University Hospitals Coventry and Warwickshire NHS Trust

Inspection report

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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Good**

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

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.

(Sources: Routine Provider Information Request (RPIR) – Beds and Total staffing; trust website)

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

What this trust does

A list of the sites at the trust is below:

(Source: Routine Provider Information Request (RPIR) P2 - Sites)

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, in vitro fertilisation (IVF) and maternal health, diabetes and kidney transplants.

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Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

Summary of findings

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 23 and 27 April 2018, we inspected the core services of urgent and emergency care, medical care, surgery, critical care, maternity, children and young people, end of life care, outpatients at University Hospital Coventry. We also inspected the additional services of neurosurgery and diagnostic imaging. Whilst we have rated these two additional services, we do not include their ratings in the overall aggregation of core service ratings at the location level.

Between 1 and 2 May 2018, we inspected the cores services of urgent and emergency care, medical care and surgery at Hospital St Cross.

We also carried out unannounced inspections on:

- 10 May 2018 to University Hospital Coventry.
- 11 May 2018 to University Hospital Coventry.
- 12 May to Hospital St Cross.
- 18 May 2018 to University Hospital Coventry.

We carried out the well-led review from 29 May to 1 June 2018.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed ‘Is this organisation well-led’?

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- Whilst improvements were seen in many services, overall, safe and responsive were rated as requires improvement. University Hospital Coventry was requires improvement overall. Hospital of St Cross was rated as good.
- Effective, caring and well led were rated as good. Improvements were noted in trust wide leadership with a clear overarching vision and strategy, underpinned by the drive for innovation.
- Four core services at University Hospital improved their overall rating to good overall: medical care, surgery, services for children and young people and end of life care. Medical care services at Hospital St Cross also improved their overall rating to good.

Are services safe?

Our rating of safe stayed the same. We rated it as requires improvement because:

- Urgent and emergency care and maternity at University Hospital were rated as requires improvement. Not all staff had mandatory training and we found potential risk to patient care in some areas.
- Medical care, surgery, critical care, end life care, children and young people and outpatients were all rated as good, showing improvements from the last inspection overall.

Summary of findings

- All services at Hospital of St Cross were rated as good for safe.

Are services effective?

Our rating of effective improved. We rated it as good because:

- Critical care was rated as requires improvement at University Hospital. Records were in a poor state in the cardiothoracic critical care unit. There was not an effective system to monitor patient outcomes.
- At University Hospital, urgent and emergency care, medical care, surgery, maternity, children and young people and end of life care were all rated as good, showing improvements from the last inspection overall. We inspect but do not rate effective for outpatients.
- All services at Hospital of St Cross were rated as good for effective.

Are services caring?

Our rating of caring stayed the same. We rated it as good because:

- All core and additional services inspected at both hospitals were rated good for caring, apart from end of life care, which was rated as outstanding.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- Urgent and emergency care, surgery and outpatients were rated as requires improvement at University Hospital. There was not always access to timely care and treatment.
- At University Hospital, medical care, critical care, maternity, children and young people and end of life care were all rated as good, showing improvements from the last inspection overall.
- At Hospital of St Cross, our rating for responsive stayed the same and we rated it as good overall. Surgery was not meeting referral to treatment targets.

Are services well-led?

Our rating of well-led improved. We rated it as good because:

- We rated well-led at the trust as good overall. This was an improvement from the last inspection. The trust leaders had a clear vision for what it wanted to achieve and workable place to turn it into action developed with involvement from staff, patients and key groups representing the community.
- Managers across the trust promoted a positive culture that supported and valued staff, created a sense of common purpose based on shared values. Staff in most areas felt supported, respected, and valued.
- 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. Although in some areas, such as across the adults and children's emergency departments and cardiothoracic critical care, this was not well developed.
- The trust was very committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. There was trust wide commitment to innovation with patient experience and safety at the heart of improvements.

Summary of findings

However,

- The trust was in a challenging financial position with a control deficit in 2017/18 and although had achieved their cost improvement programme in 2017/18, over half of this had been non-recurrent money.

Ratings tables

The ratings tables in our full report show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all the core service ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

We inspected the neurosurgery and diagnostic imaging services as additional services and whilst we rated these services, we did not aggregate these ratings with the core service ratings.

