clinical governance review

University Hospitals Coventry and Warwickshire NHS Trust

SEPTEMBER 2001

CHI

Report of a clinical governance review at

University Hospitals Coventry and Warwickshire NHS Trust

SEPTEMBER 2001

Contents

Foreword

This report looks at clinical governance in University Hospitals Coventry and Warwickshire NHS Trust. The report is in two main parts. The first is a question and answer section, which is designed to tell the public what CHI found in an easy to understand way. The second part is intended principally to be of value to the trust itself, so that it knows in detail, and in a language it will understand, what CHI found and where it needs to take action. The second section will also be of interest to other NHS organisations in the area and to the wider NHS as there are lessons that the whole NHS should take note of.

CHI's findings – questions and answers

Q **What is the trust like? And what does it do? What kind of population does it serve?**

A University Hospitals Coventry and Warwickshire NHS Trust provides a wide range of hospital services to people in Coventry, Rugby and the surrounding areas. The trust also draws patients from further away for some of its specialist services.

The trust covers three sites. The Walsgrave hospital and the Coventry and Warwickshire hospital are both in Coventry. The hospital of St Cross is in Rugby. The population served by the trust is diverse - some areas are wealthier and healthier than the country as a whole, while others are considerably poorer than average.

A new hospital is planned for the Walsgrave site and is due to be completed by 2005.

Q **What – if anything – did CHI find that the rest of the NHS can learn from?**

A Nothing that many other hospitals are not already doing.

Q **What – if anything – did CHI find that is cause for concern?**

A There were five areas that CHI was concerned about:

- the unacceptable risk to patients of putting five beds in bays designed for four
- death rates for both emergency and non emergency admissions are higher than the national average
- accident and emergency services
- the breakdown in communication between some senior medical consultant staff and senior trust managers
- the failure of the trust to ensure that, until the new hospital opens, services continue to be provided safely and effectively

Q **To what extent does the trust board and senior management team have the information they need about the quality of patient care? To what extent do they refer to it? Do they compare themselves with other trusts? Do they use the information to monitor the services and to help them make decisions about priorities? How is this reflected in the teams that deliver services to patients?**

A The trust board receives a good range of information on clinical outcomes, waiting lists, finance, complaints and incidents but this needs to be used consistently to indicate areas for action and improvement. The trust is involved in some benchmarking activities, but findings need to be shared with the teams that deliver services.

Q Do the board and the senior management team make sure that they receive regular information from patients about what they think of the services? Do they have a positive attitude towards complaints and take complaints seriously? Do they make sure staff have a positive attitude towards complaints and that they learn from them? How is this reflected in the teams that deliver services to patients?

A The trust board regularly receives reports about complaints and individual complaints are acknowledged quickly. However, there is often a delay in addressing the underlying concerns and CHI feels that addressing patients' complaints promptly is not a high priority for the trust.

Q Do they involve patients and their relatives in helping to plan and improve services in the trust as a whole and in specific services?

A The trust has talked to local people about some of the major changes to services in the past and also involves patients and their carers in their treatment, but overall it is not good at consulting and involving people in planning and developing services.

Q Does the trust have the staff it needs to deliver the services? Does it manage its staff well? Does it supervise junior staff and trainees adequately? Does it do the necessary routine checks on doctors and nurses?

A There are sufficient staff to deliver services. However, there are considerable staffing vacancies, especially in nursing. The trust employs temporary staff to remedy the situation.

Relationships between some senior medical consultants and trust managers are very poor.

The trust makes the appropriate checks on locum medical staff and policies are in place to ensure that registration for other staff is checked. It also has induction programmes but these are not always attended by staff. Appraisal systems are in place but not all staff have regular appraisals.

Q How well do the trust and the staff anticipate things that might go wrong? Does the trust encourage staff to report problems? Does it have systematic methods for collecting information about risks to patients? Does it have systems for making sure managers and staff learn from mistakes?

A Although staff are generally aware of the process to report their concerns, some senior staff feel intimidated about doing so. The trust does not learn from mistakes because staff feel they would be unfairly blamed for mistakes they reported.

Q **Does the trust make sure that the clinical staff keep up to date? Does it support research? Does it make sure the clinical treatment and care are based on the most up to date evidence of good practice? Does the trust make sure the staff comply with national guidelines?**

A There are lots of opportunities for staff to keep up to date through training and development, they also have access to a good library and the internet. The trust is involved in medical research. The trust does carry out some audits but not right across the trust and its systems for sharing good practice and national guidelines are poor.

Q **How effective is the leadership of the trust? Does it have a positive attitude to feedback from outside? How well does it work with other organizations locally? Does it have good clinical leadership?**

A The management of the trust is described as aggressive by partner organisations with a reluctance to consult. This has improved during planning for the new hospital and medical school, which has been the main focus for the trust. The trust is failing to ensure that services are safe and effective until the new hospital is open.

The trust has been successful at meeting targets based on how many patients it treated and how much it spent. Its management appears to be severely challenged by being assesed on how well it treats patients.

