)*

Managers monitored the number of delayed discharges. Data from the trust showed that from May 2018 to April 2019; ward 43 had a total of 1624 patient discharges. Of these, 44 were delayed. This equated to less than 3% of total discharges for the ward. Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. Managers worked to minimise the number of surgical patients on non-surgical wards.

**Learning from complaints and concerns**
It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

**Summary of complaints**
From May 2018 to April 2019 the trust received 32 complaints about neurosurgery at University Hospital Coventry (5.0% of total complaints received by the hospital). For the 26 complaints that had been closed at the time of data submission, the trust took an average (mean) of 42.5 working days to investigate and close these complaints. This was longer than the trust’s target of 25 working days. The six complaints that were open at the time of data submission, had been open for an average of 56.7 working days. This was longer than the trust’s target of 25 working days. A breakdown of complaints by ward or unit is shown below:

<table>
<thead>
<tr>
<th>Department</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 43 - neurosurgery</td>
<td>24</td>
<td>75.0%</td>
</tr>
<tr>
<td>Admin office / secretaries</td>
<td>4</td>
<td>12.5%</td>
</tr>
<tr>
<td>Administration (waiting list, booking, etc)</td>
<td>2</td>
<td>6.3%</td>
</tr>
<tr>
<td>Outpatients department</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td>Operating theatres</td>
<td>1</td>
<td>3.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

A breakdown of complaints by subject is shown in the table below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical treatment</td>
<td>10</td>
<td>31.3%</td>
</tr>
<tr>
<td>Communications</td>
<td>7</td>
<td>21.9%</td>
</tr>
<tr>
<td>Patient care including nutrition / hydration</td>
<td>6</td>
<td>18.8%</td>
</tr>
<tr>
<td>Admissions, discharges &amp; transfers (excl delayed discharge due to absence of care)</td>
<td>3</td>
<td>9.4%</td>
</tr>
</tbody>
</table>
The service clearly displayed information about how to raise a concern in patient areas. Information was displayed in areas in which patients and visitors had access to. Patient liaison and advice service leaflets, and friends and family feedback forms were located at the main reception desk in area one. Staff provided some relatives with a welcome leaflet which also contained information on how to make a complaint. Staff understood the policy on complaints and knew how to handle them. Staff we asked told us they were aware of what to do if a patient made a complaint. They referred it to a manager and were able to advise patients of suitable channels such as the Patient Advice and Liaison Service (PALS) located in the trust.

Managers investigated complaints and identified themes. Patients received feedback from managers after the investigation into their complaint. We saw clear evidence of compliant responses made by ward managers. These were transparent and contained investigation findings and actions taken to prevent recurrence. Managers shared feedback from complaints with staff and learning was used to improve the service. This was shared via team meetings, safety huddles and production boards.

Number of compliments made to the trust
Managers shared feedback from compliments with staff. From May 2018 to April 2019 the trust received 33 compliments about its neurosurgery services at University Hospital Coventry. The trust noted that the main theme arising from 1,600 compliments received across the trust over the same 12-month period were how well staff demonstrated the trust’s values, particularly compassion, pride and respect. Recent compliments mentioned the professionalism and responsiveness of their staff.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

<table>
<thead>
<tr>
<th>Package - see integrated care)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointments</td>
<td>3</td>
</tr>
<tr>
<td>Values and behaviours (staff)</td>
<td>2</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

**Is the service well-led?**

**Leadership**

Leaders mostly had the skills and abilities to run the service. They understood and managed the priorities the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The trauma and neuro services group was an experienced triumvirate leadership team, comprising clinical director, group director of operations (GDO) and group director of nursing and allied health professionals (AHPs). The three group directors provided clinical and operational service strategy and managed this through a monthly group board meeting. Delivery and service improvement was managed locally by a matron, group [general] managers, and consultants. The theatres service was similarly managed by a triumvirate of clinical director, group director of nursing and AHP’s and group director of operations for the clinical group clinical support services. The theatres service covered a wide range of services and was therefore not directly managed by the neurosurgery service.
Local leaders within theatres and on the ward; such as ward managers and the speciality lead for neurology in theatres presented as credible, with the skills, abilities and motivation to run the service and drive improvement. These staff were able to identify priorities and issues that the service faced; and had clear plans and actions set to drive improvement. The ward managers were supported by two matrons at the time of the inspection who enabled a clear line of governance and promoted the ward managers to work autonomously to manage day to day issues. The ward matrons were described as supportive, and accessible to raise and escalate concerns.

Ward meetings were held to share information; however, ward managers acknowledged these had not been consistent. Information was regularly shared twice daily at shift changeover during the safety huddle meeting; and once daily Monday to Friday at a production board meeting. Staff spoke to reported that they received updates and information pertinent to their role and duties each day. Band six nurse team meetings were held monthly. Minutes from ward based meetings were printed and kept in the staff room for staff who were not able to attend. Compliments and celebrations were shared with ward staff at production board meetings.

The local managers within theatres had not been in post long; despite this, they demonstrated initiative and drive to improve services and to bring the theatres in line with best practice. Staff spoke positively of these leaders in terms of feeling supported to deliver a good service. However, as discussed more within culture and governance below; at the time of the inspection these local managers were not fully aware of the range of their roles, responsibilities and areas of oversight. This meant they were less able to identify and deal with local risks to the service as they arose.

Two leadership summit events for nursing staff had recently been held for band 6 (senior staff nurses) within the ward. These involved events with input from a range of managers, including the executive team to promote a consistent approach to work and ward management. Managers told us that they had seen a positive impact following these events including a more standardised practice. Several staff members had also been nominated to attend a leadership programme run trust wide. Consultant surgeons were being enabled to attend leadership courses at the time of the inspection; therefore, promoting a consistent approach to delivering medical leadership.

After the core service inspection, the trust told us that it recognised that the neurosurgery department had not had the improvement in culture required under its current leadership and steps had been taken to address this with the appointment of a clinical service lead post to lead the consultant body, professionally supported by the group clinical director and deputy chief medical officer. In addition a Head of Services for Neurosciences had also been appointed.

**Vision and strategy**

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The neurosurgery service had a five year plan which had commenced earlier in 2019. One aim of this plan was to undertake neurosurgery at other appropriate locations to expand the capacity and therefore treat more patients in a timely way. Other elements of this plan included addressing historical cultural concerns and included action such as consultant away days and structured engagement with the consultants. Senior management told of future plans and aspirations such as moving elective surgery off site in order to enable to neurosurgery service to evolve and develop.
Staff we asked were aware of the values of the trust; and demonstrated these through their behaviour and approach towards patients.

Culture

Staff did not all feel respected, supported and valued. The service did not have an open culture where patients, their families and staff could raise concerns without fear. However, staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development.

During our inspection, we found culture amongst staff varied. Some staff felt respected, supported and valued and reported enjoying their work. Some staff told us they thoroughly enjoyed their work but at times felt constrained due to a lack of resources, mainly enough nurse and health care assistant staffing overall. Other staff told us of a bullying culture where they felt afraid to be open and honest; or alternatively they had been open and honest but had seen no response to raising such concerns. This was mostly evident within theatres where we received and observed evidence that inappropriate practice had been undertaken which was not in line with national standards. However, despite this being raised over several years; this continued to happen. One such example was the inappropriate conversion of elective surgical cases to emergency cases to complete an operation on the designated day if no critical beds were available. Whilst this meant the patient was operated on sooner; it also put that and other patients at risk of not being able to receive adequate or appropriate post-operative care due to a lack of bed space. We were also given examples of aggressive and unprofessional behaviour by certain consultants and managers towards both internal staff members and third party individuals. These examples were corroborated by several different sources. We spoke to the group directors for neurosurgery about this who informed us they were aware of concerns and had dealt with these to the extent that all the consultant body now worked within trust expectations of performance and behaviour. We were provided with specific examples of actions and activities to promote a healthier culture such as consultant away days. However, evidence provided to us by a range of staff clearly outlined this was the improvement in this area was not as great as suggested by the group directors and concerns were active and ongoing at the time of inspection.

We did find evidence of some general improvement in the working environment within theatres; several staff cited a newly appointed specialist lead nurse as being proactive in managing and promoting this. Furthermore; staff reported that an influx of new staff including consultants had led to a positive working environment which enabled new practice to flourish. All staff we spoke with told us they would be happy to have a relative or friend attend the hospital as they felt they would receive a high level of medical care and treatment. However, some staff did express concerns that staff shortages may result in some basic care needs not being met in a timely manner.

After the core service inspection, the trust told us that the group clinical director had held one away day with the consultants and another away day was planned with a focus on developing a five year strategy for the service. The chief medical officer had met with the consultant body on 6 September 2019 and articulated concerns arising from the previous CQC report and current concerns around ongoing communication within the department being the cause for poor nurse staffing levels. The trust was exploring options for the provision of an external support package to work with the consultants to improve culture within the department. The deputy chief nursing officer had held two nurse leadership summits with ward 43 (neurosurgery) focused on quality of care, which had been positively received.
Governance
Leaders did not consistently operate effective governance processes, throughout the service. Whilst governance was clear from the ward; within theatres this was not embedded or clear. Some staff at management levels were not clear about their roles and accountabilities. However other staff and managers were and had regular opportunities to meet, discuss and learn from the performance of the service.