Outstanding practice

We found examples of outstanding practice across a number of services.

For more information, see the Outstanding practice section in this report.

Areas for improvement

We found areas for improvement including one breach of legal requirements that the trust must put right. We also found 87 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve the quality of services.

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued a requirement notice to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in urgent and emergency services, neurosurgery, maternity, and end of life care services.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

- Funded by the West Midlands Strategic Health Authority, the West Midlands Surgical Training Centre was located within the main University Hospital building to provide comprehensive simulation of a real operating environment and deliver medical, educational, and instructional teaching using plastinated specimens. (Plastination is a technique or process used in anatomy to preserve bodies or body parts). It was one of only a handful of UK medical

training facilities to have been granted a Human Tissue Authority licence that allowed trainee surgeons to practise on donated body material, providing them with what lecturers stated was a far more realistic operating experience than they would get via more conventional practice on models. The centre had a state-of-the-art surgical suite and an adjoining 30-seat seminar room. The centre attracted delegates nationally and internationally.

- The ‘Morbidity Scorecard’ was a digital tool that enables tracking of all post-surgical complications / morbidity by surgeon for each patient. It enabled learning and helped reduce complication rates and identified trends in complications and morbidity. This innovation has been recognised regionally and locally by partners and other regulators.
- The trust and the local hospice motor neurone disease team had received an 'Extra Mile' award from the Motor Neurone Disease (MND) Association for its outstanding contribution to coordinated support for people living with MND in Coventry.
- The innovative ‘Care Clox’ application developed by the trust was shortlisted for numerous national awards. The application, which was developed by the ICT system development team in partnership with nursing staff tracked the amount of time nurses and other frontline staff spent on tasks, to help them make sure they are spending as much time as possible on patient care, and to improve efficiency.
- A massive haemorrhage protocol video was recorded in the trust’s simulation labatory within the clinical skills department. This was initially downloaded onto on the Trust intranet as a training and update tool. The video had now been made available on the internet with increased interest from both the specialist NHS trust for blood and transplants and the military.
- The trust had been nominated for a national award for its 'Implementation of a Red Blood Cell (RBC) calculator and Application'. The RBC calculator is a tool used to calculate how much blood / RBC is prescribed based upon patient weight. This innovation had seen a decrease in RBC usage resulting in significant cost savings. In addition, prior to its introduction there had been three reported cases of transfusion circulatory overload (TACO). Since full implementation in 2017, the cases of TACO at the trust had decreased to zero.
- The integrated frailty service, comprising a range of linked services, patient reviews, and home-based care had been shortlisted for a national award in primary care innovation. Transport home for patients was facilitated by the local service, providing a home safety check.
- The trust’s biobank was the most significant collection of reproductive health tissues in the UK. Operating on a virtual basis, with its server based at the trust, it stored biological samples collected by scientists and clinicians at the trust, and six universities across the UK. The tissues, donated by women who had a history of pregnancy problems, and their clinical data was to help scientists find new causes and cures for miscarriage, stillbirth, and premature birth.
- The emergency department (ED) was awarded ‘ED Training Department of the Year ‘at the Royal College of Emergency Medicine inaugural Annual Awards in October 2017.
- The trust took the innovative step to second a member of the dietetics service to the major trauma service for 12 months. This meant the nutritional needs of the major trauma patients were assessed and nutritional expertise was accessed earlier than they would have been previously. One of the innovations provided by the major trauma dietitian was to introduce the provision of carbohydrate rich drinks to pre-operation neck of femur fracture patients, to aid their post-operative recovery. This work had been recognised nationally.
- The ‘BOD POD’ was a highly technological advanced system that took detailed measurements simply by patients sitting within it for less than ten minutes. The BOD POD was a non-invasive device, which used a technique called air displacement plethysmography that, combined with highly accurate scales, allowed for a detailed analysis of body mass, fat mass and body volume. (Air displacement plethysmography is a recognized and scientifically validated

Summary of findings

method to measure human body composition.) Run by the dedicated research-unit run by the trust (UHCW) in partnership with the local medical school, it provided a fundamental understanding of the nature of metabolism and metabolic disorders, and enabled research to uncover new relationships between diet composition, life-style, and long-term health in the population at large.

