https://www.cqc.org.uk/provider/RKB/reports/AP6587/well-led-assessment/well-led#Shared-direction-and-culture

- **SERVICE PROVIDER**

University Hospitals Coventry and Warwickshire NHS Trust

This is an organisation that runs the health and social care services we inspect

Report from 15 August 2025 assessment

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Well-led

15 August 2025

This service scored 69 (out of 100) for this area. Find out what we look at when we assess this area and How we calculate these scores.

Shared direction and culture

Score: 2

We scored the trust as 2. The evidence showed some shortfalls. There were areas of the culture within the trust that required improvement after criticisms from staff in their annual NHS survey, for which most indicators were below national averages. There was insufficient board assurance or oversight of the actions needed to show improvement. The 2023 CQC inpatient survey gave poor results for the trust and reported a significant deterioration since the previous report. Nevertheless, there was a desire among the leadership to effect change in the culture and feedback from staff and patients. There was more work to be done to ensure people with a learning disability or people with autism experienced care which met their needs and gave them good outcomes.

However, the trust had a clear shared vision and strategy which was based on community, equity, preventative care, and engagement with people. It was regularly reviewed by the board for its progress. The objectives were embedded in trust objectives. Nonetheless, there was evidence of the strategy not being communicated well, recognised or embedded with all staff.

Our findings:

There were areas of culture and wellbeing of staff in the organisation which were doing well but some other areas were a cause for concern. The NHS 2023 Staff Survey was completed by almost 4,000 trust staff – around 40% of the staff number (although this was 5% below the peer group average within 122 equivalent NHS trusts). In the nine primary indicators in the survey, the trust scored worse than average for eight of the measures. Although the question 'we are always learning' did score better than average while the questions around 'morale' and 'we are a team' were close to the average.

There had been a decline in a number of important questions within the staff survey over several years. These included:

- Care of patients is my organisation's top priority – Fallen from 78% in 2019 and 2020 to 73% in 2023. The peer group average in 2023 was 75%.
- I would recommend my organisation as a place to work – Fallen from 65% to 59% since 2019 to 2023. The average in 2023 was 61%.
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation – Fallen from 77% in 2020 to 63% in 2023. The average was also 63% in 2023.

The following two indicators of staff morale were worse than the national average:

- 32% of staff said they often thought about leaving the organisation.
- 23% said they would look for another job in the next 12 months.

In our conversations with a wide range of trust staff, there were varied views of culture. These ranged from some staff in junior roles in the organisation telling us they did not feel they had a voice. However, more senior staff such as consultants and senior nurses did report feeling well supported most of the time and were

entrusted to provide strong and caring leadership. The staff we met at the Hospital of St Cross at Rugby on many occasions described the culture as “like a family.”

However, we were told there was a lack of engagement between the trust and those officially representing staff, although the trust reported there were regular meetings involving senior leaders and staff representatives. Some staff said more of them and their colleagues were becoming unwell due to stress and high workloads meaning they were not getting breaks. We were told the trust’s people support team were excellent, but there was insufficient focus on the things affecting staff directly, such as no opportunity to take a break at times. We were told this was not being scrutinised, and staff were concerned about the effect on patient safety from tired staffing or those suffering burn out. The workforce report from September 2024 (presented to the board in October 2024) said around 27% of sickness absence related to stress, which was the highest factor of all reasons given.

In responses which in each case were worse than the national average, staff who responded to the NHS Staff Survey from 2023 said:

- 46% had felt unwell in the last year due to stress.
- 57% said they had come to work in the last three months despite not feeling well enough to perform their duties.
- 46% felt worn out at the end of their shift.

However, in all of the data above, the results for each had improved since the previous year and some were in a downward (improving) trend. The trust’s workforce report from September 2024 recognised high levels of sickness absence due to mental ill health and had responded with the following steps:

- A new ‘supporting attendance’ policy
- Data to support managers to identify ‘hot spots’
- The extended on-site staff counselling service offering a safe space for staff to discuss any personal or work-related issues

The trust response to the staff survey carried insufficient balance. The trust board report concentrated on the positive aspects of a weak staff survey, and it was therefore unclear if focus would be drawn to the areas of concern and the board assured of this. There was no further follow-up at board to provide assurance of the progress around the staff survey action plan.

The trust board were provided with a summary of the staff survey in April 2024. In the key results, the report failed to highlight how in eight of the nine key indicators the trust scored worse than the average. It was also below the average score for the Midlands region in eight of the nine indicators. Instead it concentrated on how five of the seven 'people promise' indicators had improved over the previous year. It did not report that five of the nine areas had no statistically significant change from 2022 to 2023 with one being "significantly lower" than the previous year ('we have a voice that counts').

The report stated how 'we are always learning' was "significantly higher than the comparator average score." The trust scored 5.69/10 for this indicator against a national average of 5.61/10 with the highest trust in the peer group scoring 6.07/10. This difference of 0.08 was considered significant, when the difference in 'we work flexibly' of 0.14 against the average was not considered significant. The summary stated the results "showed many positives…" The report was therefore not a realistic reflection of the results in the summary presentation.

In other areas of the board paper, there was recognition of the deterioration over the last four years of the recommender scores. These were staff being happy with the standard of care that would be provided to friends and family and recommending the trust as a place to work. The peak for the trust was 2020 but the standard of care indicator had fallen by 14% from 77% in 2020 to 63% in the four years to 2023. The national average had also fallen, but by 11%. The recommending as a place to work score had fallen by 6% from 65% to 59% in the four years which was the same drop as seen in the national average.

In response to this area, the trust board were told how clinical and corporate groups would be supported to fully analyse their results, take ownership of them and to build specific and targeted interventions to drive improvements in local teams. The agreed actions would then be fed into local 'people plans' which were to be supported through regular challenge and support sessions led by the Chief Executive Officer commencing in June 2024. The people strategy included an ambition to be in the top 10 in the NHS for these indicators so there was significant work to be done.

One area which led to comments from almost all staff we spoke with was the newly installed electronic patient record system. This system went live in July 2024 after some delays but with staff said to be given the time and training to be able to adapt to the system quickly. Results were varied, but with the majority of staff we spoke with concerned it was having a significant impact on wellbeing as it was implemented. More senior staff felt it was taking time to get used to but was showing benefits.

A number of nursing staff we spoke with commented on how patients had told them the new system meant staff were always behind a screen and communication had suffered as a result. Other staff described having to turn their back on the patient too often to input data (such as those working in operating theatres). Some staff told us they felt senior leaders did not listen to staff concerns which were described as "dismissed" by a number of clinical staff. We were given multiple examples of areas of concern by staff including the lack of IT support and slow response to issues. We were told staff felt it unlikely that senior executives were aware of the issues they were facing.

However, we were told by the trust how the electronic patient record system implementation was the largest in Europe at the time and it should be recognised how the implementation of any new system could lead to some disruption and frustration. There was no evidence that the disruption experienced by the trust was disproportionate and evidence was provided around the measures the trust had taken to effectively mitigate the impact.

Some of staff we met from the fairly new community services acquired in July 2024 said they were not yet feeling part of the organisation. Some said they felt welcomed by their immediate counterparts and thought the situation was getting better. A number told us how not yet using the new electronic patient record system was somewhat isolating, but they understood there were plans to roll this out as soon as was practical.

The trust had more to do to give patients a positive experience. In the CQC annual inpatient survey from 2023 (published August 2024), the overall experience of patients (431 out of 1,250 responded) was reported as 'worse than expected' when compared with other trusts. Although we recognise this was a small patient group, this was a deterioration from the previous three years where the trust was rated 'similar to expected' each year. In 2023, the trust was placed the second worst in England out of 131 acute and specialist trusts. The board had openly discussed the results at its October 2024 meeting and actions had been proposed with follow-up through patient engagement and executives spending time in wards and departments.

There was more work to be done to ensure equity of care and experience for people with a learning disability and autistic people. There is more detail in our assessment service group reports, but in summary we found some places where there was good care and experience for people with a learning disability or people with autism, but in others this was not always acceptable. We met with a group of senior nurses and staff who were all committed to equity in care for people with diversities. Also, in our assessment of services at the trust, we identified pockets of good practice where staff were often personally committed to getting this right, but more to be done in some areas. This was not helped by the trust's new electronic patient record system not flagging people who needed different support, but this was recognised by the trust and solutions were being created.