Since our previous inspection; the leadership structure from ward to board had changed. At this inspection, three group directors oversaw the trauma and neurosurgery services which included neurosurgery, although this did not include theatres. These directors worked under the executive team and above the local management structure which comprised matrons and ward.. The matrons supporting the neurosurgery ward had been through a restructuring process also in order to provide a robust level of support. Neurosurgeons held two separate governance meetings; one for theatres and one for the trauma and neurosurgery group. Additional joint meetings were set up to share information between the two groups. Quality improvement and patient safety meetings (QIPs) were held to discuss quality and performance. These meetings themselves were reviewed to ensure compliance to a productive agenda and that representatives from relevant staff groups were in attendance. The management team responsible for the neurosurgery ward used production boards as a way to ensure the flow of information was escalated and cascaded from ward to board. The ward managers held a daily production board with staff on the ward. A weekly production board was held between the ward managers and matrons; and following that a weekly meeting was held between the matron and the group director of nursing and allied health professionals.

We found that lines of governance and responsibility was not clear in theatres. Two band seven (senior nurses) managed neurosurgery as part of their roles and were both new in post. They were overseen by the matron for theatres. We found that the leadership present at the time of inspection were not clear on who was responsible for monitoring, auditing and managing different aspects of the theatres such as theatre cleanliness, equipment checks and maintenance, the safer surgery checklist compliance, and infection prevention and control. This resulted in a lack of awareness and knowledge around areas of potential risk. For example, no one was able to tell us who was responsible for auditing the safer surgery checklists during our inspection; or who was responsible for maintaining oversight of daily checks on the anaesthetic machines. We asked the group directors for neurosurgery about this who told us this fell under a different group directorate covering theatres specifically; and that joint oversight for shared areas was not usually undertaken. We acknowledge that local leadership in theatres were new in post; and therefore, this may have contributed to a lesser awareness of governance structures. However, during our inspection, we found that the culture of theatres as discussed above impacted on staff being aware of clear lines of responsibility and accountability.

Management of risk, issues and performance
We found concerns that although leaders and teams used systems to manage performance, not all responsible individuals were reporting concerns or adverse incidents transparently or openly. However, for the main, the service did identify relevant risks and issues had identified actions to reduce their impact.

Senior managers identified risks to the service as nurse staffing, referral to treatment targets, finances and medical vacancies. Specific actions were in place to mitigate these risks such as placing a hold on any registered nurse transfers from ward 43 to other areas in the hospital until staffing had improved. Ward managers identified risk to the ward more locally as staffing, violence
and aggression and a lack of critical care beds resulting in elective patients being cancelled for none clinical reasons. These were in line with what we observed during our inspection.

We saw medical staff recorded risks and ongoing problems; such as no dedicated emergency theatre for neurosurgery. Where possible, actions were set to mitigate risks or problems and were allocated a named person to oversee this. However, at the time of the inspection, the specific risk of no dedicated emergency theatre did not look open to rectification imminently.

Ward and directorate management met to discuss serious incidents in a timely manner. We observed a patient safety response meeting after a patient with a category three pressure ulcer had been identified. This was appropriately categorised as a serious incident; incidents leading up to this were discussed and learning identified. Specific information to feedback to staff on the ward was agreed including to ask ward staff for their ideas to prevent recurrence. We later saw evidence that staff on the ward had been involved in this discussion; and had the opportunity to make suggestions and reflect upon the care given to patients.

Regular audits were completed to monitor performance and compliance to required standards. Improvements were made as a result of these audits. For example, following a quarterly pharmacy audit in 2019; ward 43 were identified as a ward with one of the highest rates of medicine errors and omissions across the hospital. After this identification managers undertook further audits and a four week ‘deep dive’ to explore the reasons for this this; and where compliance was low. Themes were identified and fed back to staff, along with expectations of performance. Following this a further re-audit was completed four weeks later. Whilst performance had improved overall; it was found that one area (blank boxes in the medication administration record) remained at a low compliance. Therefore, further actions were embedded such as monitoring this daily to act on omissions contemporaneously. After 12 weeks; significant improvement was noted and changes that had been made were implemented trust wide as an expected standard of performance.

The ward displayed quality and performance boards which were updated each month and included information on days since the last avoidable category three or four pressure ulcer, number of falls in a month, days since the last *c. difficile* case, MRSA screening compliance, appraisal compliance, mandatory training compliance, cannula compliance, catheter compliance, safety checklist compliance and cleaning audit figures. Additionally, coloured arrows indicated whether the scores had improved or declined since the previous month.

For August 2019 we saw:

<table>
<thead>
<tr>
<th>Area monitored</th>
<th>Compliance</th>
<th>Improvement or decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last avoidable category three or four pressure ulcer</td>
<td>Jan 2019</td>
<td>Improvement</td>
</tr>
<tr>
<td>Number of falls in a month</td>
<td>3</td>
<td>Improvement</td>
</tr>
<tr>
<td>Days since the last <em>c. difficile</em> case</td>
<td>August 2016</td>
<td>Improvement</td>
</tr>
<tr>
<td>MRSA screening compliance</td>
<td>Emergency: 85%</td>
<td>Elective: 95%</td>
</tr>
<tr>
<td>Appraisal compliance</td>
<td>83%</td>
<td>Decline</td>
</tr>
<tr>
<td>Mandatory training compliance</td>
<td>92%</td>
<td>No change</td>
</tr>
<tr>
<td>Cannula compliance</td>
<td>57%</td>
<td>Decline</td>
</tr>
<tr>
<td>Catheter compliance</td>
<td>90%</td>
<td>Improvement</td>
</tr>
<tr>
<td>Safety checklist compliance</td>
<td>100%</td>
<td>No change</td>
</tr>
<tr>
<td>Cleaning audit figures</td>
<td>93%</td>
<td>Improvement</td>
</tr>
</tbody>
</table>

This enabled staff, patients and visitors to see performance in an easy to view format as they entered the ward. The medical team undertook regular audits to ensure clinical effectiveness and
adherence to best practice. However, during our inspection we received information about staff being encouraged to not report certain adverse events. We were told that adverse event reporting differed noticeably when certain consultants were on leave; and therefore, not showing their usual figures.

**Information management**

The service collected data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

On the ward, managers displayed a holistic overview and understanding of information including performance data. This was used to promote development of care and treatment to ensure quality of care was improved; in addition to using this information for assurance of areas that were performing well. Ward managers used systems to collate and display relevant, valid and up to date information, so this could be viewed by staff, patients and visitors. When concerns or issues had been identified; managers gathered further information and conducted further audits to understand this; such as conducting a ‘deep dive’ audit into medicines documentation to identify poor performance. During our inspection, we saw examples of where information had been collated and used to drive improvements. For example, recent audits into cannular management had identified that audit failures were due to cannular information not being added into patient records. As a result, a pilot was in place to enable doctors to enter information into the electronic device used to record patient observations in order to increase compliance.

**Engagement**

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Senior leaders including group directors had been taking part in Gemba rounds each Friday; these involved managers attending a specific locality to engage with staff directly in their working environment. The trust used staff surveys to gather the staff voice. Staff involved patients and their relatives in decisions about care and treatment. Staff were open to holding conversations and sought to gather the views of people using the service. As previously reported, staff worked with a third party charity for people with brain injuries to promote a more holistic support service. Staff and the charity worked together to facilitate a positive experience for patients and their families. Where required staff liaised with third party organisations to plan and manage services. For example, service level agreements were in place with other NHS trusts who provided linked services. From a trust wide perspective, links had been made with the local Deaf community and volunteers had been recruited to support patients whose first language was British Sign Language. The trust also made links with other third sector voluntary organisations and social groups to promote support for patients; and to gain a wider perspective on how to best support patients.

**Learning, continuous improvement and innovation**

Staff were committed to continually learning and improving services. Managers had a good understanding of quality improvement methods and the skills to use them.

Since neurosurgery had become part of the wider trust wide trauma group in terms of a departmental re-structure, some developments were noted. For example, to enable trauma and
orthopaedic surgeons to give spinal injections therefore sharing a rota for this. Medical staff had organised ‘boot camps’ which aimed to provide five days of high quality neurosurgery simulation training for junior doctors. This had been running for three years at the time of inspection. Course evaluations showed attendees found the course useful to their practice.

After the inspection, the trust told us that the service was part of the “Pathway to Excellence, Ward/department accreditation” work which was focused on delivering the trust strategic objective of safest patient care and excellent patient experience. The pathway to excellence provided staff with more opportunities of leadership, shared decision making, professional development and welfare. In turn, patient standards would be more visible, more often with particular emphasis on excellent safety, care, and dignity.