- The pathology department at UHCW was seen as an international leader in the use of digital histopathology. This has had a number of benefits:
- Improved workflow through pathology and multidisciplinary teams.
- Improved flexibility in staffing solutions enabling staff to work from home.
- Development of algorithms to aid in the diagnosis of certain cancer types.
- One of the trust's vascular surgeons has led on the development of a smart chip to diagnose stroke. (A smart chip is an extremely small piece of hardware that includes a microprocessor for computing, or other resources for high-level data handling.) The test was intended for use in the emergency department and by paramedics on any patient satisfying the FAST (Face, Arms, Speech, Time) algorithm for suspected stroke. The test used a hand-held reader and disposable biosensor to measure the level of purines in a finger-prick blood sample. The trust has led clinical trials relating to the chip to determine efficacy in the clinical environment.
- The end of life care and chaplaincy service were working in partnership with the local community trust and hospice to develop a Compassionate Communities initiative. The initiative provided a service where specially trained volunteers worked to support people in the community. The trust took the lead in providing the volunteers and coordinating the service. The service included support for those in the last year of life, those in the last days of life and their carers, and those who had been bereaved. Other community projects included support for patients with respiratory conditions who were at risk of unplanned admission to hospital, with initial evidence suggesting a 20% reduction in admission to hospital for this group of patients.
- The neonatal unit had achieved Baby Friendly (Unicef) level two accreditation status and was the first trust in the West Midlands to achieve this and only one of 7% of units to achieve this nationally. We spoke to parents in the Transitional Care Unit which provided parents with the facilities to take the lead in caring for their child. Parents were unreserved in their praise for the care they had received on the TCU. One parent told us they would score the service 11 out of ten.
- We saw evidence of outstanding care and responsiveness to patients with complex needs such as those living with dementia or a learning disability in medical care wards. We spoke with two activity coordinators who worked across medical inpatient wards. There was an activity day room on ward 20. The activity coordinators introduced newly admitted patients to the room and discussed their interests with them. The coordinators provided a range of activities for patients such as music therapy, live bands, afternoon tea, art days, and movie days. Art work of patients was displayed in the day room.
- The maternity department won the Royal College of Midwives midwifery service of the year award for 2017.
- The maternity service had opened a research centre dedicated to researching the causes of early miscarriage.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve the quality of services.

Summary of findings

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with legal requirements. This action related to four services: urgent and emergency services, neurosurgery, maternity and end of life care services**.**

In urgent and emergency services at University Hospital Coventry:

- Ensure effective systems are in place to monitor and mitigate risks in relation to the oversight of deteriorating children, including assessment and relief of pain, and to monitor that sufficient staffing with the right skills and qualifications are available to meet the needs of all patients in the emergency department.

In maternity at University Hospital Coventry:

- Ensure effective systems are in place regarding cardiotocography (CTG) monitoring to ensure it is carried out in line with trust procedures.

In end of life care at University Hospital Coventry:

- To ensure that effective governance systems are in place so consent to care and treatment is always sought in line with legislation and guidance in relation to records of mental capacity assessments relating to decisions regarding 'Do not attempt cardiopulmonary resuscitation' (DNACPR).

In neurosurgery at University Hospital Coventry:

- To implement a systematic programme of clinical and internal audit to monitor quality of consultant's work to help assess the quality of neurosurgery and stimulate improvement in safety and effectiveness by learning from relevant data.

Action the trust SHOULD take to improve

We told the trust that it should take action either to comply with minor breaches that did not justify regulatory action, to avoid breaching a legal requirement in future, or to improve services.

In urgent and emergency services at University Hospital Coventry:

- Work with the local mental health trust to reduce delays in admission to a mental health unit for patients with serious mental health problems.
- Produce a clinical strategy for the children's ED agreed between the leaders of the paediatric service and the adult ED.
- Further reduce delays for patients requiring admission to general wards.
- Provide more space for patients in the resuscitation room.
- Continue to monitor that all children are clinically assessed within 15 minutes.