One particular area the trust was proud of was from the growing and developing shared decision-making councils. These groups started around 2019 as a devolved model of leadership to enable staff to effect change closer to where they were

working and without extensive bureaucracy. There were councils that were formed in a ward, across a specialty service, or for a theme. Each council had a chair appointed who met together as a coordinating council every six weeks with the Chief Nursing Officer and other senior leaders.

Areas of success celebrated by the teams included the renal team acquiring sit-down pedal bikes to enable patients to pedal from their chairs to prevent deconditioning; different coloured crockery to highlight patients who needed support with eating and drinking so their food was not left to get cold; and an activities coordinator for the ward. They also developed peritoneal dialysis alert cards for patients attending AE to ensure staff took this condition into account at the earliest opportunity. Ward 52 had produced a food and drink preference A4 card to support patients who could not easily communicate. The anti-racism council was awarded the first Royal College of Nursing Foundation anti-racism grant for developing five videos for learning and development around anti-racism.

The internationally-educated-staff council ran monthly cafes in the faith centre for staff to share experiences and seek support. The maternity team obtained privacy screens for mothers breastfeeding babies in the labour ward triage area. The urgent treatment centre team organised power banks to enable patients to charge their mobile phones. They produced quizzes to keep people occupied while they waited. We acknowledged the enthusiasm and commitment of the chairs we met at a focus group when on site in Coventry. Shared decision-making councils were seen as one of the key ways of identifying issues and driving improvement.

There was a clear, comprehensive strategy which was monitored for progress and delivery. The trust had published an ambitious strategy covering an eight-year period from 2022 to 2030. A summary document described the way the strategy was developed which involved around 1,300 people including staff, the public and stakeholders. The key drivers of the strategy were:

- Local integrated care
- Research, innovation and teaching

- Valuing and enabling our people
- Centres of excellence
- Sustainability

Each individual purpose was supported by detailed objectives. For example, local integrated care included population health; health inequalities; and accessible services. The objective was for people to live happier, healthier lives. The plans to deliver the strategy included implementing the 'improving lives programme'; completing the expansion of the Coventry emergency department; and new pathways for musculoskeletal services, among others.

The strategy document was a framework by which other linked strategies, teams and services were aligned with. It was described as the basis for corporate objectives and personal objectives. Delivery was to be monitored by the trust board who were to track progress and determine the impact it was having on patients, carers and the community. Learning from the pandemic, the document was also intended to evolve with unforeseen events and changing priorities.

The most recent update to the trust board included progress on each of the areas of purpose and any risks to their delivery. There were 32 different projects within the five areas, and each was reported at high-level, but supported by a detailed spreadsheet. In December 2024, the board were given an honest appraisal of each area and whether there were avoidable or unavoidable delays in effective delivery. This included finance issues to be resolved, and changing landscapes in health and social care.

Delivery of the strategy was managed by different teams and each individual programme or project led by a named member of staff. For example, the strategy as it affected staff was managed within the connected People Strategy 2023 – 2030 and led by the Chief People Officer and their team. The people strategy set out measures by which to judge if the strategy was taking effect. This included:

- The vacancy rate not exceeding 10%

- Mandatory training being not below 95%
- Staff turnover remaining not exceeding 10%
- Sickness not exceeding 4%

The statistics in the most recent detailed and comprehensive workforce report to the board (covering September 2024) aligned with the measures above. Vacancy and turnover measures were meeting the standard set, although there were some individual staff groups which were above the 10% vacancy target (such as community at 12%, although this service had only been recently added to the trust's services and this was being addressed). In the 2023 NHS Staff Survey, there was an increase in the number of staff who said there were enough staff at the organisation for them to be able to do their job properly. This was agreed by 32% of staff, which was above the national average. Also, 49% of staff said they were able to meet all the conflicting demands on their time. This was up 4% from the previous year and 2% above the national average.

In other metrics, staff turnover had fallen since October 2022 when it was over 13% to below 9%. Sickness, which for the 12-month average was 5.6%, was above the 4% target and creeping upwards, and mandatory training was 93% - slightly below, so both slightly missing the objective. Mandatory training had not quite met the target since earlier in 2024 but was relatively stable. The focus on implementing the new electronic patient record was cited as an impacting facto

Other strategies including the finance, estates and digital strategies were provided on the trust website, but these were not those linked to the overarching strategy and were three years out of date. The people strategy was the only current supporting delivery document.

Although the trust executive team were clear on the trust's strategy and shared vision, and had detailed work continuing to deliver it, some of the staff we met said they did not feel connected to it or could describe it. Some told us they did not feel they had any opportunity to contribute their thoughts or ideas. However, the trust

had given staff the opportunity to contribute and had staff and stakeholder consultation when developing the strategy. Some staff reported they were told about decisions made at executive level, but did not always have information to explain why decisions were taken or how this was linked to the strategy. Nevertheless, most staff recognised the trust's values with which they felt more connected.

There was an effective process to protect doctors in training, but further work required to update the board on developments and improvements seen or required. The trust had appointed a consultant physician as the guardian of safe working hours (GSWH) with the current appointee to the role having been in post for around a year. This role was introduced by NHS England alongside the new junior doctor's contract in 2016/17. The GSWH must be (and was) independent of trust management and a champion for safe working hours for doctors in training and oversee safety-related exception reporting. Exception reporting included doctors working longer hours than scheduled, not able to take rest breaks, limited educational opportunities (due to workload) and absence of senior support when needed.

Capable, compassionate and inclusive leaders

Score: 3

We scored the trust as 3. The evidence showed a good standard. The trust had leaders at all levels who understood the context in which they delivered care, treatment and support and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty.

Our findings:

Leaders showed they had the skills, knowledge, experience and credibility to lead effectively. They understood the challenges faced by the organisation and the wider

community. There was a strong focus on the vision for the organisation and care and attention meant there was good oversight of this being delivered.

Our engagement with the trust executive team and other senior leaders found them to be open and honest with strong integrity and recognition of the importance of the patient being at the centre of everything the trust does. They demonstrated they had compassion and strong values.

Leaders demonstrated they understood the value of inclusion, and this area of work in the trust rarely stood still. This included a focus on equality and diversity and the recognition of there always being more to do to be better. There was an understanding of the diversity of the people who used the trust's services, and this included bringing services closer to people's homes. This was not just for convenience or timesaving for patients, but a recognition this would reach a wider and more disparate groups of patients. This included groups who were known to be seldom heard or who had anxiety about accessing healthcare. The plans included opening a Coventry Clinical Diagnostics Centre (due January 2026) and increasing the number of surgical procedures undertaken at the Rugby hospital.

Leaders were visible and approachable to most staff. However, some staff we met said they rarely saw any of the executive leadership team and did not feel connected with them. They recognised though this was not always easy in such a large organisation. Newer staff mentioned how they saw the Chief Executive Officer at their induction, as he attended all inductions. However, most staff felt connected with their own more direct senior management. For example, staff at the Hospital of St Cross, Rugby commented on the great visibility and approachability of the senior nursing staff on site.

Most staff thought their leaders were compassionate about patient care and staff wellbeing. In the 2023 NHS staff survey 6.83/10 staff who responded (about 40% of the staff group) said they felt there was compassionate leadership. This was up from 6.76 in the previous year but was below the peer group NHS average of 6.96.

In more direct management questions in the NHS staff survey, staff reported on their managers' support in these responses (all of which had improved over 2022):

• 70% said their immediate manager was interested in listening to them when they described the challenges they faced. This was a 2% improvement over the previous year and just slightly below to the national average for the NHS trust peer group.

• 68% said their immediate manager cared about their concerns. This was a 2% improvement over the previous year and just slightly below to the national average for the NHS trust peer group.

• 64% said their immediate manager took effective action to help them with any problems they faced. This was a 1% improvement over the previous year and just slightly below to the national average for the NHS trust peer group.