Hospital of St Cross

Facts and data about this hospital

University Hospitals Coventry and Warwickshire NHS Trust has approximately 1,175 inpatient beds and 116 day case beds located across two acute locations: University Hospital which is located in Coventry and Hospital of St Cross which is located in Rugby. These two hospitals serve a combined population of over one million people. The trust is a major trauma centre and the specialist cancer centre for the region. In addition, it specialises in cardiology, neurosurgery, stroke, joint replacements, invitro fertilisation (IVF) and maternal health, diabetes and kidney transplants. The number of staff employed by the trust as of January 2018 was 8,136. The trust’s services are commissioned by Coventry and Rugby Clinical Commissioning Group.

Services provided at this hospital include:

- Diagnostics.
- Medical care.
- Outpatients.
- Surgery.
- Urgent care centre.

Outpatients

Facts and data about this service

The trust’s outpatients’ service provides a mixture of elective and rapid-access clinics. The latter can be accessed via urgent care pathways. Outpatient specialties provided by the trust include cardiology, ear nose & throat (ENT), gastroenterology, neurology, ophthalmology, plastic surgery, rheumatology and urology. The trust provides a number of multidisciplinary ‘one stop’ clinics, where patients see a clinician along with other members of the multidisciplinary team (for example, allied health professionals).
Total number of first and follow up appointments compared to England
The trust had 854,234 first and follow up outpatient appointments from March 2018 to February 2019. The graph below represents how this compares to other trusts.

(Source: Hospital Episode Statistics - HES Outpatients)

Number of appointments by site
The following table shows the number of outpatient appointments by site, a total for the trust and the total for England, from March 2018 to February 2019. Please note that 22,002 spells were assigned to University Hospital Coventry and Warwickshire NHS Trust, as the site was not specified.

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Number of spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital Coventry</td>
<td>755,538</td>
</tr>
<tr>
<td>Hospital of St Cross</td>
<td>133,930</td>
</tr>
<tr>
<td>University Hospital Coventry and Warwickshire NHS Trust</td>
<td>22,002</td>
</tr>
<tr>
<td>Coventry City Centre Health Facility</td>
<td>7,462</td>
</tr>
<tr>
<td><strong>This Trust</strong></td>
<td><strong>918,932</strong></td>
</tr>
<tr>
<td><strong>England</strong></td>
<td><strong>109,324,322</strong></td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)

Type of appointments
The chart below shows the percentage breakdown of the type of outpatient appointments from March 2018 to February 2019. The percentage of these appointments by type can be found in the chart below. Please note that some spells were assigned to University Hospital Coventry and Warwickshire NHS Trust, as the site was not specified.

Number of appointments at University Hospital Coventry and Warwickshire NHS Trust from March 2018 to February 2019 by site and type of appointment
Is the service safe?

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The trust set a target of 95% for completion of mandatory training.

Mandatory training completion rates: Nursing staff – Hospital of St Cross

Nursing staff received and kept up-to-date with their mandatory training.

A breakdown of compliance for mandatory training courses as of April 2019 at trust level for qualified nursing staff in outpatients at Hospital of St Cross is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Manual handling - people</td>
<td>7</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>2</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>7</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>7</td>
</tr>
<tr>
<td>Information governance</td>
<td>7</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>7</td>
</tr>
<tr>
<td>NPSA preparing and administering a transfusion of blood or blood products</td>
<td>2</td>
</tr>
<tr>
<td>Fire safety - annual</td>
<td>7</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>7</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>7</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>6</td>
</tr>
</tbody>
</table>

During our inspection we received evidence which demonstrated that there was 100% compliance with the 11 mandatory training modules for which qualified nursing staff were eligible. The mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with told us that they had completed mandatory training, stating it was easy to access. Training modules were a combination of face to face and online learning. All staff had access to an electronic system which indicated their compliance with mandatory training requirements. Managers monitored mandatory training and alerted staff when they needed to update their training. Reminder emails were sent to staff when training was due to be updated. Managers could view training compliance for all staff in their teams through the electronic system and they also maintained a paper copy of each staff members training needs.

No medical staff were mapped to the outpatient service at Hospital of St Cross in the training data supplied by the trust. It should be noted that only five members of medical staff were mapped to the outpatient service at University Hospital Coventry. A breakdown of compliance for mandatory training courses as of April 2019 for medical staff in outpatients at Hospital of St Cross is shown below:
<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>5</td>
</tr>
<tr>
<td>Health and safety (slips, trips and falls)</td>
<td>5</td>
</tr>
<tr>
<td>Advanced life support update</td>
<td>4</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>4</td>
</tr>
<tr>
<td>In-hospital resuscitation including AED</td>
<td>1</td>
</tr>
<tr>
<td>Conflict resolution</td>
<td>5</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>5</td>
</tr>
<tr>
<td>Hand hygiene clinical (annual)</td>
<td>5</td>
</tr>
<tr>
<td>Fire safety - annual</td>
<td>4</td>
</tr>
<tr>
<td>Information governance</td>
<td>4</td>
</tr>
<tr>
<td>Moving &amp; handling - medical and dental</td>
<td>3</td>
</tr>
</tbody>
</table>

In outpatients at University Hospital Coventry the 95% target was met for eight of the 11 mandatory training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The trust set a target of 95% for completion of safeguarding training. The tables below include preventing radicalisation training as a safeguarding course. This training module works to stop individuals from getting involved or supporting terrorism or extremist activity.

Nursing staff – Hospital of St Cross

A breakdown of compliance for safeguarding training courses as of April 2019 for qualified nursing staff in outpatients at Hospital of St Cross is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>7</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>7</td>
</tr>
</tbody>
</table>

At Hospital of St Cross the 95% target was met for all five safeguarding training modules for which qualified nursing staff were eligible.

No medical staff were mapped to the outpatient service at Hospital of St Cross in the training data supplied by the trust. In the absence of data for Hospital of St Cross, this section has been
populated with medical staff training data for the outpatient service at University Hospital Coventry. A breakdown of compliance for safeguarding training courses as of April 2019 for medical staff in outpatients at University Hospital Coventry is shown below:

<table>
<thead>
<tr>
<th>Module name</th>
<th>As of April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff trained</td>
</tr>
<tr>
<td>Preventing radicalisation level 3, 4 &amp; 5 (prevent awareness)</td>
<td>5</td>
</tr>
<tr>
<td>Preventing radicalisation level 1 &amp; 2 (basic prevent awareness)</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding adults level 1</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding adults level 2</td>
<td>4</td>
</tr>
<tr>
<td>Safeguarding children level 2</td>
<td>5</td>
</tr>
</tbody>
</table>

In outpatients at University Hospital Coventry the 95% target was met for all five safeguarding training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

All staff we spoke with told us they had completed safeguarding training for both adults and children in line with trust policy. Staff were able to describe what would constitute a safeguarding concern and describe the process for escalating any concerns. There was a named safeguarding lead for outpatient services and a trust safeguarding nurse who staff could access for advice and support. We reviewed the adults’ safeguarding policy (OPER-POL-004-10) which is easily accessible on the staff intranet. However, we noted that the policy should have been reviewed by 30/08/2019. After the inspection, the trust informed us that this policy had now been reviewed. Female Genital Mutilation (FGM) was included in level two safeguarding training, which all clinical staff completed.

Staff demonstrated awareness of FGM and staff in one area described how they escalated concerns spotted at an appointment for an adult female in a gynaecology clinic. Prevent awareness training, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, was included within the adult safeguarding training. Child Sex Exploitation (CSE) was included within level two and three safeguarding training. CSE is a form of child abuse and reportable to children’s social services in line with safeguarding procedures.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All outpatient areas we visited, including waiting areas, consultation rooms and treatment rooms were found to be visibly clean and tidy. Staff were observed hand hygiene guidance and were ‘arms bare the below the elbow’ in line with the hospital’s infection control policy.

Staff followed infection control principles including the use of personal protective equipment (PPE). Personal protective equipment (PPE), such as gloves and disposable aprons were available within the consultation rooms and treatment rooms. Hand sanitiser was available at the entrances to the main outpatient areas and within the waiting areas. We saw staff members using appropriate PPE and hand sanitiser throughout our inspection. We also saw staff prompt patients to use hand sanitiser before and after consultations. Infection, prevention and control measures were audited. Hand hygiene audits were completed weekly. We reviewed three recent audits and found all were
100%. These were completed by the senior sister. Reusable devices that required decontamination were removed at the end of clinic, placed into a sealed bag, into a sealed box and were sent to the sterile services department (SSD).

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeepers employed by the trust were responsible for the cleaning of the environment and daily checklists were completed to evidence this.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Clinical equipment was cleaned in each clinical area daily by nursing staff, and we saw records were signed to confirm when the task was completed. We observed that staff used the green ‘I am clean’ stickers to record the date a piece of equipment was cleaned. We observed seating in the waiting areas and couches in the consulting rooms were in good condition without rips and tears. These were wipe clean, which meant that they were in line with the hospitals’ infection control policy.