In medical care at University Hospital Coventry:

- Monitor staff compliance with mandatory training
- Monitor staff compliance with safeguarding training.
- Ensure bed move data is accurately reviewed and monitored.
- Continue to work to improve the timeliness in which patients with sepsis are treated.
- Review how mental capacity assessments are recorded.
- Continue to work to improve RTT performance in medical specialties.

- Continue to work to improve resolution timeliness for complaints.

In surgery at University Hospital Coventry:

- To monitor staff compliance with the infection control practices across the surgical service.
- To monitor how records are stored safely and confidentially maintained.
- To monitor that all staff complete their mandatory training.
- To monitor all medical staff are trained to the required level of safeguarding for both adult and children.
- To reduce the number of patients whose operation was cancelled and not treated within 28 days.
- To continue to work to improve the admitted referral to treatment time.

In critical care at University Hospital Coventry:

- 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.

In maternity at University Hospital Coventry:

- Review staffing levels to consistently meet the nationally recommended 1:28 midwife-to-birth ratio.
- Monitor the service can demonstrate all women who need one-to-one care on both the midwifery led unit and delivery suite consistently receive it.
- Ensure all staff are up-to-date with their mandatory training and annual emergency skills drills training.
- Review the storage of resuscitation drugs, epidural drugs and medical gases.
- Review the maternity dashboard to ensure it includes all required performance indicators and local or national targets.
- Monitor that records are safely stored.
- Monitor that staff completed mandatory training and in particular are up-to-date with neonatal resuscitation training.
- Increase the monitoring of information and performance in order to drive improvement in the maternity service.
- Maintain accurate bed occupancy levels to obtain full oversight of bed occupancy levels.

In neurosurgery at University Hospital Coventry:

- Review systems so that staff keep appropriate records of patients' care and treatment so that it is in line with 'The Records Management Code of Practice for Health and Social Care 2016'.

- Monitor that patient records stored securely in line with ‘The Data Protection Act, 2018’.
- Continue to work to have timely access to an interventional radiologist to ensure patients are not at risk of coming to avoidable harm because their urgent health needs are addressed in a timely manner.
- Review immediate access to a dedicated emergency theatre to ensure patients do not come to harm because their urgent health needs are not met in a timely manner.
- Consultants should contribute to Spinal Outcome Registries such as the Spine Tango.
- Review the pre-operative assessment process to afford patients and significant others privacy and dignity.
- Monitor that management and the consultant team work collaboratively to resolve conflict quickly and constructively and share responsibility to deliver good quality care.
- Provide clarity about the consultant’s roles and what they are personally accountable for so that there are clear lines of responsibility.
- The trust should monitor that all staff complete mandatory training and additional training for their role in line with trust policy.
- Monitor that waiting times for treatment are in line with current good practice.
- Promote seven day working and appropriate access to support services.

In children and young people’s services at University Hospital Coventry:

- To review the current arrangements for the provision of formal safeguarding supervision for nurses on the paediatric wards.
- To review with commissioners the provision of a seven day CAMHS to the trust.
- To monitor that that medical staff in children’s services comply with the trust standard for appraisals.
- To take steps to improve the response rate the FFT questionnaires in paediatrics.
- To review the management of young people with challenging behaviours on ward 14 to ensure that the necessary safeguards are in place to support the welfare of children and staff.
- To continue to work in partnership with commissioners and mental health services to develop services address the demands of CAMH patients in the trust and the wider community.
- Review systems so that patient notes are stored securely in the children’s service.
- To continue to review the RTT for children referred to the paediatric dietetic service
- To review the role and function of ward 14 to ensure it is not providing a CAMHS service rather than functioning as an acute paediatric ward.

In end of life care at University Hospital Coventry:

- To prioritise action to improve mandatory training achievement.
- To continue to address the improvement of facilities for having difficult conversations with relatives in clinical areas.
- To prioritise the use of accurate and complete activity data that demonstrates the responsiveness of the specialist palliative care team in relation to referrals.
- To continue to develop plans to provide a seven-day face to face service to support the care of patients at the end of life, with clear action and timelines identified.