Staff spoke about their wellbeing and felt there were places this was done really well. Teams were said to work well together and senior managers on wards would use a 'stop the clock' process when pressures were escalating to see what tasks could be delegated or done differently. The 'huddles' which were standard practice across the organisation were widely praised. These were held each day at various times and brought as many staff from the area as possible together to look at the state of play around safety, patient care, processes (such as discharge and medicines management) and safe levels of staffing. We observed a number of these sessions and found them clearly valued, a great way of sharing information, and enabling of quick change and problem solving.

There was investment and opportunities for leadership development and training. This included the members of the board (the board recently held a 2-day leadership summit) right through to all levels of staff in or aspiring to leadership roles. There were regular sessions for staff through the trust's UHCW Leader programme and a range of opportunities for studying and learning leadership skills. This included accredited leadership apprenticeships. 'Lean' training was also available for leaders. This was learning to work more efficiently with a focus on eliminating waste (time,

resources, energy, and money for example) and treating more patients with the same resources. There were regular monthly sessions for senior leaders across the trust which included an opportunity to share new ideas or learning. Local leadership forums took place across specialties, clinical job roles, and directorates.

The Chief Pharmacist and the Senior leadership team were visible, supportive and approachable. There was a positive culture of listening and a supportive network for staff within the pharmacy department. The workforce strategy ensured talent was identified in pharmacy roles, and opportunities were available for secondments and acting up to different roles to upskill staff. This ensured there was always someone in training to act as cover if needed and for the potential to apply for the next job role.

Staff discussions included what was going well and what further improvements could be made for staff and patients. New staff spoke about feeling included to feel part of the team with meetings with the senior leadership team within six weeks of starting. Individual success was celebrated and awarded which staff were proud about.

Freedom to speak up

Score: 3

We scored the trust as 3. The evidence showed a good standard. The trust fostered a positive culture where people felt they could speak up and their voice would be heard. However, there were some areas where numbers of staff below the national average did not feel their concerns would be addressed, and insufficient evidence to show outliers for high levels of reporting were investigated.

Our findings:

There was a localised culture of speaking up where staff actively raised concerns and those who did (including external whistleblowers) were supported, without fear of detriment. However, we were told speaking up was mostly contained within

teams and less so through the Freedom to Speak Up Guardian, which data supported. Freedom to Speak Up Guardians were established in 2016 after recommendations from Sir Robert Francis's inquiry into serious failings at the Mid Staffordshire NHS Trust.

We met with the trust's Freedom to Speak Up Guardian and found them to be passionate and committed. They had been appointed to the role fulltime (substantive since 2019) through a competitive process. They were supported by 12 'ambassadors' across the organisation. They were based away from the main hospital site, which enabled staff to have somewhere more private and confidential to meet. There was a good working relationship with the trust board and one of the non-executive directors was the speak-up sponsor on the board. They held monthly sessions with the Guardian and were available to other staff if needed. The Guardian was supported to reflect on and seek support for the emotional aspects of the role from senior staff including the Chair and Chief People Officer with whom they held regular meetings.

The Guardian was being supported to relaunch the Speak Up service in January 2025 and endeavour to increase the numbers of ambassadors among staff significantly to around 100 (including for the recently acquired community healthcare teams). They had completed a self-reflection tool as required by the National Guardian's Office every two years. The majority of the scores were at the highest level of confidence, with good evidence provided. The worse than average results from the NHS 2023 Staff Survey and the comparably low contact rates were mentioned with actions included around communication and localised surveying of staff for future improvement.

In focus groups with a wide range of staff, we were told staff knew who the Freedom to Speak Up Guardian was and how to contact them. Several said there was now an App you could use, and you could be anonymous if you wished. There were no concerns with the process or contacting the Guardian. However, most said they would be more likely to approach their manager or other people in their own team with any issues they had about which they wanted to speak up. Most staff felt this

was a positive indicator and showed a willingness by managers to address issues quickly and locally. None said they would not approach the Guardian, but we heard about a strong sense of teamwork which meant most issues were discussed with managers. The NHS 2023 Staff Survey supported this view with all of the questions around relationships with managers and teams having improved and being around the national average for comparable trusts. For example:

• 68% of staff said their immediate manager cared about their concerns.

• 64% said effective action was taken to help staff with any problems they faced.

• 72% said their immediate manager encouraged them at work.

• 68% said their manager took a positive interest in their health and wellbeing.

All of the above indicators were at the highest level for the past five years.

Local resolution therefore appeared to be working reasonably well. However, in a different aspect around confidence and safety in speaking up, and issues being addressed, the NHS 2023 Staff Survey results showed less positive results. Only 59% of staff said they felt safe to speak up, which had declined from 2019 when 62% felt safe to do so. The national average was 61%. Only 47% of staff said they felt confident the organisation would address their concerns. This had declined from 49% in 2022. The national average in 2023 was 49%.

In two indicators slightly worse than the national average, only 68% of staff (average 70%) felt secure in raising concerns about unsafe clinical practice. Alongside that, only 54% of staff felt confident the organisation would address their concern (average 56%).

Data from the National Guardian's Office for the financial year 2023/24 reported the trust 13th in the group of 17 comparable-sized NHS trusts in the Midlands for the number of contacts made with the Freedom to Speak Up Guardian. This showed an average of around 25 each quarter, which compared with around 120 each quarter

for the trust at the top of the list and overall average for all trusts of around 50 per quarter. In the Guardian's report to the trust board's people committee (June 2024) although overall contacts were still comparably low, there was a significant spike in reports from 'medical and dental' staff – around six times higher than the national average for this group.

The planned presentation from the Speak Up Guardian to the trust board in October 2024 (the previous being February 2024 – the report came twice a year) was postponed until December so this significant data outlier had yet to be brought before the board. However, minutes from the board committee in June 2024 acknowledged the significantly low contact rate and said it needed investigation. However, there was no discussion in the minutes about the negative outlier from the magnitude of 'medical and dental' contacts (reported to be from the trauma and neurological services and relating to poor behaviour/attitudes, and bullying). With the report to the board from October delayed, there was no further evidence to show this information had been considered by the board or addressed.

In the minutes of the meeting of the people committee in June 2024 (PC/24/31) there was a comment about detriment to staff. The NHS had clear objectives that no staff should be subject to detriment or discrimination from speaking up. It was reported to the committee that there had been one member of staff said to have suffered detriment as a result of speaking up in 2023 (none in the previous year). This was therefore a low number but was also among a low number of overall contacts. The minutes of the meeting reported how the trust's definition of detriment differed from the national definition, but not how and whether any action was required to bring it into line. This was not recognised through the self-reflection tool in the section about detriment.

Pharmacy staff spoke of a positive culture where they felt they could speak up to anyone within the senior leadership team and their voice was heard and listened to both within the department and outside. Two examples were given where staff proposed solutions to the senior leadership team to improve workflow in the dispensary. Staff felt listened to, and positive action was taken.

Workforce equality, diversity and inclusion

Score: 2

We scored the trust as 2. The evidence showed some shortfalls. There was work to be done to improve metrics for inequalities and the experience of staff and evidence was needed to show there was impact from actions taken. There were no actions associated with addressing the gender pay gap. However, the trust valued diversity in its workforce. The senior leaders worked towards an inclusive and fair culture by improving equality and equity for people who worked for them.

Our findings:

There was a culture where equality, diversity and inclusion mattered but work to be done to continuously improve the experiences of staff. The trust had committed through its strategy to its people being 'welcomed, included, valued and enabled.' People (both staff and patients) were considered through the lens of the Equality Act 2010 with recognised protected characteristics. The trust lead for workforce inclusion presented at the trust's people committee and also directly at the trust board. They had a strong commitment to workforce inclusion and a determination to make a difference. There was also a connection being built with the Freedom to Speak Up Guardian to capture the obvious overlaps with their work and share learning and align objectives.

There were staff networks to support the strategy which included the Pride network (LGBTQ+ staff and allies – this was to be relaunched as currently was not operational); SPOC network (supporting people of colour); and DAWN network (disability and wellbeing). A neurodiversity network had been formed in May 2024 and was already growing quickly, and the Menopause network had been established for around 18 months. We met members of the latter two groups which both had executive sponsors and felt supported and encouraged to build strong networks. Both networks were ambitious for their work to change attitudes and to interconnect with each other for mutual benefits. The pharmacy leadership team were committed to continuously improving the culture within the department.