Clinical waste was stored and disposed of appropriately. In all clinical areas, there was correct segregation of clinical and non-clinical waste into different coloured bags. This was in line with the Health Technical Memorandum 07-01, ‘Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations’. Sharps disposal bins were available in consultation and treatment rooms. This was required to ensure appropriate disposal of sharps, for example needles. Sharps bins we saw were appropriately labelled and not overfilled.

We saw that there was a tap flushing process in place, including keeping logs to record this, to reduce the risk of Legionella bacteria in water supplies throughout the outpatient departments.

Environment and equipment
The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The outpatients’ department was located off the main corridor not far from the main entrance. It was all on one level and had different areas for each clinic. Staff carried out daily safety checks of specialist equipment. Staff were specifically trained to do this. We saw evidence of their signed competencies. Electrical safety checks had been carried out on mobile electrical equipment and labels were attached which recorded the date of the last check. The service had enough suitable equipment to help them to safely care for patients. Nursing staff told us they had enough equipment to carry out specific tests for patients. There were hoists and wheelchairs available for when they were needed.

Staff disposed of clinical waste safely. There were arrangements for managing waste and clinical specimens; for example, segregation, labelling and handling of waste where appropriate. We saw that there were arrangements in place for managing specimens, such as blood samples, taken in the phlebotomy department. The process included confirming the patient’s identity and correct labelling of blood bottles. We checked the resuscitation ‘grab bags’ located throughout the departments. The bags were secure and sealed. We saw that regular checks had been completed.

Assessing and responding to patient risk
Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
Staff responded promptly to any sudden deterioration in a patient’s health. A trust policy was in place to identify a deteriorating patient; staff told us they would call the ‘crash’ team where required. There were clear pathways and processes for the assessment of people within outpatient clinics or who were clinically unwell and required hospital admission. Staff were trained in life support techniques and had access to emergency resuscitation equipment. Resuscitation bags contained adult and paediatric emergency equipment. Doctors were available within clinics to assist in the event of medical emergencies. There was an emergency internal phone number to call if a patient had a cardiac arrest and required a specialist team to provide advanced life support.

Staff received training on the ALERT course, this gave nurses and health care assistant knowledge of the deteriorating patient. Additionally, they completed NEWS2 training. NEWS is the national early warning score, a score is made once a patient’s blood pressure, heart rate, respiratory rate and temperature had been recorded to recognise and act upon early signs of a patient deteriorating.

Staff completed risk assessments for each patient on arrival in the department and updated them when necessary using recognised tools. We saw the patient’s care record included risk assessments for moving and handling, pressure areas (Waterlow skin care assessments) and venous thromboembolism (VTE) or blood clots. Outpatient staff completed risk assessments including national early warning score (NEWS), pre-assessment for procedures and pain assessments. These were recorded appropriately in the medical records and nurses escalated any concerns to medical staff in clinics. Staff knew about and dealt with any specific risk issues.

The service had access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health). Staff reported they were aware of how to manage patients whose behaviour presented a risk to others or themselves. Staff told us they knew there was a mental health liaison team who could assess and support patients’ mental health. Staff in the department told us they were aware of the service’s major incident plan.

Staff shared key information to keep patients safe when handing over their care to others. In the department, there was a daily safety huddle to review staffing and any concerns about the clinic running that day. This included discussions about any complex patients or issues with equipment.

**Nurse staffing**

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe. We spoke with senior staff to establish how staffing requirements were ascertained, as there are no national standards or guidelines for how outpatient clinics should be staffed. They told us this was done on the demand of clinics mapped for each day. Staffing was planned in advance with the aim to always include qualified nurses to coordinate the clinics. We saw from staffing rotas, that this was the case. We observed that there were reception and nursing staff available to support all clinics that were running during the inspection. The department used no agency or bank staff. All new staff received a local induction to each area on their first shift.

**Hospital of St Cross**

The table below shows a summary of the nursing staffing metrics in outpatients at Hospital of St Cross compared to the trust’s targets, where applicable:
Outpatients annual staffing metrics
May 2018 to April 2019

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Annual average establishment</th>
<th>Annual vacancy rate</th>
<th>Annual turnover rate</th>
<th>Annual sickness rate</th>
<th>Annual bank hours (% of available hours)</th>
<th>Annual agency hours (% of available hours)</th>
<th>Annual unfilled hours (% of available hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Staff</td>
<td>21.8</td>
<td>8%</td>
<td>9%</td>
<td>2.3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>6.3</td>
<td>32%</td>
<td>13%</td>
<td>1.8%</td>
<td>334 (3%)</td>
<td>0</td>
<td>4,431 (37%)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing Bank Agency tabs)

Qualified nursing staffing rates within outpatients at Hospital of St Cross were analysed for the past 12 months and some indications of improvement were identified. Over these 12 months the trust reported no agency usage for qualified nursing staff. After the inspection, the trust told us that median vacancy rate of 32% shown above did not match the median of 24.05% for qualified nurses as listed for outpatients at Rugby St Cross.

Vacancy rates

Vacancy rates had reduced over the past year. Monthly vacancy rates over the last nine months for qualified nurses were stable.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Bank and agency staff usage
Bank and agency usage had reduced over the past year. Monthly bank usage over the last nine months for qualified nurses was stable.
(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Medical staffing
The service had enough medical staff to keep patients safe.

Medical staffing was provided to the outpatient department by the various specialties that had clinics. Doctors who worked in outpatients were associated to the various core services rather than the outpatient department, so this data was not collected or monitored by the outpatient department. Medical staff were required to give at least six weeks’ notice of any leave in order for clinics to be managed or adjusted.

Medical staff gave two weeks’ notice to add any extra clinics to their list, for example, Saturday clinics. This made sure the outpatients manager could coordinate staff rotas accordingly.

No medical staff were mapped to the outpatient service at Hospital of St Cross in the staffing data supplied by the trust.

Records
Staff kept detailed records of patients’ care and treatment.

Patient notes were comprehensive, and all staff could access them easily. Patient’s individual care records were written and managed in a way that kept people safe. Staff could access patient records easily and there were no delays in staff accessing patient records. The outpatients’ service used a combination of paper and electronic patient records. Paper records were used to document clinician reviews. Records were stored securely. Following each patients’ appointment, the clinician would give the completed paper record to the nurse or healthcare assistant assisting them, who then stored the paper records in a tamper evident container. These were then sent to an external provider to scan to the patients’ electronic record.

We reviewed seven paper records and found they contained relevant information such as patient details, medical history, clinical observations, test results, diagnosis, management plan and/or risk assessments, where applicable. Records were legible, dated and all signed by the clinician. However, the signature of the clinician was not legible on three of the records reviewed and their GMC number had not been recorded. Information needed to deliver safe care and treatment was available to staff in a timely and accessible way. The trust used several electronic systems to store and manage patient information such as diagnostic test and imaging results, GP referral...
letters and assessments. Staff told us it was uncommon for patient records to be unavailable for clinics. The outpatients manager reported that no patients were seen as outpatients, in the past year, without the full medical record being available.

A medical records supervisor ensured the records were obtained for the consultant prior to seeing the patient. If these are required out of hours or when the medical records supervisor was not available, other staff members were trained to access and track medical records. We were told that if the paper record was missing or unable to be scanned in time for the outpatient appointment, clinical staff could access the computerised systems for referral letters, electronic discharge summaries and diagnostic results. Any risk of temporary admission notes being unavailable for follow-up outpatient appointments was mitigated by ward clerks, who checked future outpatient appointments and prioritised those records for scanning or ensured outpatient staff received the patients’ paper records.

The electronic records system had a process in place to alert staff if a patient had a pre-existing condition, such as living with dementia or a mental health condition.

**Medicines**

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. There were effective systems in place regarding the handling of medicines. Outpatient nursing staff did not administer medicines but consultants and the clinical nurse specialists working in the clinics did use some medicines for injection, such as local anaesthetic and steroids. They followed the trust’s and national guidance for these.

Staff stored and managed medicines and prescribing documents in line with the provider’s policy. We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines were within the use by date, including intravenous fluids (fluid given via a vein), emollients and creams.

Blank NHS prescription pads (FP10 prescriptions) were stored securely and monitoring systems were in place to ensure all prescriptions were accounted for. The audit record detailed each prescription issued and included the name of the person who issued the prescription, the date it was issued, the patient name and NHS number and prescription number. This was in line with national guidance (Department of Health Security of prescription form guidance (August 2013)).

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. If there were any national medicines safety alerts, these were disseminated to the department through the pharmacy team and shared.

**Incidents**

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The service had processes in place to prevent harm to patients and staff understood their responsibilities to raise concerns, to record
safety incidents and to report them internally and externally. The hospital used an electronic online system for reporting incidents. Staff described the process for reporting incidents and gave examples of when they had done this. Staff reported all incidents that they should report. Staff told us that there was a positive incident reporting culture within the trust.