Executive summary

The Commission for Health Improvement (CHI) conducted a clinical governance review at University Hospitals Coventry and Warwickshire NHS Trust between February and July 2001. The review is part of a rolling programme of all NHS organisations to provide robust assessments of their arrangements for clinical governance. This report contains the key findings, assessments and areas for action.

There are five major areas of concern which require immediate action.

1. The practice of placing a fifth bed in a four bed bay is unsafe and patients are put in danger. It is difficult for staff to bring resuscitation and other equipment to the bedside and to examine patients. These conditions compromise patient safety, privacy and dignity. This practice must stop immediately.

2. Death rates for non emergency admissions are significantly higher than the national average. Reasons may include patients with more complex conditions, bad data or patient care but these need reviewing and analysing.

3. The organisation of care between the two accident and emergency (A&E) departments and the emergency admissions unit is unacceptable. CHI is concerned that this compromises patient safety. This must be addressed immediately.

4. Relationships between some consultant medical staff and senior managers have broken down. In particular, some doctors do not feel it is safe to raise concerns about clinical risks. These doctors and managers must build effective working relationships immediately.

5. A new hospital development is planned, but the trust has serious service problems now. The trust must address these problems and not wait until the new hospital is opened.

Key findings, assessments and areas for action

The patient's experience

The trust performed significantly worse than the English average in two of the seven national clinical indicators and significantly better in one of them.

Death rates for both emergency and non emergency admissions are above the national average.

Readmission rates are higher than the national average and there is significant variation between individual consultants.

The number of patients being discharged within 28 days with fractured neck of femur is better than the national average.

During 1999-2000 financial year the trust achieved its inpatient waiting list and waiting time targets.

Day case overstays are above the national average.

There was little evidence of the development of clinical care pathways.

There was an overall perception that care and treatment were provided in a competent and caring way, but there were instances where dignity and privacy were not respected.

Some waiting and treatment areas were clean and modern and staff had made the best of challenging areas. Others were dirty and unmodernised.

The emergency admissions unit was extremely cramped and needs urgent review.

Use of information

ASSESSMENT

There has been worthwhile development at corporate level and some development at divisional level in the use of information about the patient's experience, resources and processes.

The prime focus for information strategy is the new hospital development, which is at least four years from opening.

Relevant performance information is regularly reported to the trust board, but this should inform clinical practice and link to the component parts of clinical governance.

Consultation and patient involvement

ASSESSMENT

There has been no trust wide approach in the development of consultation and patient involvement systems but there has been some development at clinical team level has been made in patient involvement.

There has been no systematic approach to the development of consultation and patient involvement at a strategic level.

There are some examples of patient involvement through surveys, the use of suggestion boxes and individual care planning.

The trust has established a strategy to develop consultation and patient involvement.

There is no specific budget for the development of consultation and patient involvement.

Clinical risk management

There is some development at corporate, divisional and clinical level in implementing clinical risk management.

A just culture, in which staff would not be blamed unless they had recklessly made errors, is rarely evident.

Clinical risk management is seriously undermined by the fact that some senior medical staff feel intimidated when reporting clinical risk.

The practice of putting five beds in bays designed for four is unacceptable and should cease immediately.

The current configuration of A&E and the emergency admissions unit may put patients at risk and an immediate clinical risk assessment is required.

The trust has developed a clinical risk management strategy but this is not consistently applied throughout the trust and there are few feedback mechanisms as part of the reporting process.

Clinical audit

There is some development at corporate and divisional level in clinical audit.

The trust has established a clinical audit department with a dedicated budget to support its work.

There is some effective clinical audit activity and subsequent service development and change, but audit is not embedded in all areas of the trust and some areas undertake no clinical audit activity whatsoever.

Research and effectiveness

There is some some development at directorate level in research and effectiveness, but this is not trust wide.

The trust does not have a strong history or culture of research activity but has just revised its strategy to develop its research capability.

Staffing and staff management

There is some development at corporate, divisional and clinical team levels in staffing and staff management.

The trust has some staff management procedures and policies; however, these are not always followed.

There is a serious breakdown of communication between some senior medical consultants and senior managers within the trust.

Education, training and continuing personal and professional development

There is strategic grasp and substantial implementation in education and continuing professional development with alignment across corporate, divisional and clinical teams.

There is evidence of worthwhile development and commitment to staff education, development and continuing professional development at both strategic and operational level.

Strategic capacity

Clinical governance is not integrated well in all areas of the trust and needs to be embedded in the trust culture.

Strategic leadership, focus and planning have been dominated by the development of the new hospital, but the trust needs to also focus on delivering services until the new hospital opens.

EXAMPLES OF NOTABLE PRACTICE

The work of the chaplains to ensure a multi-faith service is notable. The trust clearly acknowledges the diversity of need of individual faiths and beliefs.

The GP out of hours co-operative at St Cross hospital is an example of integrating other care with A&E.

The GP run maternity unit is an example of giving women safe choices effectively integrated within maternity services.

Patient diaries, developed by the Coventry and Warwickshire cancer user group in conjunction with the trust and Coventry Health Authority, are a notable example of patient involvement in their own care.

Opportunities for experience in specialist clinical areas for trainee doctors and continuing professional development, particularly for nursing staff, are notable examples of staff development.