Some staff told us they were not aware of the networks and thought the terminology or the names might not resonate with everyone. There were also issues for them with the time needed to attend networks which was far from easy to find. They felt the advertisement of the network groups was not always effective – although admitted there was a lot of information generally to receive and process.

Our reflection on equality, diversity and inclusion networks was how more work was needed to capitalise on these groups and ensure those which needed relaunching or better support were enabled to be at their best. Staff we met at the Hospital of St Cross in Rugby commented on how they believed equality and diversity had much improved with good education and felt all staff treated each other with respect and kindness.

The trust inclusion strategy, which was approved by the trust board and monitored by the people committee, had 10 high-impact actions which included among others, auditing recruitment processes to ensure fairness (an external charity with expertise in this area was undertaking the work and potential actions being considered from their initial report); a new direct reporting tool for staff to report violence, aggression, and discrimination; and development of an anti-racism toolkit.

The anti-racism toolkit was produced in July 2023 and was for the identification, elimination, and prevention of racism through policies, behaviours and beliefs. It was developed by the trust's anti-racism shared decision-making council. It covered support on challenging racism from colleagues, from leaders, and caring, belonging, and authentic inclusion. It included practical guidance on what actions to take, people who could offer support, and resources and training materials.

The trust had highlighted positive examples of valuing diversity in its workforce. One initiative was the introduction of the Health and Social Care Employability Academy. This was aimed at bringing about change across the health and care system by working collaboratively with partners, specifically other NHS trusts, and widening access to employment and training opportunities. The academy launched in September 2023 with a focus to support underrepresented groups: specifically care

leavers, people with refugee status, people with disabilities and other under-represented groups. Ninety participants were supported into employment or volunteering between September 2023 and March 2024 across the local Integrated Care System. An ambitious target had been set for 2024/2025 of supporting 650 people on programmes and 50% in employment or volunteering.

The trust equality metrics revealed both progress and ongoing challenges for the trust.

The trust took note and action from surveys of staff in terms of their race and disability. However, there was insufficient evidence to show how actions taken had made any impact. As part of its broader commitment to promoting workforce diversity and inclusion, the trust tracked progress through the Workforce Race Equality Standard (WRES). The 2024 WRES data presented a mixed picture of both progress and challenges. The WRES data helps organisations to understand the experience of people from ethnic minority backgrounds and act to ensure they have equal access to career opportunities and received fair treatment in the workplace.

The Workforce Disability Equality Standard (WDES) was a set of measures which enabled NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff and ensure disabled staff received fair treatment in the workplace.

The trust's performance in the WDES metrics was mixed, with many indicators flagged as worse than the national value. For example, equal opportunities for career progression among the ethnic minority workforce, experiences of discrimination, and representation on the trust board were areas for improvement. In 2024, there were no members of the executive board who reported as being from an ethnic minority background. For white staff, 60% reported feeling the trust provided equal opportunities for progression, but this was just 46% among staff from an ethnic minority. In discrimination, 7.6% of white staff said they had experienced discrimination from a colleague, but this rose to 17.6% for ethnic minority staff. Neither of these indicators had shown improvement over 2023.

The number of staff reporting who declared a disability at 6% was quite significantly below the number that completed another internal staff survey at 22%. Improvements were reported including an increase in the number of staff declaring disabilities in senior roles. There were also reductions in the number of people with disabilities feeling pressure to come to work when unwell. However, although this was highlighted, there remained 32% of staff with disabilities who had this experience against a peer average of 29% (national value 26%). It had nevertheless reduced from 36% in 2021. The areas for improvement were perhaps most notable in metric 4, which covered people's experiences of bullying, harassment or abuse of which incidents had increased.

The board approved the WRES and WDES action plans for the 2024 reports at its October board meeting. The WRES and WDES action plans were broken down into four areas, namely: recruitment and retention; violence and aggression; belonging; and leadership. The board were informed through the report of improvements in representation of ethnic minority staff across different pay bands. In WRES data, there was a reduction in incidents of harassment, bullying, or abuse, and equal access to training and development opportunities. However, it was recognised that more work was needed in the areas of equal opportunities for career progression, experiences of discrimination and representation on the executive board.

The board report included planned actions and measures to determine if progress was achieved. Our reflection of an area missing from the board and committee reports was an explanation of the success or otherwise of previous actions taken around equality, diversity and inclusion from the WRES and WDES. There was no evidence presented for assurance to show where actions taken in past years had succeeded or needed to be different. We were also not able to see a commitment as yet for a consistent and well-understood plan around reasonable adjustments for staff.

The trust published its gender pay gap but there was insufficient assurance that any actions beyond recognition of the issue would have an impact. The gender pay gap

relates to reporting the difference between average rates of pay for men and women in an organisation.

The trust reported its data being for all directly employed staff including bank staff. In the most recent report to the board (June 2024 for the financial year 2023/24) the trust data showed there were 78% of staff who were female and 22% male. This ratio had changed only marginally over the last few years but more so in the most recent year with an increase in female staff. The largest number of female staff were employed in the lowest quartile (lowest paid) group and the largest number of male staff in the highest quartile (highest paid) group. This had remained largely unchanged over the reporting period since 2017.

In 2023/24, the trust had a 19.3% gap between the median hourly pay for men and women. This meant women earned on average around 81p for each £1 earned by male colleagues. The median gender pay gap figure is the difference between the hourly pay of the median man and the hourly pay of the median woman. The median for each is the man or woman who is in the middle of a list of hourly pay ordered from highest to lowest paid. When comparing mean average hourly pay, women's pay was 30.8% lower than male colleagues. The mean gender pay gap figure uses hourly pay of all employees to calculate the difference between the mean hourly pay of men, and the mean hourly pay of women. The average rates of pay were affected significantly by the disproportionate number of staff by gender working in the lower or higher paid bands.

In terms of bonus pay, there was no difference in the payment rate between men and women, but considerable difference in the number of people receiving bonuses. For 2023/24, 12.7% of men received a bonus compared with 1.9% of women. The only bonus scheme used by the trust related to the clinical excellence scheme, which was available to consultants, where this was awarded rather than applied for as in the past.

The trust board report stated there was still further work to be undertaken to address the gender pay gap, and it stated the actions would be incorporated into

the equality, diversity and inclusion plan. There was an action listed on that plan (p25), but it was to "generate greater understanding…where women are underrepresented in leadership roles". However, there were no other actions associated with where this understanding would lead and what measures of success were being used. Our reflection was of there being no measurable actions as evidence of this area being addressed despite recognition of further work needed.

Governance, management and sustainability

Score: 3

We scored the trust as 3. The evidence showed a good standard. The trust had clear responsibilities, roles, systems of accountability and good governance. They used these to manage and deliver good quality, sustainable care, treatment and support within a difficult climate for health and social care services. They acted on the best information about risk, performance and outcomes. However, the board needed to demonstrate assurance of learning from governance processes, such as avoidable deaths and complaints. The corporate risk register needed to be clear on how risks were included and if and when deadlines were achieved.

Our findings:

Across the leadership of the organisation from the trust board through the clinical groups, there were clear responsibilities, roles, and systems of accountability. The board governance structure was clear and covered all aspects of the trust's responsibilities and services, including new and future planned services. The trust board met every two months in public with a full set of papers and presentations. Invited staff presented to the board around their areas of responsibility and expertise. We attended the October 2024 board meeting where there were presentations from the executive and non-executive directors, but also the lead for equality, diversion and inclusion, and the patient experience manager, among others. Our view of the meeting was it was open, honest, recognised areas of excellence and those needing improvement, and there was good challenge, despite the inevitable time constraints.

Each member of the board had a clear delineated portfolio of responsibilities, and these overlapped between executives and non-executives as expected. For example, non-executive directors chaired the board committees and executives and other staff with responsibility for certain areas presented to the committee. We attended one committee (the quality and safety committee) which was independently chaired by a non-executive director and received presentations from across the trust's services and responsibilities. There was good challenge throughout the committee and a good level of detail to the reports presented.