Never Events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2018 to June 2019 the trust reported no never events for outpatients at Hospital of St Cross.
(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS: Hospital of St Cross
In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SI’s) in outpatients at Hospital of St Cross which met the reporting criteria set by NHS England from July 2018 to June 2019.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff told us they were aware of the Duty of Candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. The duty of candour is a legal duty on healthcare providers that sets out specific requirements on the principle of being open with patients when things go wrong. Staff knew what duty of candour meant and could describe their responsibilities relating to it.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff had feedback on incidents and action taken through staff meetings, team briefings and information on staff noticeboards. Staff working in the outpatient department told us that learning from incidents was fed back and disseminated through local meetings which were facilitated by the matron. Managers debriefed and supported staff after any serious incident. Staff explained an incident whereby a patient became disruptive and abusive to staff. We were told by management that all staff would receive a debrief to ensure they were well and to explore which further support they may require. This process was confirmed by staff spoken with.

Safety Thermometer
The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. Staff collected safety information and shared it with staff, patients and visitors. This information was intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide. The trust reported outpatient monthly RTT performance levels and did not attend rates within each clinical area. Staff collected safety information and shared it with staff, patients and visitors. This information was intended to help staff focus their attention on reducing patient harm and improve the safety of the care they provide. The trust reported outpatient monthly RTT performance levels and did not attend rates within each clinical area.

Is the service effective?
Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Polices seen were up to date and reflected national guidance. Staff had ready access to polices via the trust’s internet.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients’ religious, cultural and other needs.

Patients nutrition and hydration needs were identified, monitored and met. New patients had their nutrition and hydration needs assessed and addressed, where indicated. This was in line with national guidance (NICE, Patient experience in adult NHS services: Quality Statement (QS) 15; Quality statement 10 (February 2012)). Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. There was access to dietary and nutritional specialists when needed. Patients could be referred to the dietetic service by their GP or consultant. Staff made sure patients had enough to eat and drink. Including those with specialist nutrition and hydration needs. Staff told us they offered hot and cold drinks to patients if they were in the department for any length of time and could also provide food if needed, such as for those awaiting patient transport. If patients with diabetes were in the department around lunchtime staff would offer them food and drink to meet their health needs. The main outpatients’ department was located close to the hospital café and shop where patients and visitors could purchase food and drink. Glucose preparations were available for patients with diabetes, when needed. Glucose preparations are recommended when a patient has a ‘hypo’ and needs to increase their blood glucose levels rapidly (a ‘hypo’ is commonly used to describe hypoglycaemia, where the blood glucose level falls below the normal range).

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients’ pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients we spoke with had not required pain relief during their attendance in the outpatient clinics. However, one patient told us the consultant routinely asked them about their pain and pain management, during their outpatient appointment.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in local and some national clinical audits. There was participation in organisational audits, for example of hand hygiene and the environment. We saw the results of the environmental audit displayed outside each consulting room and main waiting areas. Managers
had a comprehensive audit programme. They audited outpatient performance measures that impacted on patient experience and outcomes, such as waiting times. Managers used information from the audits to improve care and treatment. Measures such as referral to treatment times and other dashboard indicators were discussed at clinical governance and operational meetings and ways in which they could be improved were discussed. Managers shared and made sure staff understood information from the audits. This information would be discussed at regular staff meetings. Improvements were checked and monitored. The service had an outpatient dashboard which managers used to monitor referral to treatment times, ‘did not attend’ rates, clinic cancellations and other key measures.

Local Managers undertook a range of audits in outpatients including:

- Infection control audits (ICNA).
- ISS Maximiser audits.
- Uniform audits.
- Hand hygiene audits.
- Monthly safety/quality matrix (includes audits against crash trolleys, sharps boxes, medicines safety checks, cleaning, IPC, equipment, pride and documentation).
- Waiting times audit.
- Internal transfer audit.

The following audits undertaken within the trust during 2019/2020 involved reviewing an element of practice within the outpatient setting at Rugby:

- National Ophthalmology Audit (Adult Cataract Surgery).
- National Paediatric Diabetes Audit (NPDA).
- National Audit of Seizures and Epilepsies in Children and Young People (epilepsy 12).
- Audit of Dermatology Consent.
- National Diabetes CORE Audit.
- National Early Inflammatory Arthritis Audit (NEIAA).
- British Society for Rheumatology (BSR) Multi-Region Audit on the Management of Adults with Systemic Lupus Erythematosus (SLE) 2018.
- Re-audit of Breast Screening Measures.
- National Audit of Cardiac Rehabilitation.
- An Audit of Biochemistry Result Acknowledgment process in Specialist medicine directorate in Outpatient and Inpatients.
- Uptake rates of influenza and pneumococcal vaccines in patients on long term disease modifying drugs.

Follow-up to new rate
From March 2018 to February 2019, the follow-up to new rate for Hospital of St Cross was consistently higher than the England average. Please note that some spells were assigned to University Hospital Coventry and Warwickshire NHS Trust, as the site was not specified.

Follow-up to new rate, University Hospital Coventry and Warwickshire NHS Trust.
Competent staff

The service made sure staff were competent for their roles. Managers appraised staff’s work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. All clinics were run by clinicians with the appropriate experience and training in the field. Managers gave all new staff a full induction tailored to their role before they started work. Staff received a comprehensive induction when they commenced work at the trust. This included a trust wide induction and local induction. The local induction included orientation to the area and support to complete local competencies. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The senior sister showed us competency folders which they had created to ensure that staff had the skills and knowledge for their role. Staff confirmed they had received training to identify and manage potential issues arising from patients with mental health conditions, learning disability or dementia.

There were two plaster room technicians who had been trained to apply casts and splints to patients following an accident or surgery or for particular orthopaedic conditions. Casts and splits are used to keep limbs and joints in position while they heal. The service also had staff champions for dementia care, vulnerable adults and learning disability. They attended additional study days and meetings. Managers identified poor staff performance promptly and supported staff to improve. The outpatients manager told us of previous management of poor staff performance, this had been identified and managed appropriately.

Appraisal rates: Hospital of St Cross

From May 2018 to April 2019, all nursing staff in the outpatients department at Hospital of St Cross received an appraisal compared to a trust target of 90%. The breakdown by staff group is shown in the table below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>May 2018 to April 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals received</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics)
### Additional clinical services

<table>
<thead>
<tr>
<th>Service</th>
<th>Staffed</th>
<th>Required</th>
<th>Completion</th>
<th>Target</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional clinical services</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td>7</td>
<td>7</td>
<td>100.0%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Administrative and clerical</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25</td>
<td>26</td>
<td><strong>96.2%</strong></td>
<td>90%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The 90% completion target was met for all staff groups in outpatients.

No medical staff were mapped to outpatients at Hospital of St Cross in the appraisal data supplied by the trust. In the absence of data for Hospital of St Cross, it is worth noting that from May 2018 to April 2019 66.7% of medical staff (four out of six) in the outpatient service at University Hospital Coventry had received an appraisal.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

We saw that care was delivered in a coordinated way and that staff in different teams were involved in providing person centred care. We observed positive interactions between medical, nursing and support staff. Staff we spoke with confirmed there was effective multidisciplinary working within the outpatients’ service. Medical and nursing staff worked alongside clinical nurse specialists and allied health professionals, such as physiotherapists, dietitians, podiatrists and occupational therapists, to provide a multidisciplinary approach to care provision.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. These meetings were held at University Hospital Coventry and Warwickshire. There was documentation in patients records if there had been an MDT meeting held.

Staff worked across health care disciplines and with other agencies when required to care for patients. Copies of clinic letters following patient’s appointments were sent to GPs to keep them informed of treatment plans and when patients had been discharged from services.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff were able to refer patients for mental health assessments and for psychological support where necessary.

### Seven-day services

**The service did not routinely provide seven-day services.** Outpatient clinics were held at various times from 9am to 6pm, Monday to Friday. Clinics in the main outpatient department did not routinely provide a seven day a week service. However, some waiting list initiative clinics were held at weekends to reduce the number of patients waiting for an appointment. There were long-term plans to work towards seven-day services within outpatients. Clinical Support Services had a ‘7 day Services Strategy’ which was developed in August 2019 in response to the previous (2018) CQC inspection. This was presented to the trustwide Centralised Outpatient Governance Group on 09/09/19 and discussed at Group Management Board on 30/10/19.

### Health Promotion

**Staff gave patients practical support and advice to lead healthier lives.**

The service had relevant information promoting healthy lifestyles and support in patient areas. In all areas, we saw a range of health information and advice leaflets and posters.
Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. The department supported the national priorities to improve the population’s health. Patients were given relevant information and referrals to clinics, for example, smoking cessation and local weight loss groups.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients’ liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had a good understanding of the need to assess patient’s capacity to make decisions when necessary.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients told us they were given full explanations, together with the risks and benefits of any procedure they might be having. When alternative options were available these were discussed with them. When patients could not give consent, staff made decisions in their best interest, taking into account patients’ wishes, culture and traditions. Staff explained that when patients were unable to give informed consent, they were supported to give their views and the patient’s relatives and carers were involved to provide further information about the patient’s wishes. There was multi-disciplinary involvement in reaching a best interest decision for the patient. Staff made sure patients consented to treatment based on all the information available.