Action following the review

The trust's action plan in response to this report will be available from the Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust, Trust Administration Building, Walsgrave Hospital, Clifford Bridge Road, Coventry, CV2 2DX.

What is clinical governance?

The government's white paper, *A First Class Service*, defined clinical governance as

> *"...a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."*[1]

The purpose of clinical governance is to ensure that patients receive the highest quality of NHS care possible. It covers the organisation's systems and processes for monitoring and improving services, including:

- consultation and patient involvement
- clinical risk management
- clinical audit
- research and effectiveness
- staffing and staff management
- education, training and continuing personal and professional development
- the use of information about the patient's experience, outcomes and processes

Effective clinical governance should therefore ensure:

- continuous improvement of patient services and care
- a patient-centred approach that includes treating patients courteously, involving them in decisions about their care and keeping them informed
- a commitment to quality, which ensures that health professionals are up to date in their practices and properly supervised where necessary
- the prevention of clinical errors wherever possible and the commitment to learn from mistakes and share that learning with others

Clinical governance reviews

CHI is carrying out a rolling programme of reviews in every NHS health organisation in England and Wales to provide independent and systematic scrutiny of the clinical governance arrangements in each trust.

Reviews take around 24 weeks to complete from starting the review to having a report ready for publication. This timescale is long enough to collect and analyse data rigorously but intensive enough to mean that the evidence on which the review findings are based is current and useful.

1. *A First Class Service: Quality in the New NHS*, Department of Health, 1998.

Each review follows the same timetable:

Pre-visit preparation (15 weeks)

During this phase, CHI collects and analyses data and documents about the trust and its services from a wide variety of sources. It examines the national data available, asks the trust to put together information that will demonstrate how clinical governance works, talks to local organisations involved in providing health and social care and holds individual meetings with members of the public and other local organisations such as patient groups. It also collects information from a sample of patients about their recent hospital experience. All of the information collected is used to identify areas for detailed review during the site visit and to brief the review team.

Site visit (1 week)

A CHI review team visits the trust to interview trust staff, observe practice, verify information already obtained and gather further information. Each team normally comprises a nurse, a doctor, an NHS manager, a lay member and another clinical professional who is not a doctor or a nurse, for example a pharmacist or physiotherapist. The aim of the visit is to collect information about how well clinical governance is working throughout the organisation and to examine the experience of patients first hand.

Production of report (8 weeks)

The review team brings together all the evidence it has collected about the trust to agree its key findings and form an assessment of clinical governance arrangements. These are presented to the trust four weeks after the visit and then turned into a written report.

After the site visit, CHI runs a workshop with the trust to help it consider the areas for action in CHI's report, identify its future priorities and translate them into achievable and measurable objectives. The trust then draws up an action plan, which is approved and monitored by the Regional Office or, in Wales, the National Assembly. In some cases, the action plan will involve other organisations in the local health community that are involved with the trust in providing health and social care.

The review at University Hospitals Coventry and Warwickshire NHS Trust started in February 2001. The review visit (stage 2) took place from 4-8 June 2001. During the review information was received from 148 patients, carers, GPs and other members of the public. Twelve meetings were held with neighbouring organisations. Sixty-eight meetings were held with trust staff involving 108 individuals. Full details of sources of evidence are in appendix B.

The review

1 | Introduction

1.1 The Commission for Health Improvement (CHI) conducted a clinical governance review at University Hospitals Coventry and Warwickshire NHS Trust (the trust) between February 2001 and July 2001. The review is part of a rolling programme of reviews of all NHS organisations that will provide robust assessments of their arrangements for clinical governance.

1.2 The review looked in depth at arrangements for patients who

■ had suffered a head injury

■ had suffered acute chest pain

■ required general surgery

1.3 Clinical teams were defined to include staff in other departments who look after the patients at some point in their care including those in accident and emergency (A&E), the emergency assessment unit, radiology, pharmacy, anaesthetics, theatres, physiotherapy, occupational therapy, infection control, pain management, the intensive care unit, wards, hotel services, chaplaincy services and outpatients' departments.

1.4 The teams were selected following analysis of the trust's own information and data, reports of other external reviews of the trust and after local consultation. They were chosen to illustrate a range of challenges and achievements in clinical governance.

1.5 The purpose of this report is to give an objective description of clinical governance arrangements, which will enable the trust to identify areas for improvement and help spread knowledge throughout the NHS.

1.6 The report has four main chapters:

■ chapter 3 describes the common experiences of patients cared for by the trust, including their outcomes following hospital treatment

■ chapter 4 examines the extent to which the trust uses information about the experiences of patients and about the performance of its staff and processes to help improve services

■ chapter 5 looks at how the trust ensures that its staff are able to provide the best care and treatment of patients, for example through training, supervision and education. It also examines how the trust checks and improves the quality of its services

■ chapter 6 describes the capacity of the trust to implement clinical governance and, through it, improve services for patients

1.7 CHI is developing its review methods so that the topics covered by these four chapters can be assessed in a way that is reliable, fair and consistent. This work is still underway and in this report assessments are made of the topics in chapters 4 and 5 only; the topics covered in chapters 3 and 6 are described but not assessed. A fuller description of CHI's method for assessing clinical governance is in appendix C.