All the key areas of managing an NHS trust were covered by the trust board. To that end, the trust had recently appointed an executive director for digital services, and executive director of governance and assurance. We understood there was consideration of creating an associate non-executive role to support digital services, given the growing and extensive profile of this portfolio.

The non-executive directors we met were confident their role in holding the board to account was well understood and respected. If they were to challenge information at the board or committee, this was given respect, and they felt heard. They said this had notably improved in more recent years. They felt they were able to act as an independent voice and used time visiting patients and staff to get a broader understanding of the organisation. They found the staff they met open and honest and staff we met told us they appreciated seeing them and having the chance to share their experience.

At the time of our assessment, the most recent performance data was from October 2024. Some metrics were improving, but cancer standards were worse than the England average. There was some good performance data from the emergency department. Just 39 patients (2%) spent more than 12 hours on a trolley, which was significantly below the England average of 12%. By comparison, at a neighbouring trust there were more than 2,000 patients waiting over 12 hours in the same month. Ambulance handover delays of more than 60 minutes were also below the England and regional averages. However, only 34% of type 1 patients (the most seriously unwell) were seen, discharged or admitted within four hours, against the national

standard at the time of 73%. The overall performance of the emergency department was boosted by the four-hour standard for minor-injury patients, which achieved 86% in the month and equally was relatively stable.

The trust was not showing a risk for infection prevention and control metrics or for those associated with mortality. However, it was above target for patients spending more than 21 days in hospital. At 207, this was around double the target set. There was an improvement in diagnostic waiting times to 92% although this remained below the 95% target and 98% NHS standard.

The trust had no patients in October 2024 who had been waiting more than 78 weeks to complete a referral to treatment. However, 56% of patients, a small increase from the previous month, had been seen within 18 weeks against a standard of 92%. This was below the national average of 59%. There were 3,278 patients waiting over 52 weeks against a target for the trust of 1,302. However, this had dropped by 434 in the month.

In cancer performance, the trust reported to 58% of patients with their diagnosis within 28 days (the faster diagnosis standard) against a national average of 77.1%.

The board heard directly from patients and staff. There was a patient story talk given to the board at one meeting following by a staff story at the following meeting. In the story we heard at the October meeting, the parent of a young patient described their experience and how they had been enabled to share areas of concern. This led to staffing being enabled to make future improvements and avoid some misinterpretations when the patient had specific and possibly unusual conditions to consider.

The board were given clear metrics about staffing and their workforce. There was a comprehensive report covering workforce data which enabled the board to gain assurance (or otherwise if that was the case) that many of the leading indicators around vacancies, turnover, sickness and training were either meeting or close to objectives. There was sufficient detail to see possible emerging or new risks and

areas for closer attention. The trust used statistical process control indicators to evaluate data, so there was sufficient clarity in the data to check for unanticipated variances or emerging concerns.

Our primary concerns around governance are described elsewhere in this report but relate to the demonstration of learning from intelligence or adverse events or incidents. This required the board to have, for example, effective governance and oversight around learning and improvement from patient complaints, avoidable death, and better insight into support for junior doctors leading to effective change.

It was unclear from board or committee reports how the board were assured of learning from serious incidents or that the duty of candour owed to patients, or their families when something went wrong, was complied with. The trust incident review group met to discuss all serious incidents. We reviewed a number of reports from these meetings alongside the patient safety incident investigation report. There was good evidence in the reports that areas for improvement and safety recommendations were determined in each case. However, investigation reports or summaries from the review group did not report if the duty of candour had been applied and we were unable to see evidence of this or learning from serious incidents given for assurance to the board or committees.

The trust had a concise and clear board assurance framework. A board assurance framework (BAF) is a document designed to capture, describe and manage risks causing uncertainly on achieving an organisation's objectives. The trust's BAF was described as a "living" or "dynamic" document that was designed to be updated when anything contained within it changed. It was therefore considered at the trust board committees in the relevant areas for ongoing assurance. For example, the risk to cyber security was to be considered at the audit and risk assurance committee before coming before the board.

We noted in the quality of care and patient experience BAF matrix how the recent national adult inpatient survey had been discussed in detail at the quality and safety committee. The discussion was reflected through into the BAF with associated

actions. It was stated in a report to the board on this matter how more information would be provided as it became available to respond to this area of concern.

The current BAF was arranged by critical risks. Some trust boards used strategic objectives as subject matter headlines, but this trust had elected to adopt a format which saw the risks sit beneath the linked board committee. Nevertheless, the five matrices (with some areas combined from the original seven) in the current framework were connected to one of more of the trust's five strategic objectives. For example, operational performance was connected to both 'local integrated care' and 'centres of excellence' objectives. Quality of care and patient experience and service stability were connected to the same objectives but included also the 'research, innovation and teaching' objective.

The structure of the BAF listed how assurances to judge any residual risk to objectives being achieved were gained. These were mostly from updating data and intelligence from major reports and audits. Gaps in (or risks to) achieving the objectives were listed along with mitigating factors and actions being taken. Risks on the corporate risk register were also mapped to the specific subject. This led to the overall level of assurance being set for each area.

The level of assurance was reviewed at the end of board and committee meetings to ensure anything not considered, noted as improved or worsened, was accounted for. All current risks to achieving trust objectives were honestly appraised and rated as 'amber' in each instance. The meant risks were being managed but there were gaps requiring further assurance. Otherwise, there was no evidence of intolerable or intractable risk being overlooked or not having responsible ownership at executive level.

The risk register was clear and not overly complicated, but some of the criteria for inclusion and how risks were tracked if they were not meeting set targets were not clear. The trust risk register was being upgraded at the time of our assessment from a spreadsheet to being held on the trust's incident management programme. Risks were categorised within the responsible trust board committee (or some were

jointly owned) and graded by their perceived seriousness. A score of 15 to 25 categorised risks at their highest level of which there were five on the current register which related to performance and patient safety. Each risk had mitigating actions which in some cases lowered the risk score, but understandably not always.

There was a lack of clarity around whether all risks were escalated to the trust board. There were risks rated as high in other services (such as 1 rated 20 risk in surgery services for example) which did not appear on the corporate risk register despite being categorised as serious. There was a date by which the risk was required to be reduced to a lower and acceptable target score, but it was not clear how missing this date or risk reduction could be tracked for board assurance of risk governance.

The trust board received comprehensive information at each board and relevant committee about performance both in quality and safety and also finance and workforce. The information was detailed, clear and enabled decisions to be taken where needed to look for improvements in all aspects of performance. All relevant risks, issues and priorities around quality, safety and performance were recognised and well-understood by the Chief Operating Officer and their team. Those staff affected on the frontline were listened to for their input into where improvements could be made. The objective to keep issues and risks in strong focus was met by providing a good level of detailed oversight to the board and its committees.

There was good financial governance. The trust delivered a break-even position against its financial control total in 2023-24 and received a positive opinion on its annual accounts from its external auditors. The Internal Auditor 360 Assurance tool had given the trust “significant assurance” about the effectiveness of its systems of internal control. The trust was evaluated by NHS England in its financial oversight framework with a grading of 2. This meant support was reviewed on a formal basis each quarter basis by the regional team and not considered of significant concern. Trusts in segment 4 were those considered as needing mandated intensive support.

The trust's target was to deliver a financial deficit plan in 2024-25 of £5 million, after receiving £20 million of non-recurrent cash support. The trust executive team recognised the plan included financial risks of around £9 million relating to additional income required to deliver agreed activity; unplanned additional costs; and a waste reduction/increased efficiency target of £58.4 million, of which £25 million was planned to be a recurrent reduction in costs. The senior team acknowledged they were reporting slippage against financial targets but expressed confidence they would deliver its agreed plan.

However, it was also acknowledged that by increasing reliance of one-off cost reductions in 2024-25, plans for 2025-26 would be more challenging. The trust had developed a financial recovery plan and established a financial recovery board chaired by the Chief Executive Officer to monitor progress.

The trust had planned to implement its electronic patient record system in October 2023 but had had to defer to June 2024. Executive staff told us that while the 'recovery phase' post-implementation was now complete, optimisation and benefits realisation would take time. The inspection team were advised how implementation had impacted all levels of the trust, but priority had been the maintenance of patient care during transition.