Staff told us that all patients were given information leaflets before their clinic appointments with all the relevant information. If patients needed more time or wanted to discuss treatments further, this would take place before consent was taken. Staff clearly recorded consent in the patients’ records.

Most consent for outpatient appointments that did not require an invasive procedure was implied consent. We heard consultants explaining examinations to patients, and observed patients complying with requests to be examined, we did see consent routinely documented in the patients’ medical records when required.

**Mental Capacity Act and Deprivation of Liberty training completion**

Training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) is not currently included in the trust’s mandatory training. The trust reported that it was planning to introduce mandatory training in MCA and DoLS for registered practitioners and medical staff by September 2020. This will be included in a new mandatory safeguarding adults level 3 training module. The trust also reported that in the meantime the trust’s safeguarding team had been providing MCA training to priority staff groups since September 2018.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Although Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was not currently included in the trust’s mandatory training we saw evidence that all nursing staff completed MCA and DoLS training. Staff understood their roles and responsibilities under the Mental Health Act 1983 and Mental Capacity Act 2005 (MCA). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

**Is the service caring?**

**Compassionate care**
Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff speaking to patients with respect whilst seeking consent, taking observations and delivering care. Staff introduced themselves to patients and interacted respectfully and considerately. We saw communication between staff, patients and relatives was positive with personal, cultural, social and religious needs being considered. Patients said staff treated them well and with kindness. All patients we spoke with were complimentary of the staff in the service. Patients told us that staff were very friendly, helpful and polite and that receptionists were friendly and efficient. Patients told us they were given clear explanations of their treatment and were reassured.

Patients were offered chaperones. There were posters in the clinics informing patients of their right to a chaperone and notices were displayed on individual consulting room doors to prompt patients to request a chaperone if they required one. It was unclear if a request for a chaperone by a patient was recorded on the patient’s notes. Staff followed policy to keep patient care and treatment confidential. Systems were in place to protect patient’s privacy and dignity, and we saw that staff respected patient’s privacy and dignity. There were signs at the reception desks asking patients to stand back so that conversations were not overheard. We also saw staff knocking on clinic room doors before entering. Clinics had individual clinic rooms with doors that could be locked if necessary.

**Emotional support**

**Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients’ personal, cultural and religious needs**

Staff gave patients and those close to them help, emotional support and advice when they needed it. A healthcare support worker or nurse was present with patients during their appointments. This ensured that the patient had an advocate during their appointment who would check that they understood what was being said. Staff we spoke with told us they would always check patient’s understanding at the end of the appointment before they left the department.

Written information was readily available for patients about their condition and the support services available to them, if necessary. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There was a team approach evident to supporting patients in the clinics. Reception staff told us they were aware to look out for patients who were struggling or distressed, and nursing staff were aware of observing waiting areas to identify patients who may be in need of emotional as well as physical support. We observed staff supporting patients emotionally. This included spending time with them answering questions or by offering additional support to those patients who may be isolated or attending their appointment alone. Staff were seen to be kind and caring. There were volunteers based in outpatients to support patients moving between services outside of the main outpatient area e.g. to phlebotomy/radiology, and to particularly support patients with reduced mobility.

**Understanding and involvement of patients and those close to them**

**Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.**

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us they felt involved in their treatment and care. They told us that clinical staff
were open in their approach and that information was readily available, both verbally and in written formats to help them understand their condition and treatment plans. Patients told us they had the time and opportunity to talk to staff about any concerns or treatment options. This was in line with NICE QS15 Statement 5: Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff could communicate with patients by using their own preferred methods of communication. Patients were asked to alert the department to any communication issues prior to their appointment so that staff knew in advance. Referral forms included information about the accessible information standard and we saw posters referencing this in waiting areas. Patients gave positive feedback about the service. Patients told us they felt listened to and respected by the staff working in the outpatient department. The results were displayed on notice boards around the outpatient clinics, for example in outpatient departments the survey found 95% would recommend the service. The feedback from the Friends and Family Test was positive for all clinics.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Facilities and premises were appropriate for the services being delivered. The department was on the ground floor of the hospital and was accessible to those using mobility aids. It had its own entrance from the car park with dedicated disabled parking bays. Everyone we spoke with had found a parking space on-site. There was a community transport service available for patients without their own transport. The environment was appropriate, and patient centred. It was comfortable with enough space and seating. Further waiting areas were available outside individual clinics. There was a small play area in the main waiting area which assisted with distraction for children while visiting the hospital.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. This was done through the mental health team based at University Hospital Coventry and Warwickshire. The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. Reminder texts were sent to patients who had provided their mobile phone details prior to the appointment. Managers ensured that patients who did not attend appointments were contacted. All patients that did not arrive were contacted by the department and offered another appointment. The consultant would also make a decision as to whether the patient could be signed off. If they did not attend on repeated appointments, they would be sent back to GP to be re-referred.

**Did not attend rate**

From March 2018 to February 2019, the ‘did not attend’ rate for Hospital of St Cross was consistently lower than the England average. The chart below shows the ‘did not attend’ rate over
time. Please note that some spells were assigned to University Hospital Coventry and Warwickshire NHS Trust, as the site was not specified.

Proportion of patients who did not attend appointment, University Hospital Coventry and Warwickshire NHS Trust

(Source: Hospital Episode Statistics)

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Patients in these groups were highlighted on the electronic patient record system, which enabled the booking team to allocate earlier appointments. The department was able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe manner. Bariatric equipment was readily available. A care trolley had recently been provided by ‘The Friends of Hospital of St Cross’, a charitable organisation that raises funds for the hospital. The care trolley was equipped with a pressure relieving mattress suitable for frail patients who may have to spend time on a trolley while receiving treatment.

Staff supported patients living with dementia and learning disabilities by using ‘This is me’ documents and patient passports. We saw in most areas that a list of staff on duty was written on a clinic board, and in some areas, there were photographs of staff working in the department displayed. This helped patients to identify different types of staff and feel welcomed and treated as important partners in the delivery of their care. The outpatient department had nurse champions, such as dementia and learning disability within the trust. This meant that staff had access to specialist support and could ask for advice if required.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. There were hearing loop facilities within the outpatient department. The translation service was readily available for those who did not speak English as their first language. The service had information leaflets available in languages spoken by the patients and local community. The service provided a range of paper-based information leaflets for patients within each speciality of outpatients. We found they were all current and relevant. Information was available in accessible formats. Managers made sure staff, patients and carers could get help from interpreters or signers when needed. Patients were provided with either face to face or a telephone-based translation service. Staff had a good understanding of how to access the service and in consultation rooms contact details for the interpreter service and a hands-free
telephone to use for this service was available. Menus options were available to meet cultural and religious needs: foods available were for example, vegetarian, kosher, and halal.

**Access and flow**

People could mostly access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were mostly in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Referral to treatment (percentage within 18 weeks) – non-admitted pathways

From July 2018 to June 2019, the trust’s referral to treatment time (RTT) for non-admitted pathways was consistently lower than the England overall performance. The latest figures for June 2019, showed 82.8% of this group of patients were treated within 18 weeks versus the England average of 86.7%.

Referral to treatment rates (percentage within 18 weeks) for non-admitted pathways, University Hospital Coventry and Warwickshire NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) non-admitted performance – by specialty

Nine specialties were above the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>96.8%</td>
<td>94.9%</td>
</tr>
<tr>
<td>General medicine</td>
<td>94.7%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>92.2%</td>
<td>86.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>91.1%</td>
<td>85.6%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>89.4%</td>
<td>85.9%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>88.7%</td>
<td>87.6%</td>
</tr>
<tr>
<td>Oral surgery</td>
<td>87.0%</td>
<td>79.9%</td>
</tr>
<tr>
<td>Neurology</td>
<td>86.4%</td>
<td>77.0%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>81.3%</td>
<td>80.7%</td>
</tr>
</tbody>
</table>
The trust’s non-admitted RTT performance for the “other” specialty was the same as the England average (89.6%).

Nine specialties were below the England average for non-admitted pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General surgery</td>
<td>87.2%</td>
<td>88.3%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>84.8%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>81.9%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Trauma &amp; orthopaedics</td>
<td>81.5%</td>
<td>85.5%</td>
</tr>
<tr>
<td>Urology</td>
<td>80.8%</td>
<td>84.1%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>72.5%</td>
<td>88.4%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>71.2%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Ear nose &amp; throat (ENT)</td>
<td>67.1%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>53.0%</td>
<td>79.9%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – incomplete pathways

From July 2018 to June 2019 the trust’s referral to treatment time (RTT) for incomplete pathways was consistently worse than the England overall performance. There was little change in the trust’s performance over these 12 months. The latest figures for June 2019, showed 85.2% of this group of patients were treated within 18 weeks versus the England average of 85.8%.