1.8 Judgments and conclusions published in this report are those of the Commission for Health Improvement (CHI) alone. In reaching its judgments and conclusions, CHI uses information received from many organisations, staff of the body under review and members of the public. The contribution of these organisations and individuals is gratefully acknowledged but CHI remains responsible for the contents of the report and the evidence it relies upon in reaching its conclusions.

1.9 The trust's action plan in response to this report will be available on CHI's website (www.chi.nhs.uk) or from the Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust, Walsgrave Hospital, Clifford Bridge Road, Coventry, CV2 2DX.

Acknowledgements

1.10 CHI would like to thank staff of local organisations, patients and members of the public who contributed to this review. Within the trust, CHI would particularly like to thank:

- David Loughton, Chief Executive
- Janet Monkman, Nursing Director and trust coordinator for the review
- Jim Macartney, Medical Director
- all the staff who gave time to speak to the review team and who provided information

2 | The trust's context

The trust's nature and size

2.1 University Hospitals Coventry and Warwickshire NHS Trust provides acute and specialist healthcare primarily to the city of Coventry and the surrounding areas in Warwickshire. The trust also serves a catchment of around one million for some of its specialist services, including kidney transplant in alliance with University Hospital Birmingham, neurosurgery, plastic surgery, cardio thoracic surgery and invasive cardiology, major trauma, specialist diagnostic services, cancer screening and neonatology (including neonatal intensive care).

2.2 The trust has the largest cardio thoracic unit in the West Midlands, became a sub-regional cancer centre in 1997 and is part of the English pilot for the colorectal cancer screening programme.

Hospital sites

2.3 The trust has three sites, Walsgrave hospital, Coventry and Warwickshire hospital, which are both in Coventry, and the hospital of St Cross in Rugby.

Developments

2.4 The trust formally changed its name from Walsgrave Hospitals NHS Trust when it achieved teaching hospital status in 2000. Walsgrave Hospitals NHS Trust was formed in 1992 and later merged with the Rugby NHS Trust to incorporate the hospital of St Cross in 1998. Planning approval has been granted for a joint University Hospitals Coventry and Warwickshire NHS Trust and Coventry Healthcare NHS Trust acute and mental health hospital on the Walsgrave site. The scheme is set for completion in 2005. The investment includes a new clinical sciences building, due to be completed in 2003, to house the medical school. The Coventry and Warwickshire hospital site will be disposed of as part of the scheme, with services provided at St Cross hospital in Rugby maintained.

Staffing and beds

2.5 There are 1,379 beds and approximately 4,650 members of staff.

Training

2.6 The trust provides training for doctors, allied health professionals, nurses and midwives in collaboration with the local universities of Warwick and Leicester.

Volume of activity

2.7 The trust is within the West Midlands region of the NHS Executive and the main host authorities are Coventry Health Authority, which provides 72% of the trust's activity, and Warwickshire Health Authority which provides 22%.

Figure 2.1: Breakdown of activity by health authority

Health authority	Percentage (%) of trust's activity in FCEs
Coventry	71.6%
Warwickshire	22.3%
Leicester	1.3%
Northamptonshire	1.2%
Other	3.7%

Source: CHI analysis of PAS date

2.8 The trust provides the following volume of activity:

Figure 2.2: Trust activity 1999–2000

Finished consultants episodes	98,557
Outpatient attendances	339,825
A&E attendances	146,187

Source: Trust figures for finished consultant episodes (FCEs) from CHI analysis of PAS data and outpatients and A&E attendance's from hospital activity statistics DoH (1999-2000)

2.9 General medicine accounts for 22% of the trust's activity, general surgery accounts for 14%, trauma and orthopaedics 10% and obstetrics 8%.

Figure 2.3: Trust facilities profile by site

Walsgrave hospital	Coventry and Warwickshire hospital	Hospital of St Cross, Rugby
3,328 WTE staff	844 WTE staff	479 WTE staff
789 general beds	149 general beds	143 general beds
73 critical care beds	4 critical care beds	22 day beds
82 maternity beds	22 day beds	Outpatient clinics
9 private beds	A&E (82,000 attendances per annum)	3 main theatres and 1 day surgery theatre
86 day beds	Outpatient clinics	A&E (32,000 attendances per annum)
Outpatient clinics		

Figure 2.3: Trust facilities profile by site (continued)

Walsgrave hospital	Coventry and Warwickshire hospital	Hospital of St Cross, Rugby
Emergency admissions unit (EAU)	5 main and 2 day surgery theatres	Endoscopy room
Rehabilitation day hospital	8 X-ray rooms	3 main and 1 OP X-ray rooms
Endoscopy day surgery suite	Ultrasound	Emergency admission unit (EAU)
7 X-ray rooms	Breast screening	Rehabilitation day unit
12 main and 2 day surgery theatres	Microbiology	ECG
Cardiac catheter suite	Physiotherapy and occupational therapy	Ultrasound
Clinical neurophysiology	Post graduate medical centre	Physiotherapy and occupational thereapy
Ultrasound	Health records department	Continuing care facility
Nuclear medicine department	Well women's health and information centre	Medical records
Haematology, biochemistry, histopathology and cytology		
Physiotherapy and occupational therapy		
ECG, EEG, MRI CT etc		

The local population

2.10 The population of both Coventry Health Authority and Warwickshire Health Authority have a similar age profile to England as a whole.