The trust operated its services in Coventry from a hospital financed through a Private Finance Initiative (PFI). The trust, together with NHS England, was in detailed discussions with the PFI provider to seek to mitigate risk and assure future sustainability. The finance team described in detail the steps being taken to provide assurance about the continuation of Private Finance Initiative-provided services, and the associated governance.

There was effective governance, management and accountability structures in the pharmacy team. Staff all knew what their roles and responsibilities were, and the senior leadership team had oversight. There was also a strong governance structure for the safe use of medicines. There was a clear line of reporting through the organisation from the Medicine Safety Committee and Medicine Management

Committee. Both committees reported into the Medicine Optimisation Committee which then reported into the board-level Patient Safety Committee. This ensured there were clear lines of governance for medicine safety risks and incidents.

The trust followed the NHS England guidance for ensuring those persons who met the criteria in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were fit and proper to carry out their roles. A new framework was produced by NHS England in September 2023 covering annual assessments and responsibilities for NHS trusts. The accountability for adherence to the framework was with the Chair of the trust. The latest update to the trust's fit and proper person policy was produced in February 2023 and was therefore in advance of the new NHS guidance. The trust was aware of the gaps in its policy when set against the new guidance, and this would be addressed when the policy was updated in January 2025. These gaps were not seen as material to undermine the trust's position.

We reviewed a number of trust files for executive and non-executive directors and found the sample of documents to be in good order. This included evidence such as references, qualifications, self-declarations, disqualification and insolvency registers, and criminal record checks. Any executives that were members of other bodies through their trust role, such as sitting on the local Integrated Care Board were confirmed as fit and proper by the trust Chair. The trust executive with oversight for legal requirements maintained a spreadsheet with all the required information for this Regulation which was complete and up to date. Declarations of interest were made by executives and recorded at each trust board meeting and papers made public.

Partnerships and communities

Score: 3

We scored the trust as 3. The evidence showed a good standard. The trust understood its duty to collaborate and work in partnership, so services worked

seamlessly for people. Staff shared information and learning with partners and collaborated for improvement.

Our findings:

The trust understood its duty to collaborate with stakeholders and work in partnership and strategically with key organisations. This included both providers and commissioners of health and social care and the local authority, but also the organisation behind the Private Finance Initiative (PFI) contract for the Coventry hospital and its services. As we report below, there was also partnership working with key stakeholders around the environment, net-zero carbon emissions and sustainability. This had led to some effective changes and improvements.

One of the significant relationships for the trust was with the Integrated Care Board (ICB) for the Coventry and Warwickshire Integrated Care System (ICS). The ICB's key strategy around population health and wellbeing (Integrated Care Strategy) was published in June 2023. It was accompanied by the Coventry and Warwickshire Integrated Health and Care Delivery Plan with priorities for 2023-28. The focus was on:

• Tackling health inequalities.

• Improving access and trust in services.

• Addressing immediate system pressures while building resilience.

Progress was reviewed in March 2024, and it was reported how although there had been notable progress on longer-team goals, much of the work to deliver the ambitions had been "fragmented and short-term…and the transformative and system-wide change needed has not been fully realised or scaled across the system at the necessary pace to address the system financial challenges." (Trust board paper, strategy and partnerships update October 2024). The trust were therefore requested to place a renewed focus on this and work together with all system partners to determine which services delivered the strategic objectives. The trust's

team responsible for strategy reported to the board the key opportunities they saw for supporting this renewed focus, namely:

• Transforming the recently acquired community services (transferred in July 2024).

• Taking a lead role in the review of integrated urgent care provision.

• Further developing the 'Health on the High Street' strategy.

• New operating models initially for oncology and urology.

The trust was part of the emerging Care Collaboratives Committee and Forums (one for Coventry and another for Warwickshire). These were relatively new initiatives sponsored by the ICS with the objectives of bringing together partnerships of providers and commissioners of health and care across a specific geographical area. This was to enable delivery of health and care services tailored to the local community and its needs. Decisions should be taken closer to people, patients and communities. These decisions needed to align with the long-term future plans and strategies for the integrated care system.

The trust played a pivotal role in the Improving Lives programme. This was tied to the strategy of the Care Collaboratives in its 'supporting people at home' objective. The trust was working in partnership with Coventry City Council, the ICB, and the local NHS partnership trust to support older people to live more independent lives in good health. The objective was also to support carers with recognition of the pressure on their wellbeing and fostering their independence too where possible. Staff were also to be enabled to focus on this goal and services to look for avoiding duplication and overlap in provision of care.

In an assessment with an expert group in 2021, the trust found:

• 37% of older people could avoid attending hospital with better access to community services and better decision making.

• 38% of patients could be prevented from being admitted to hospital through better support in the community and at the 'front door'.

• 43% of older patients could spend fewer days in hospital after being deemed fit for discharge.

• It could support an additional 1,600 people to remain independent for longer in the community.

To address these findings, the trust established two trials involving staff and patients/residents. These were around the key objectives of preventing avoidable hospital admissions, looking after more patients in the community with therapy services, and reducing delays in patients being discharged. The One Coventry Integrated Care team was piloting an integrated care model to lead on discharge planning and delivering urgent support in the community. Three teams went live in June 2024, so progress was awaited. The Hospital Processes group were looking to identify patients who could have avoided hospital admission and be better supported through community services and pathways at home. This was the opportunity to learn from cases where pathways could have been different and to consider how to embed alternatives.

In other opportunities to support to whole health and care system locally, the trust's medicines safety officer was working with GPs in order to support the management of patients dealing with the side effects of controlled drugs. The trust also provided support from trained staff for smoking cessation for patients admitted to hospital. Support was continued after discharge in community-based services.

The Chief Pharmacist liaised with other Chief Pharmacists within the ICS and attended the West Midlands Chief Pharmacist's network to support consistency across the West Midlands. As part of medicine safety there was collaboration with the ICS on pain management. Patient partnerships were valued to bring the voice and experience of the patient to make improvements in pharmacy service delivery.

For example, a patient was included in the medicine safety committee and within the chemotherapy workstream.

In terms of medical education, the Coventry site was the principal teaching hospital for Warwick Medical School where partnership working was developing innovative medical education programmes and clinical research. There was a partnership with a US-based organisation for almost 10 years which enabled the development of the UHCWi quality improvement system. The trust was one of only two healthcare trusts in Europe formally accredited to provide training and certification for other NHS organisations across the country,

Eleven young people had commenced a supported internship. The aim of the programme was to support young people who had an education, health and care plan to gain work experience and functional skills. The programme was run in partnership with Coventry City Council. The current cohort completed the programme in July 2024. Previous cohorts have had an 80% success rate in supported interns gaining employment within the trust. The trust stated it was working to increase opportunities within the next two years

The trust ran a patient partner forum and had been focused on making this more accessible and inclusive for members. This included reaching out to attract new members through community engagement events and trying different times and places to see how to optimise attendance and input. Discussions were underway to set up a children and young people's forum in 2024/25.

In 2023/24, members of the patient partner forum had been involved in committees including, compassionate communities, Hospital of St Cross governance group, the research committee, and the patient experience and engagement committee. Members had also been involved in various projects and workstreams in order to bring the voice and experience of the patient and public to decision making.

Learning, improvement and innovation

Score: 3

We scored the trust as 3. The evidence showed a good standard. The trust focused on continuous learning, innovation and improvement across the organisation and local system. Senior leaders encouraged creative ways of delivering equality of experience, outcome and quality of life for people. They actively contribute to safe, effective practice and research. However, there was insufficient focus on providing the trust board with evidence of learning and improvement from key areas such as death and complaints. Innovation, research and development could be improved by demonstrating to a wider audience the impact from its extensive work.

Our findings:

There was a common theme of good opportunities spoken about to learn and develop in the organisation. The 2023 NHS Staff Survey had mixed results, but those related to learning, knowledge and skills improvement were around the same as the national average. However, in one notable indicator in the survey, the trust advised it was in the top 30 of 120 comparator organisations and within 3.7% of the top scoring trust for staff reporting they could make improvements happen in their area. There was a culture of learning and improvement running through the organisation not least from the UHCWi (improvement) programme. This was a quality management system which required staff to consider how change and improvement must be linked with culture, value to patients and leadership. All staff were encouraged to be part of this process in not just specific one-off projects, but all their roles and responsibilities. This was well embedded with staff who told us there were no barriers to making improvements and this was fully encouraged, although well-managed to ensure trust objectives were still paramount.