Referral to treatment rates (percentage within 18 weeks) for incomplete pathways, University Hospital Coventry and Warwickshire NHS Trust

(Source: NHS England)

Referral to treatment (percentage within 18 weeks) incomplete pathways – by specialty

Eleven specialties were above the England average for incomplete pathways RTT (percentage within 18 weeks).

<table>
<thead>
<tr>
<th>Specialty grouping</th>
<th>Result</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine</td>
<td>98.6%</td>
<td>91.2%</td>
</tr>
<tr>
<td>Geriatric medicine</td>
<td>98.5%</td>
<td>95.8%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>96.7%</td>
<td>90.8%</td>
</tr>
<tr>
<td>Cardiothoracic surgery</td>
<td>94.1%</td>
<td>83.8%</td>
</tr>
<tr>
<td>Thoracic medicine</td>
<td>93.6%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>92.8%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Specialty grouping</td>
<td>Result</td>
<td>England average</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>85.7%</td>
<td>87.5%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>85.4%</td>
<td>87.7%</td>
</tr>
<tr>
<td>Urology</td>
<td>81.3%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>81.1%</td>
<td>86.2%</td>
</tr>
<tr>
<td>Ear, nose &amp; throat (ENT)</td>
<td>78.9%</td>
<td>83.6%</td>
</tr>
<tr>
<td>General surgery</td>
<td>78.3%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>74.4%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Plastic surgery</td>
<td>70.5%</td>
<td>82.2%</td>
</tr>
</tbody>
</table>

(Source: NHS England)

Cancer waiting times – Percentage of people seen by a specialist within 2 weeks of an urgent GP referral (All cancers)

In quarter 2 of 2018/19, the trust failed to meet the 93% operational standard for people being seen within two weeks of an urgent GP referral, and performed worse than the England average. However, from quarter 3 of 2018/19 to quarter 1 of 2019/20, the trust’s performance was better than both the operational standard and the England average. The performance over time is shown in the graph below.

Percentage of people seen by a specialist within two weeks of an urgent GP referral (All cancers), University Hospital Coventry and Warwickshire NHS Trust

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers)

The trust consistently met the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a diagnosis (decision to treat) from quarter 2 of 2018/19 to quarter 1 of 2019/20. The performance over time is shown in the graph below.
Percentage of people waiting less than 31 days from diagnosis to first definitive treatment (All cancers), University Hospital Coventry and Warwickshire NHS Trust

![Graph](Image)

(Source: NHS England – Cancer Waits)

Cancer waiting times – Percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment

The trust consistently failed to meet the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral from quarter 2 of 2018/19 to quarter 1 of 2019/20. The trust consistently outperformed the England average over this period. The performance over time is shown in the graph below.

![Graph](Image)

(Source: NHS England – Cancer Waits)

Most patients in the department were seen within 15 minutes of their appointment times unless there was an unavoidable delay for the consultant. In such cases the service communicated with the patients so that they are aware of any delay and had the option to reschedule. There were signs in place across the service to encourage patients to notify reception if they have been waiting for longer than 15 minutes. This meant the service was proactive with a view of trying to provide a solution where possible. Patient feedback suggested there was no concern regarding waiting times and the service monitored the time patients were kept waiting.

Managers worked to keep the number of cancelled or missed appointments to a minimum. This was done through the text messaging service. When patients had their appointments cancelled at
the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. We were told that the department very rarely cancelled patient outpatient appointments. Staff supported patients when they were referred or transferred between services. When patients became unwell in the outpatient department staff supported them and arranged for their admission to transfer to another hospital when this was necessary. A decision flow chart was available to guide staff in the process.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Concerns or complaints leaflets and information about the Patient Advice and Liaison Service (PALS) were available throughout the outpatient’s department. Staff understood the policy on complaints and knew how to handle them. Complaints were handled in line with the trust’s policy. Staff told us they would direct patients to contact the PALS if they were unable to deal with their concerns and advise them how to make a formal complaint. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff told us they received very few complaints. Staff explained that they managed to resolve the concerns by means of a verbal apology, complaints investigation and a written response was not necessary.

Summary of complaints: Hospital of St Cross

From May 2018 to April 2019 the trust received four complaints about outpatients at Hospital of St Cross (10.5% of total complaints received by the hospital). All four had already been closed at the time of data submission. The trust took an average (mean) of 21.0 working days to investigate and close these complaints. This was within the trust’s target of 25 working days. Three complaints concerned the general outpatient department at Hospital of St Cross. The fourth concerned the anticoagulation clinic. Three of the complaints concerned appointments. The fourth concerned staff values and behaviours.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Following an investigation by the outpatient’s department manager, it was found that these four complaints had been coded incorrectly by the trust and there had been no complaints received relating to the Hospital of St Cross for the period May 2018 to October 2019.

Number of compliments made to the trust

From May 2018 to April 2019 the trust received nine compliments about its outpatient services at Hospital of St Cross. The trust noted that the main theme arising from 1,600 compliments received across the trust over the same 12-month period were how well staff demonstrated the trust’s values, particularly compassion, pride and respect. Recent compliments mentioned the professionalism and responsiveness of their staff.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership
Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The outpatient service was part of the clinical support group, which had an experienced triumvirate leadership team, comprising clinical director, group director of operations (GDO) and group director of nursing and allied health professionals (GDNA). The three group directors provided clinical and operational service strategy. There was a clear management structure and defined lines of responsibility and accountability. Each speciality was responsible for its own management of demand and capacity and monitoring of referral to treatment time (RTT) targets. Delivery and service improvement was managed locally by an experienced senior sister, who worked closely with the modern matron, service leads, group manager and associate group manager, overseen by the group triumvirate. The service had a significant number of allied healthcare professionals providing direct patient care e.g. therapists, optometrists and the GDNA role directly supported this diverse service provision. Staff told us that senior leaders were visible and approachable and local leaders were readily available to provide advice and support. We were told that there was regular communication from the executive team on the intranet and through emails. We found there was positive local leadership and staff reported that clinical leads were accessible. Staff members spoke highly of the senior leaders. Staff said they were approachable and open.

Leaders told us that wards and departments reviewed quality through daily safety huddles, department meetings and ward level quality data. Each speciality and clinical group held a monthly multidisciplinary Quality Improvement Patient Safety (QIPS) meeting. These meetings reviewed patient safety, clinical effectiveness and patient experience in line with the trust strategy. Outcomes of the Group QIPS meetings were submitted to the Group Management Board to provide assurance that actions arising are being undertaken in a timely way. The clinical group was accountable to Chief Officers for the delivery of performance through quarterly performance reviews. Clinical groups met regularly with Chief Officers and corporate directors to review performance. Chief Officers also conducted ‘Genba walks’ when compliance was reviewed, core processes were inspected, and visibility of the executive was improved. The trust informed us that the change in management structure in April 2019 bought St Cross outpatient services into the wider outpatient service portfolio (previously this was managed separately). The trust told us that this has resulted in greater peer support demonstrated by:

- ‘Senior sister and junior sister in place to ensure full senior nurse cover.
- Snr Sister is a member of the Nursing and Midwifery Committee (NMC) ensuring direct input to the Director of Nursing and professional nurses within the wider nursing management.
- GEMBA rounding weekly in OP areas by modern matron, daily by outpatient sisters service leads e.g. macular unit/therapy/dermatology/main outpatients
- Triumvirate Gemba round monthly as a team at St Cross site, including outpatient area.’

The trust told us that these clear responsibilities, roles and systems of accountability, and peer support mechanisms demonstrated embedded leadership, good governance and management through:

- Visible, approachable leadership.
- Improved leadership understanding of issues and challenges at service level.
- Celebrating successes / innovations.
• Direct communication with senior leadership about both what’s gone well and not gone well.
• Empowering staff to raise issues.
• Enabling problems to be identified and addressed quickly and openly.
• Proactive sharing of learning and improvement.
• Ensuring what should happen does happen.
• Alignment to UHCWi improvement work.’

Vision and strategy
The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

The trust’s strategy, vision and values underpinned a culture which was patient centred. Staff knew and understood the trust’s vision, values and strategy and how achievement of these applied to the work of their team. There was a high awareness of the trust’s vision to be a national and international leader in healthcare by ensuring that all patients received the very best care possible while their mission was to focus on providing and improving quality of care which included patient experience, safety and outcomes. The trust’s values had been developed with staff and reflected what was important. There was information about the trust vision and strategy displayed within the outpatient department. For example, we saw posters of the strategy triangle, (vision, mission and values and objectives) throughout the hospitals which enabled staff to talk about the five-year strategy during our inspection.

The trust’s organisational strategy (March 2018) included the following strategic objectives to help assess progress in delivering the strategy. These were to:
  • ‘deliver the safest care and excellence in patient experience.
  • be a model employer.
  • be a leader in operational performance.
  • lead the integration of care pathways for the populations we serve.
  • be a front runner in research, innovation and education.
  • achieve financial sustainability.’