2.11 Deprivation levels in Warwickshire are variable. Some districts experience relatively low levels of deprivation whilst others are considerably more deprived than the rest of the country. In Nuneaton and Bedworth, almost 6% of the population live in areas which rank within the top 10% of most deprived wards in England. In Coventry, almost 29% of the population live within these most deprived wards.

2.12 Coventry Health Authority and Warwickshire Health Authority have significantly lower rates of long-standing illness than the national average.

2.13 The death rates for people under 75 for the Coventry and Warwickshire area are slightly lower than for similar mixed urban and rural areas within the country, but Coventry has a death rate which is significantly higher than for England as a whole.

2.14 In the 1991 census, black and minority groups represented 12% of the population of the Coventry Metropolitan County of which 7% were of Indian origin. In Warwickshire, over 99% of people described themselves as white.

Financial context

2.15 In the 1999-2000 financial year, the trust had an income of around £190 million and met its financial targets in full. However, the end of year results showed a deficit of £1.5 million. The trust's income came mainly from health authorities and primary care groups (83%), followed by education, training and research (9%), income from other trusts (2%) and income from private patients (2%) and other sources (4%).

2.16 The majority of expenditure was on staff costs (56%), followed by supplies and services (17%), depreciation (4%), premises (3%), establishment and transport (2%) and other expenditure (18%).

3 │ The patient's experience

Chapter 3 describes the common experiences of patients cared for by the trust. The term patient's experience includes the clinical effectiveness and outcomes of care; patients' access to services; the ease with which patients progress through their care or treatment; the privacy, dignity and respect given to patients; and the environment in which care is provided.

Clinical effectiveness and outcomes of care

KEY FINDINGS

The trust performed significantly worse than the English average in two of the seven national clinical indicators and significantly better in one of them.

Death rates for both emergency and non emergency admissions are above the national average.

National clinical indicators

3.1 The NHS Executive provides annual indicators profiling the performance of trusts. The latest set of indicators was for the financial year 1998/1999, published in July 2000. The trust performed significantly worse than the English average in two clinical indicators and significantly better in one of them.

3.2 The trust is significantly worse than the national average for the percentage of patients who are readmitted to hospital within 28 days of being discharged. This may indicate that patients are being discharged before they are ready, or that the care and support that the patient gets at home or in the community is not adequate.

3.3 The trust is also significantly worse than the national average for the percentage of non emergency admissions who die within 30 days. Possible reasons for this may include patients with more severe and complex conditions, bad data or poor patient care.

3.4 The trust performs better than average in the percentage of patients over 65 who are discharged to their usual home within 28 days of emergency admission with a hip fracture. This indicates that hip fracture patients are being successfully rehabilitated.

3.5 The trust's comparative death rate score for emergency admissions is 114, compared to an English average of 100. Particular specialties with a higher than average score were cardio thoracic surgery, ENT, urology and general surgery.

3.6 The score for non emergency admissions is 160, compared to an English average of 100. Particular specialties with a higher than average score were general and geriatric medicine and cardiology.

Access to services

During the financial year 1999–2000 the trust achieved its inpatient waiting list and waiting time targets.

3.7 The trust's results were:

- 80% of outpatients were seen within 13 weeks and 95% were seen within 26 weeks
- 80% of patients admitted through A&E were seen within 2 hours
- 79% of patients were seen within 30 minutes of their clinic appointment
- 88% of patients waited less that 6 months for their operation and 99% waited less than 12 months

Organisation of care

Readmission rates are above the average and there is a significant variation between individual consultants.

Day case overstays are slightly above the national average.

There was little evidence of the development of clinical care pathways.

3.8 The services provided by the trust are managed through three clinical divisions supported by directorates across the three hospitals. Each clinical division has a general manager and clinical directors. An executive director manages each of the corporate directorates.

3.9 Day case overstays, which are those patients who are booked in as a day case but end up staying over night in hospital, are above the national average of 4.4%, at 5.8%. There are however, significant differences between specialities with ophthalmology, microsurgery, cardiology and gynaecology having higher than average overstays and ear, nose and throat (ENT) and cardio thoracic surgery lower than average overstays.

3.10 CHI found little evidence of clinical care pathway development.

Humanity of care

KEY FINDINGS

There was an overall perception that care and treatment was provided in a competent and caring way, but there were instances where dignity and privacy were not respected.

3.11 Many patients and carers felt that staff throughout the trust were supportive and informative, offering good explanations of procedures and providing competent care.

3.12 Some patients and carers were concerned about the attitude of staff. They recalled instances of individuals behaving in an unacceptable way and described them as "insensitive", "dismissive", or "unhelpful".

3.13 Individual privacy and dignity is at times compromised by additional beds in bays not designed to accommodate these, with no fitted curtaining, no call bell and limited space for personal belongings.