The trust worked in partnership as one of only five trusts in England with an American institute known for its work around innovation, management systems, and continuous improvement in healthcare. The trust's 'lean' programme, mentioned above in the leadership section, originated with this institute and came with a range of tools, support and mentoring.

There was an active innovation, research and development team involved in and having completed many projects over the years. Research was linked, among other things, to the trust's objective around Population health – focusing on proactive and preventative care. The board were provided with regular updates on progress against the innovation strategy and received an update on the 2024/25 delivery plan at their October 2024 meeting.

The board also received the annual review of research and development for 2023/24 at its October 2024 meeting. The review covered the extensive range of progress in research and development and recognised the advantages of partnership working and collaboration. What was missing from the report was a presentation of the impact of successful projects and the outcomes. The report described in a good level of detail what work had been undertaken, what was planned and what was ongoing, but there was less about the impact this had for patients and the positive outcomes that had been seen or were anticipated.

The trust had worked with a number of higher education providers but with key strategic partners being the local Coventry and Warwick universities. In March 2024, the trust launched the Coventry and Warwickshire Clinical Research Facility and an inpatient research unit with two beds for participants in research to stay overnight.

Patients and members of the public were involved in both direct research and in helping to direct and shape future research. They supported steering groups and advisory groups. Public awareness was continued through community events with a recognised need to increase engagement with communities that were harder to reach. The trust acknowledged that to focus on health inequalities meant starting, as the research team were, to understand the current demographics of research participants. This would help to engage with a more representative group of patients in future studies.

There was a large cohort of staff involved in research projects. This included around 100 clinicians leading research supported by research nurses and midwives, and allied health professionals. The trust had recruited two professors to support the

Centre for Care Excellence in partnership with Coventry University. This supported nursing, midwifery, and allied health professional research, innovation, practice, and education excellence. The trust had won awards for research and been the catalyst for the development of certain guidance by the National Institute for Health and Care Excellence (NICE).

In medicines innovation, the trust's pharmacy and IT were joining with external partners to develop the 'first of type' automated drug cabinets. This was supported through securing funding from NHS Digital.

In 2023, the trust celebrated 10 years since the introduction of robotic surgery. It had performed around 1,500 operations by robotic surgery (based on 2022 reported data) and in 2022 installed a second robotic system for a wider range of minimally invasive procedures. Trust studies had shown this had generated a reduced length of stay for patients of around 60%.

The trust has made significant strides in innovation, including fields such as atrial fibrillation treatment, Parkinson's outpatient care, respiratory patient support, and elective surgery. Research had led to advancements in personalised hip replacements, and the launch of new drug trials for multiple sclerosis treatment.

The trust had improved the facilities for patients with the completion of a £15 million emergency department expansion; the opening of the Dandelion Room for improved bereavement care; and was progressing plans for a new theatre and ward complex at the Hospital of St Cross in Rugby.

The trust met some of the requirements of the National Quality Board's requirements set out in 2017, but some key areas were missing from trust board assurance, specifically recognition of learning and change, or involvement with those bereaved. As required, the trust had an executive sponsor for learning from death (the Chief Medical Officer), and a non-executive director had oversight through the role of chair of the quality and safety committee, which received mortality reports.

Other requirements met included presentation of a report to the board from the mortality review committee. However, this appeared to be every six months rather than the required quarterly report. Deaths were reviewed through a structured judgement framework and supported by an established group of medical examiners.

However, the report did not cover a number of areas set out by the requirements. This included no clear indication for the board on the number of deaths that were avoidable or were determined as more likely than not to have resulted from problems in care. Deaths of patients with a learning disability were included within the review but in the August 2024 board paper, no deaths had occurred to be reported. There was no mention of the deaths of patients with mental health needs.

There was insufficient evidence of learning from death. The report was skewed towards statistical data and how many reports were outstanding for review, which was 75% over 30 days. There were 12 reports listed which were outstanding for more than a year. The report did not provide any context as to the reasons for the delays. However, the mortality review report for November 2024, presented to the quality and safety committee, indicated these reports would be required to be completed no later than 15 December 2024 and would be monitored by the mortality committee.

The board report also did not discuss any involvement of families in reviews of deaths. Involving families was a noted omission from all NHS trusts reviewed when this was investigated in 2017. Requirements of the board were to ensure there was sufficient, timely, compassionate and meaningful engagement with bereaved families and carers. This was not discussed in the board or any sub-committee papers.

Learning from death was the responsibility of the board to be both informed about and to ensure investigations and learning were acted upon. This was to ensure there was sustainable change to clinical and organisational practice and improvements to care where needed. It should be shown to have been shared with

all those who would benefit from learning, change or development. This learning and improvement was also to be reported in the trust's annual Quality Account. In the Quality Account 2023-24, there was a description of process, but no evidence to say the board had met its obligations to demonstrate learning or clinical/organisational change in either the Quality Account or assurance papers to the board or committees.

The trust published detailed information about complaints, but this did not describe what had been learned from the complaints or what actions were needed or had been taken to drive improvement. The trust's patient experience team reported to the board detailed information about the numbers of complaints (and compliments) received through the various routes. The report described a small backlog in the number responded to within the 25-day objective. There were also a small number that had been not resolved for more than six months, but it was not clear what was delaying these. The report outlined the themes in the complaints and what percentage of those had been upheld.

What the report did not cover was what learning could be gained from the complaints in order to make changes or improvements when this was recognised as needed. There was no examination of whether any changes, if made, had resulted in a material difference to the numbers of complaints, or to the more common themes, which remained with perceived failures in communication as the recurring top theme.

There were several innovative and development workstreams that staff were proud about. For example, the team campaigned to make diabetes training mandatory and were successful. Other examples included the medicine returns units on wards, One Stop Dispensing and the utilisation of Medicine Management Assistants to improve discharge and flow of patients on wards.

Reported medicine errors or incidents were reviewed by the Medicine Safety Officer. An incident review group met weekly to look at medicine incidents and any emerging themes for sharing and learning across the trust.

Environmental sustainability – sustainable development

Score: 3

We scored the trust as 3. The evidence showed a good standard. The trust understood any negative impact of its activities on the environment and strived to make a positive contribution in reducing it and support people to do the same. Some clarity was needed in reporting to ensure areas which were not making progress as hoped were clearly described.

Our findings:

Staff and leaders understood the threat from climate change and were taking action to reduce the impact on the environment of healthcare activity. The trust and its staff had a genuine commitment to reduce the significant threat to the health of people who used services, their colleagues, and the wider population.

In October 2020, the NHS became the world's first health service to commit to reaching a carbon footprint of net zero by 2040 for the emissions it controlled directly. The ambition is to reach an 80% reduction by 2028 to 2032. For those things the NHS can influence rather than directly control, the target is net zero by 2045 (80% is the ambition by 2036 to 2039). This was embedded into legislation in July 2022. The NHS Long Term Plan included commitments related to health and the environment, including around climate change, reduction in use of plastics, particularly single use, improving air quality, and minimising waste and water use.

To deliver this ambition, NHS trusts were required to focus on two primary actions:

• Enable and produce direct interventions to reduce waste and carbon dioxide emissions within estates and facilities, travel and transport, supply chain and medicines.

• Take actions to improve levels of waste and emissions, accelerate sustainable models of care (such as care closer to or at home), workforce impacts, networks and leadership commitments, and funding and finance mechanisms.

As required by NHS England, the trust had developed its Green Plan, the current version being for 2023-2026. The Green Plan was required to include aims, objectives and delivery plans for carbon reduction and sustainability. The plan was signed off, as required, by the trust board.

The trust had set ambitious targets including becoming a net zero provider ahead of national deadlines. The 2023-2026 plan was divided into nine areas of focus which included, among others, patient care models, travel and transportation, estates and facilities. It included the area which accounted for the largest contributor to carbon emissions: the supply chain for medicines, chemical and medical equipment (together accounting for 56% of the total carbon footprint breakdown in 2019/20). The reduction in emissions from the supply chain was the largest of all ambitions in the Green Plan trajectory. At the peak in 2020/21, the supply chain was responsible for just under 200,000 tonnes of carbon dioxide emissions (tCO2e). The plan was to reduce this figure to just under 115,000 tCO2e by 2025/26.