Each year, a set of annual goals were agreed which were directly related to achieving the strategic objectives. The goals are included in the Clinical Groups Operational Delivery Plans to ensure there was commitment to delivery. The goals were also included in the staff Personal Development Review (PDR) documentation so that the annual goals were built in, as appropriate, to the annual objectives for every member of staff. Performance against the objectives was monitored through the performance framework. A suite of key performance indicators that align with key priorities and strategic goals were produced each month and monitored in Group and trust Scorecards. These metrics were reviewed on an annual basis to ensure they remain aligned to both external and local strategic priorities. Performance against these was discussed and challenged through monthly and quarterly group performance reviews with Corporate Directors and Chief Officers as well as through key committee meetings feeding into the Board.

There was a clear outpatient strategy to deliver a patient focused world class service seven days per week, between 8am and 8pm, with appropriately skilled staff to provide a safe, effective, responsive, caring and well lead service for patients in line with trust values.
Underpinning this was the service vision, abbreviated to “Right Patient, Right Place, On Time, First Time, Every Time” is clear and visible on all production improvement boards (part of UHCW Improvement methodology) in outpatient areas.

To achieve this strategy the outpatient management team within the service were committed to ensuring:

- ‘Annual objectives are developed that will move the service towards meeting the strategy.
- Service level agreements are in place with all groups who utilise the service and are appropriately monitored.
- Members of staff are given the opportunity to engage with the management team to suggest improvement ideas.
- Members of staff are given the opportunity to progress and achieve 95% or above in mandatory training. If 100% compliant staff will also be given the opportunity to participate in additional learning that will benefit themselves and the service.’

Staff working within the service were expected to ensure:

- ‘Patient safety is at the heart of everything we do.
- Hello my name is… is used as an always event.
- Trust policies are adhered to, including staff being bare below the elbow and challenging colleagues using our environment to do the same.
- Corporate appearance policy is adhered to. E.g. no cardigans to be worn in the clinical environment, hair off collar, epaulettes in site and a clean ironed uniform.’

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

We observed a culture of commitment, teamwork and support across the outpatient department. All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the care they provided to people who used the service and were proud to work at the trust. One member of staff told us, “I love working here and enjoy coming to work each day”. Staff told us they felt well supported, valued and respected. The outpatient manager and senior sister promoted an ‘open-door’ culture and staff were encouraged to raise concerns and share ideas for service improvement. Managers told us they were extremely proud of their staff and the service they provided. We saw that all outpatient staff were focused on improving patient care and service provision. During our inspection, we observed positive and respectful interactions which were focused on meeting patients’ needs and providing safe care and treatment. There were arrangements in place to promote the safety and wellbeing of staff. Staff could contact the trust’s security team for support and assistance if patients or visitors became verbally and/or physically abusive. Staff could access the trust’s occupational health and wellbeing team if they needed additional support at any time. The outpatients’ service celebrated staff success. Compliments received were shared with staff at safety huddles, team meetings, monthly newsletters and staff social media forums. Examples of compliments received were also displayed publicly on noticeboards. There were mechanisms for providing staff with the development they needed. These included personal development reviews and appraisals. Staff we spoke with understood the role of the Freedom to Speak Up Guardian and details on how to contact the guardian were on
staff notice boards. Staff also told us they could also search the trust’s intranet for their contact details if they needed to raise any concerns with them.

After the inspection, the trust told us that in addition to continuous communication, the executive team consistently engaged with the hospital of St Cross through, Chief Officers rotating their Chief Officer Group (COG) management meetings and Trust Delivery Group (TGD) meetings to St Cross once a month. The outpatients clinical group CD was a member of TGD, the trust senior decision making group, aiming to ensure that the OP service was recognised and included in appropriate service and Trust wide developments. UHCWi ‘Stand up’ was also held at St Cross monthly. Stand up was a scheduled 15 minute event with open attendance to all staff. This was used as an opportunity for staff to share and celebrate the improvements they are doing across the trust using and embedding the UHCWi methodology.

Governance
Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A governance structure for outpatient department had been developed supported by trust wide operational and strategic outpatient groups. The aim of the outpatient groups was to bring together multidisciplinary representatives from all areas of outpatient services across the trust to share best practice and learning. The outpatient groups reported into the elective care board. Monthly governance meetings were held at directorate, group and trust wide level. These followed a standing agenda. The meeting minutes we reviewed confirmed governance matters, for example, incidents, risks, training compliance, staffing, audits, guidance, complaints and performance, were discussed. Minutes were detailed and contained copies of relevant reports and action plans. 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.

The outpatient’s department had regular staff team meetings at which performance issues, concerns and complaints were discussed. When staff were unable to attend these meetings, steps were taken to communicate key messages to them, which included e-mails and minutes of the meetings being available on the staff notice board. Effective governance processes were established at departmental level. We were assured that emergency equipment, fridge and ambient temperatures where medicines were stored, and consumables were checked regularly.

Staff were committed to improving the quality of service provision and safeguarding high standards of care. Staff were aware of how to complete incident reports and were encouraged to do so. Staff across the outpatient department had a daily safety meeting, with a ‘grand huddle’ every Monday morning, in order for information from the various governance meetings to be shared with staff. Those who did not attend were able to read the safety huddle sheet. Managers within the outpatients’ department were fully aware of the hospital’s referral to treatment (RTT) times.

Management of risk, issues and performance
Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Potential risks were considered when planning services. The service had plans in place for increased demand of clinics, for example some clinics operated at weekends. We saw processes in place to manage current and future performance through the monthly meetings at both local and management level. There were plans in place for emergencies and other unexpected or expected events such as adverse weather, a flu outbreak or a disruption to business continuity. During our inspection visit we saw there were processes in place for frontline staff to receive flu vaccinations. The service had an effective risk register that was regularly reviewed. Staff were aware of the main risks on the register. Leaders had clear monitoring oversight of referral to treatment times. Each clinical speciality was responsible for their patient waiting lists and referral to treatment time (RTT) performance. Staff within the outpatients’ directorate had a clear understanding of specialty performance and areas where backlogs were an issue. The trust had a major incident plan that outlined the pathway staff should follow in the event of a major incident. Staff could access the plan on the trust intranet. Major incident training was included within the trust induction.

Information management
Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. There were arrangements in place to ensure confidentiality of patient information held electronically and we found staff were aware of how to use and store confidential information. Computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information. No members of staff we spoke with voiced concerns about the trust’s IT systems during our inspection. Data quality was considered highly important to ensure that information presented was accurate and reliable for appropriate decisions to be made. Reported information was subject to a number of validation measures in order to provide assurance. As such, the quality of reported information was considered good by leaders. Recent audits that covered RTT and cancer data also highlighted good data quality. Routine monitoring and validations were carried out as they are essential to ensure standards were maintained for the quality of the information used by the service.

Engagement
Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they had. The quarterly Patient Experience (We Care) report brought together information on compliments, complaints, patient feedback and patient involvement. There continued to be 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. For example, the children’s play area had recently been improved. Most staff we spoke with were involved in the way services ran and could openly share ideas to manager to help improve
services for patients. For example, staff recognised areas in their own development where they could increase skills and knowledge. Staff requested training and as a result provided better care for patients.

After the inspection, the trust told us that the outpatient therapy team and main outpatient team regularly held staff engagement events with the full support of the clinical group triumvirate. These sessions helped service leads to understand the views of staff. The sessions were drop in and enabled staff to spend as much time as they needed to/are able to share their views. There would be some structure to these sessions to help gain views across a range of topics, and staff were invited to contribute.

**Learning, continuous improvement and innovation**

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

To promote a culture of openness and learning, senior leaders extended an open invitation to any member of staff to attend “stand up” Tuesday. This was held in the main outpatient department at the hospital. Stand up Tuesday offered staff the opportunity to discuss areas of learning.

‘Lean for Leaders’ was a key aspect of the trust’s quality improvement UHCWi programme and was designed to equip leaders to embed UHCW Improvement system methodology into their service. Leaders developed skills to lead change effectively by developing standard work for daily management, create visual displays to show the status of their department, organise daily staff huddles, promote daily kaizen (improvement) engaging their team in ideas generation and testing using Plan/Do/Study/Act.

The service had also developed a new, nationally significant RTT waiting time forecasting tool, based on seasonal fluctuations in referrals. This was being implemented at the time of the inspection.

After the inspection, the trust told us that the outpatient service was part of the “Pathway to Excellence, Ward/department accreditation” work which was focused on delivering the trust strategic objective of safest patient care and excellent patient experience. The pathway to excellence included all Hospital of St. Cross outpatient’s nurses and healthcare professionals world class standards of care and experience which are fundamentally underpinned by each of the CQC key lines of enquiry. The pathway to excellence provided staff with more opportunities of leadership, shared decision making, professional development and welfare. In turn, patient standards would be more visible, more often with particular emphasis on excellent safety, care, and dignity.