Summary of findings

In outpatients at University Hospital Coventry:

- Continue to improve the referral to treatment times.
- Consider ways to improve Friends and Family Test response rates.
- Monitor that all staff complete mandatory training, including safeguarding and mental capacity act awareness.
- Continue to work further towards providing a seven-day outpatient service.
- Continue to work to making all patient records electronic to ensure essential information is always accessible to all staff.
- Review ways to increase capacity in the ophthalmology department
- Monitor that letters to patients and GPs are sent out in a timely manner.
- Consider how waiting time information in clinics can be updated regularly so patients are aware of any delays.
- Monitor that complaints are managed in a timely way.

In diagnostic imaging at University Hospital Coventry:

- To review safeguarding training requirements for all staff in the department.
- To promote meaningful engagement with patients and carers.
- To monitor the privacy and dignity of patients in waiting areas.

In urgent and emergency care at Hospital of St Cross:

- Continue to monitor that waiting times for initial clinical assessment and time to treatment
- Monitor staff compliance with mandatory training.
- Implement an effective audit cycle and use outcomes to drive improvements
- Consider ways to better engage with staff, patients and the local community regarding the development of the UCC
- Review governance systems and the information collected to monitor safety and performance.
- Consider ways to strengthen local and overarching trust leadership to improve communications and engagement with all staff.
- Consider defined written procedures for emergency presentations.

In medical care at Hospital of St Cross:

- To monitor staff are compliant with mandatory training.
- To monitor that staff routinely wash their hands between patients or when entering and leaving clinical areas.
- To monitor that all staff receive an annual appraisal.
- To review processes embedded to improve discharge planning in line with national recommendations.
- To monitor that required risk assessments on patients are completed in line with national guidance.
- To monitor that patients' capacity assessments are completed in line with the mental capacity act.
- To monitor that the prescription of medicines is recorded correctly and that correct dose of administrations are documented.

- To consider how patients can access to seven-day services in line with the required recommendation for stroke and rehabilitation patients.
- Review and reduce the length of stay for non-elective patients in general medicine and geriatric medicine.

In surgery at Hospital St Cross:

- Continue to monitor that waiting times from referral to treatment times.
- Review how information about day procedures is communicated to the patient's GP.
- Review access to the wards.
- Review procedures regarding theatre staff changing or covering their theatre attire when moving between theatres and the wards.
- Provide support for medical staff to attend training on the mental capacity act and deprivation of liberty safeguards.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as good. This was an improvement from the last inspection. We rated as good because:

- The trust had managers at all levels with the right skills and abilities to run a service providing high quality sustainable care. There was a mix of experience within the executive directors with some new to the executive role and others with considerable experience.
- The trust had a clear vision for what it wanted to achieve and workable place to turn it into action developed with involvement from staff, patients and key groups representing the community. The current trust strategy built on the previous one so staff were familiar with the overarching principles.
- Managers across the trust promoted a positive culture that supported and valued staff, created a sense of common purpose based on shared values. Staff felt supported, respected, and valued.
- Effective Fit and Proper Person checks were in place.
- 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. Although in some areas such as across the adults and children's emergency departments this was not well developed.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The trust had systems and processes in place to identify learning from incidents and complaints to make improvements and to manage performance.
- The trust's learning from deaths process was well established and effective.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with secure safeguards.

Summary of findings

- The trust engaged very well with patients, staff, the public and local organisations to plan and manage services, and collaborated with partner organisations effectively.
- The trust was very committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. There was trust wide commitment to innovation with patient experience and safety at the heart of improvements.

However:

- Although the trust had a systematic approach to measure the effectiveness of its speaking up policies, procedures and culture the number of contacts was low limiting the opportunity for the review of themes and associated learning. In addition, the role of the freedom to speak up guardian (FTSUG) was undertaken by one of the directors and, whilst they were supported in this through a number of confidential contacts across the trust, the trust recognised it may not be the most appropriate person. Plans were in place to recruit a new FTSUG.
- The trust was in a challenging financial position with a control deficit in 2017/18 and although had achieved their cost improvement programme in 2017/18 over half of this had been non-recurrent money.

Use of resources

A report of an inspection of the trust's use of resources, carried out by NHS Improvement, is available here: www.cqc.org.uk/provider/RKB/Reports.