In the latest update to the trust board committee (October 2024), the Green Plan was now divided into 14 areas of focus, and it had been proposed to evolve these into four sections for future reporting. These were:

1. Changing mindsets (which included workforce, and travel and transport).

2. Sustainable assets (which included estates and facilities).

3. Good health and wellbeing (which included medicines, and waste/recycling).

4. Net zero innovation and transformation (which included sustainable models of care).

Sustainable models of care described the trust having a focus on the key NHS England objectives of preventative care being delivered in communities and tackling health inequalities. Staff recognised the benefits to patients and the environment by care being delivered closer to home or at home. They also saw the need for delivering efficient and effective patient care to reduce hospital bed days and patient and visitor travel to hospitals, GPs and clinics.

There were 148 mostly mandatory actions set out in the trust's Green Plan for the current financial year 2024/25 split across the 14 areas of focus. In this latest report, the trust had achieved 45% of these actions by September 2024 (mostly in 'workforce' and 'digital transformation') with 49% in progress (mostly in 'supply chain') and the balance of 6% to be started (mostly in 'travel and transport', followed by 'adaption').

The Green Plan and its initiatives had been developed, as it would need to be, with a range of local health and social care providers and stakeholders. This included the local authorities, the Integrated Care Board, Warwickshire Climate Forum, Coventry Climate Change Board, and other health and social care providers and partners across the Coventry and Warwickshire region.

The trust had appointed a sustainable development manager, a clinical lead for net zero, an executive sponsor for environmental sustainability, and reported regularly to the trust board, NHS England and the Integrated Care Board. There was a growing network of net zero champions, and a staff council started in 2021. The trust also produced and published an annual report on sustainability which laid out what had been achieved so far and what were the plans, challenges and risks for the future.

Each proposal for an innovation, change or development needed to answer three questions:

1. Is this the best choice for patients?

2. Is this the best choice for our economy?

3. Is this the best choice for the planet?

Anything not answering 'yes' to these questions or any identified risks from any proposed schemes or change were discussed before any progression at the relevant risk committee meetings or with the trust board.

Within the 45% of actions achieved, and those in progress, there had been several successes in efforts to reduce the carbon footprint. This included the removal of most single-use plastics from the catering supply; reusable baby feeding bottles that could go home with the baby; and stopping the use of single-use tourniquets in AE, theatres and phlebotomy for those that can be safely reused. There was also the move to reusable hats in operating theatres rather than single-use disposable hats. The pharmacy had moved to using paper bags for patients' medicines rather than plastic saving around 10,000 plastic bags each year,

One area which had yet to achieve a reduction was in the use of paper. Although the usage had reduced from the baseline year (2019/20), along with the associated carbon emissions, costs had increased significantly, with the use of recycled paper having been hampered by a shortage in supply. However, in July 2024 (albeit delayed), the trust moved over to an electronic patient record system which was expected to see a significant reduction in the use of paper in future years.

Another increase had been in the cost of gas and its emissions. The 2023/24 Annual Sustainably Report was difficult to understand in places and was not as clear in terms of gas and oil carbon emissions as it was on other topics. Although improvements in efficiencies were described, there was no clear commentary on the charts provided, which showed steep increases in usage of gas and emissions. Nevertheless, there had been a move away from taking electricity from the national grid to a combined heat and power plant using gas to convert to electricity. There was also a move over to grant-funded self-generating energy with the Hospital of St Cross introducing solar energy and the installation of an air-source heat pump. The trust also had procured 100% of renewable energy since April 2021.

Travel for business purposes by fleet vehicles had seen a reduction in both mileage and emissions although this had been rising again since 2021/22. All capital projects at the trust had to have environmental impact assessments which met expectations before further progressing.

The trust was proud of a number of initiatives. This included its network of champions (known as net zero superheroes) and departmental initiatives and successes. In September 2024, the emergency department had been awarded bronze accreditation by the Royal College of Emergency Medicine as part of the new Green ED programme. In a limited rollout of the new accreditation, the department was one of three in England to be awarded bronze, with two awarded silver. It was now working towards silver accreditation.

Working with the local authority, the trust was proud of a new cycle route from the University to the Coventry hospital. There was an arrangement with the local bus company to provide new starters with free bus travel for a month and discounts on future travel. There were also discounts arranged for patients and carers.

There were staff groups working on specific projects. The trust was proud of its 'Saving Turtles' initiative. This was a project started in operating theatres in 2019 and was a shared decision-making council established to make an impact in waste recycling. The group had grown and extended into many green project areas. Anaesthetists had significantly reduced the use of volatile anaesthetic gases in surgical procedures and were shifting away from the use of desflurane to other less pollutant anaesthetic gases. Pharmacists were focused on increasing the use of dry-powder inhalers (DPI) in accordance with the NHS Standard Contract stipulation to increase their use. DPI inhalers contain as little as 4% of greenhouse gas emissions compared with metered-dose inhalers. There were also actions around overuse of inhalers and safe disposal.

Medicines were a major factor in environmental sustainability and other initiatives included capturing exhaled nitrous oxide and reducing its use in surgery. The trust had introduced the use of reusable containers for sharp disposables with a 10-year

life span. This improved emissions by 92% when compared with single-use bins. There has been significant work in reuse of medical equipment such as walking aids which were cleaned, inspected and returned to use. The trust was reusing around 27% and working towards the NHS target of reusing 40% by 2025. Other equipment which cannot be reused for various reasons was sent to various external companies for onward distribution to charities that can use them, for use as scrap, or for renovation.

Waste was not limited to tangible items but there was also a focus on the waste of resources and time. This included waste recognised from cancelling patients' operations or clinic appointments, long waiting times for patients which added costs for both the trust and the patient. It also led to inefficiencies in services, and the extra administration associated with those things such as rebooking patients, needing repeat tests, and providing medicines, food and drink for patients having to wait to be seen.

Not least for staff and patient wellbeing, the trust had worked in partnership with the Centre for Sustainable Healthcare to create a nature reserve on the Coventry site. This contained a wetlands areas which formed part of the hospital's surface water drainage system. Staff we spoke with about environmental sustainability did report there was less waste, more recycling, and reusable equipment provided. At the Hospital of St Cross in Rugby, staff said they had a link nurse for environmental sustainability with whom they could raise ideas and suggestions for improvement.

Use of information technology and digital equipment had recognised environmental impacts. To counter this the trust was working towards a number of sustainable practices including increasing remote appointments for patients; increasing the use of video conferencing to reduce travel; introducing energy-efficient computer hardware; and championing vendors of IT equipment who prioritise sustainability and consider the lifecycle of all equipment. The trust also had a dedicated data analyst and the team we met told us they were assured their data was of good quality and recognised how this was vital to the success of any project.

There was a recognition of some key areas of work to be strengthened and some risks remaining to be mitigated satisfactorily. Some of the work on waste tracking was behind schedule and there had been recognition that the reduction in carbon emissions brought higher costs (such as the combined heat and power system).

There had been a considerable increase in the use of water at University Hospital in 2023 due to expansion and longer operating hours. The trust had installed automatic meter readers across both sites to allow for rapid identification of potential leaks for repair. However, it was quite some way from meetings its trajectory to achieve better water conservation.

The trust finance and performance committee had a number of risks laid out in the sustainable update report of October 2024. One, rated as 16 out of a possible 25 was relating to NHS England's requirement of trusts to have a net zero funding plan to demonstrate how it would fund its move to decarbonisation. The information was limited in that it did not provide detail as to when this risk arose, when the funding strategy was required to be presented, and what mitigations, if any, should be considered. It was also not listed on the corporate risk register for the trust. Also reported was a lack of board oversight of the risks associated with major climate events, particularly heatwaves, extreme cold, and flooding. All of these had been recently experienced in the UK and the committee were told work was being undertaken by external climate groups to help determine climate impacts on the trust. Data was therefore reported in this area as incomplete.