The environment

KEY FINDINGS

Some waiting and treatment areas were clean and modern and staff had made the best of challenging areas. Others were dirty and unmodernised.

3.14 CHI observed care areas where there had been considerable thought put into making the environment as suitable as possible for patients. An example was the children's orthopaedic ward at Coventry and Warwickshire hospital, where a poor environment was greatly improved by creative decoration.

3.15 The quality of waiting areas was very varied. For example, while the waiting area in radiotherapy was clean and appropriate with adequate space, the waiting area in radiology was extremely crowded and CHI was concerned about the care of patients waiting on trolleys.

3.16 The quality of clinical areas was also very varied. CHI was specifically concerned about:

- inadequate temporary ward accommodation at Coventry and Warwickshire hospital, established as part of a redecoration programme
- the positioning of mixed sex bays at Rugby hospital
- the inappropriate environment for the rehabilitation of patients with head injury at Walsgrave hospital

3.17 Crowded areas, particularly in the emergency admission unit (EAU) at Walsgrave hospital where patients sometimes waited for a considerable length of time in cramped conditions, meant that it was very difficult for staff to give patients the privacy and confidentiality they should have.

3.18 There was significant variation across the trust in cleanliness. While some areas were very clean and tidy, appearing well looked after and cared for, others were extremely dirty, unkempt and unhygienic.

EXAMPLES OF NOTABLE PRACTICE

The work of the chaplaincy to ensure multi faith provision is notable. The trust clearly acknowledges the diversity of need of individual faiths and beliefs.

The GP out of hours cooperative at St Cross hospital is an example of primary care being integrated with A&E services.

The GP run maternity unit is an example of giving women safe choices effectively integrated with maternity services.

KEY AREAS FOR ACTION

Immediate action is required to address the unacceptable environment within the emergency admissions unit and the environment within the waiting area in radiology.

Immediate action is required to review death rates for emergency and non emergency admissions to understand their significance and take action as a result of the analysis.

Action is required to explore potential reasons for the variation in readmission rates across consultants and how this is monitored and agree actions to reduce readmission rates.

Action is required to review facilities within waiting areas.

Action is required to improve cleanliness and maintenance for all three hospitals over the next four years.

Action is required to develop care pathways.

4 │ Use of information

The availability and use of information about the experience of patients cared for by the trust and about the performance of the trust's staff and processes underpins the trust's ability to improve services. This chapter examines what information is available and how effectively it is used by the trust.

Information about the patient's experience and resources and processes

ASSESSMENT

There has been worthwhile development at corporate level and some development at divisional level in the use of information about patients' experiences, resources and processes.

KEY FINDINGS

The prime focus for information strategy is the new hospital development, which is at least four years from opening.

Relevant performance information is regularly reported to the trust board, but this should inform clinical practice and link to the component parts of clinical governance.

4.1 The strategy for information management and technology (IM&T) has been developed as part of the Coventry health community local implementation strategy for information for health. It outlines the vision for IM&T as supporting clinical decision making, facilitating clinical governance and providing improved information for patients, carers and the public.

4.2 Much of the planning and development is linked to the new hospital, which is at least four years from opening.

4.3 Systems are not translating into support for care.

4.4 The trust routinely collects information about complaints, clinical incidents and claims, which are reported to the trust board. This information was not used to inform component parts of clinical governance and routine reporting is not fed back to clinical staff to develop services.

4.5 Performance reports relating to key indicators such as waiting times and cancelled operations, financial information and human resource issues such as recruitment are regularly presented to the trust board.

4.6 Some clinical staff said that they were frustrated at not having data to assist in the planning, delivery and development of services or clinical governance.

4.7 There appears to be no effective system for the dissemination of NICE guidance or other national guidelines to clinical staff.

4.8 During the course of the review CHI was encouraged to hear that the trust has begun to measure its performance against other similar hospitals. Radiology is already involved in the Keele based radiology benchmarking work.

KEY AREAS FOR ACTION

The trust needs to develop and implement plans for IM&T to support current services and to assist work with partner organisations.

The trust needs to ensure a clear plan is developed and communicated about how information will be used to develop services.

5 | Resources and processes

This chapter looks at how the trust ensures that its staff are able to provide the best care and treatment of patients, for example through training, supervision and education, and at the processes the trust uses to check and improve the quality of its services.

Processes for quality improvement

Consultation and patient involvement

ASSESSMENT

There has been no trust wide approach in the development of consultation and patient involvement systems but there has been some development at clinical team level in patient involvement.

KEY FINDINGS

There has been no systematic approach to the development of consultation and patient involvement at a strategic level.

There are some examples of patient involvement through surveys, the use of suggestion boxes and individual care planning.

The trust has established a strategy to develop consultation and patient involvement.

There is not a specific budget for the development of consultation and patient involvement.

5.1 CHI found examples of patient involvement through patient surveys and feedback which have resulted in some improvements in information and facilities, but this needs to be consistent across the trust and within an overall plan.

5.2 The trust has developed a strategy to improve patient consultation and involvement.

5.3 CHI found examples of patients being consulted on service change or relocation and of involvement in individual care planning, but there is no specified budget to support patient involvement and consultation.

5.4 Some areas have patient information available, some of which is in languages other than English, but this is inconsistent and some areas have no written information available at all.

5.5 There is no evidence of an overall programme to meet the information needs of minority groups or for individuals with special needs.

5.6 The trust board regularly receives reports on complaints. Ninety percent of complaints in the 1999-2000 financial year were acknowledged within two days and 31% were replied to within twenty days.

5.7 CHI heard from patients and carers who had raised issues under the complaints procedure who said that, after receiving an initial acknowledgement of their complaint, they were very concerned about the length of time it took to investigate the issues raised and to gain information on what, if any, action would be taken.

5.8 The trust believes that the complex nature of some complaint issues may be responsible for delays but this still leaves 69% of complaints not replied to within 20 days.

5.9 There is a policy for 'consent to treatment' which CHI found is being adhered to and the trust has a 'do not resuscitate' policy.

EXAMPLE OF NOTABLE PRACTICE

Patient diaries, developed by the Coventry and Warwickshire cancer user group in conjunction with the trust and Coventry Health Authority, are a notable example of patient involvement in their own care.

KEY AREAS FOR ACTION - CONSULTATION AND PATIENT INVOLVEMENT

The trust needs to establish programmes for patient involvement and consultation in service planning, delivery, development and monitoring.

The trust needs to develop effective working relationships with local organisations and groups to develop patient and carer involvement and in particular patient information for services across the trust.

Clinical risk management

ASSESSMENT

There is some development at corporate and divisional and clinical team level in implementing clinical risk management.

KEY FINDINGS

The trust has developed a risk management strategy, but this is not consistently applied across the trust and there are few feedback mechanisms as part of the reporting process.

A just culture, in which staff would not be blamed unless they had recklessly made errors, is rarely evident.

Clinical risk management is seriously undermined by the fact that some senior medical staff feel intimidated when reporting clinical risk.

The practice of putting five beds in bays designed for four is unacceptable and should cease immediately.

The current configuration of A&E and the emergency admissions unit may put patients at risk and an immediate clinical risk assessment is required.

5.10 The risk management strategy for the trust states that the clinical divisions have the responsibility for developing and implementing clinical risk management strategies but we found little evidence of this working consistently and effectively in practice.

5.11 The trust has achieved level one, the lowest level, of the clinical negligence scheme for trusts.

5.12 Staff were aware of the reporting mechanism for clinical risk but overall received little feedback on lessons learnt, changes to practice or how information from the reporting process is fed back into improvements in clinical care.

5.13 A wholly unacceptable clinical risk reported to CHI by clinical staff was the regular placing of an additional bed in bays not designed for this purpose. Generally this involved four bed bays having a fifth bed. In some cases six bed bays had a seventh bed. This practice risks there being worse access to gases and equipment, an increased risk of infection and poorer assessment and treatment as a result of staff having more difficulty reaching the patient than would otherwise be the case.

5.14 CHI found evidence of occasions when resuscitation attempts were severely hampered for patients in the additional bed due to lack of access to oxygen, and suction equipment and of staff having to work in a cramped conditions with a lack of space to accommodate emergency equipment next to the patient.

5.15 Observation by CHI confirmed the cramped and unsafe conditions for the person in the additional bed who also had no curtains or access to a call button. We were also concerned about the health and safety of staff working in reduced space and about the effect of the conditions for the other patients in the bay.

5.16 Clinical risk management is seriously undermined by the fact some senior clinical staff feel intimidated and threatened by senior managers after raising concerns about clinical practice, equipment or procedures.

5.17 A major concern expressed by clinical staff was split site working and the transfer of very sick patients between hospitals. The clinical concern was for people admitted through accident and emergency services and through the emergency admission unit. For example, people seen at A&E at Coventry and Warwickshire hospital or at A&E at Rugby St Cross hospital may be transferred to Walsgrave hospital due to a lack of facilities within the accident and emergency departments. There is also an absence of senior medical cover within the emergency admission unit at Walsgrave hospital at night.

5.18 CHI was extremely concerned at the inadequate clinical risk assessment and review of the current services provided by the two A&E departments and the emergency admission unit.

5.19 CHI was also concerned by the lack of resident paediatric medical cover at both hospitals within the A&E departments.

5.20 Staff reported that there was no training for clinical risk assessment and management with the exception of infection control. Infection control training is part of the corporate induction but medical staff, whether temporary or permanent, do not always attend this. Locum medical staff are supposed to be given a copy of the infection control policy however this does not always happen.

5.21 The infection control team has been consulted on the development of the new hospital but not always on the purchase of equipment or on general support services.

5.22 Bank and agency nursing staff have been employed in clinical areas with little or no orientation or supervision or instruction in their duties and responsibilities. Information is generally exchanged at ward handovers between shifts, but these may not be attended by bank or agency nurses who may work different hours to permanent staff. There have been occasions when a ward's nursing staff is made up solely of bank and agency staff. The risks are obvious.

5.23 There is no evidence of involvement of partner health organisations, such as primary care or neighbouring trusts, in clinical risk management.

KEY AREAS FOR ACTION – CLINICAL RISK MANAGEMENT

Immediate action is required to stop the wholly unacceptable practice risk of placing additional beds in bays not designed for this purpose.

Immediate action is required to promote a just culture within the trust, where staff are actively encouraged and supported to report risks and concerns.

Immediate action is required to undertake a clinical risk assessment of the clinical pathway for patients seen through A&E departments and the emergency admissions unit. This should determine how these services should be configured and their function until the new hospital opens. The role of each unit, and the relationship between each unit, should be clear. The current policy for medical cover and function overnight of the emergency admissions unit should also be reviewed.

Action is required to review medical paediatric cover in the A&E departments.

Action is required to develop involvement of partner organisations.

Action is required to ensure that learning and knowledge about clinical risk, identification of trends and dissemination of information is fed back into clinical governance practices and used for developing services.

Action is required to train staff in risk assessment and management.

Clinical audit

ASSESSMENT

There is some development at corporate and divisional level of clinical audit systems.

The trust has an established audit department with a designated budget to support audit activity.

There is evidence of some effective audit activity and subsequent service development and change, but audit is not embedded in the culture of the trust and some areas undertake no audit activity at all, which is unacceptable.

5.24 The trust has an established audit department, a designated budget and a programme of audit activity. There are some examples of audit with evidence of resultant changes to practice. The trust selects topics for audit from decisions within the clinical divisions based on clinical opinion and national priorities, but CHI found little evidence of a systematic selection of audit topics coordinated with trust activity and priorities. We found uncertainty amongst many clinical staff about the existence of, or role of, the clinical effectiveness committee and little awareness amongst staff about the strategic management and leadership of clinical audit. There was evidence of some multidisciplinary activity but little evidence of patient involvement in audit activity.

KEY AREAS FOR ACTION – CLINICAL AUDIT

The trust needs to develop a clear strategy and implementation plan for multidisciplinary audit activity across the organisation that links to clinical incident reporting, national and local priorities and information technology.

The trust needs to develop partnership audit across the health community.

The trust needs to ensure patient and public involvement in audit activity.

Research and effectiveness

There is some development at directorate level in research and effectiveness, but this is not trust wide.

The trust does not have a strong history or culture of research activity but has just revised its strategy to develop its research capability.

5.25 The trust has recently appointed a new medical director with the specific responsibility for the development of research within the trust.

5.26 The research projects currently being supported include some in partnership with external organisations or as part of a regional network, but there is little evidence of how research outcomes are fed back into the trust and of what impact they have on services and care delivery.

5.27 Current research activity is dominated by doctors rather than being multidisciplinary.

5.28 Computer based training in research methodologies is available and the trust has established links with local educational organisations. There is a good library, which has internet access, although access to the library for non medical staff is limited.

5.29 There is a research interest group for nursing staff but this appears to reach very few nurses.

5.30 There is a system to disseminate national guidelines and standards such as NICE guidance throughout the trust, but this is not effective in reaching clinical staff, who reported a lack of leadership regarding clinical effectiveness.

KEY AREA FOR ACTION

KEY AREAS FOR ACTION – RESEARCH AND EFFECTIVENESS

The trust needs to develop a culture to support research.

Action should be taken to ensure the development of multidisciplinary research activity.

Action should be taken to develop effective systems to disseminate and implement clinical guidance and research outcomes into practice.

Action should be taken to develop patient and carer involvement in research activity.

Action should be taken to develop partnership working across the health, social care and education communities.

Staff focus

Staffing and staff management

ASSESSMENT

There is some development at corporate, divisional and clinical team levels in staffing and staff management.

The trust has some staff management procedures and policies; however, these are not always followed.

There is a serious breakdown of communication between some senior medical consultant staff and senior managers within the trust.

5.31 The trust manages its services through three clinical divisions and a number of corporate directorates. Some staff perceive this to be an ineffective structure for organising and managing services, primarily due to the size of each division and lack of clarity about the roles and relationships of the clinical directors and the divisional directors.

5.32 The trust has recently revised its human resource function with plans for the implementation of the working time directive. It also has established a new deal monitoring committee.

5.33 The trust operates a zero tolerance policy against violence and aggression.

5.34 The trust regularly collects data on staff vacancies, turnover and sickness and has a workforce plan for medical staff. Workforce information does not seem to be disseminated nor used for workforce planning by other staff groups.

5.35 Systems for recruitment, induction, appraisal and clinical supervision are evident but implementation is variable across the trust. Not all staff attend induction, are regularly appraised or having personal development plans. Bank and agency staff do not always have mandatory training.

5.36 Systems are in place to check registration of locum medical staff; checks for agency staff are the responsibility of the agency.

5.37 CHI found effective relationships between staff side organisations and trust management.

5.38 CHI found some extremely effective team working and had the opportunity to meet a number of enthusiastic and motivated staff members, who were committed to providing effective care and services.

5.39 However, we found that some senior clinical staff felt isolated, disempowered and unvalued. We were deeply concerned by the number of consultant medical staff who reported feeling bullied, intimidated, threatened and oppressed by senior managers when raising concerns about clinical care or conditions. Some medical staff reported fear of speaking out for fear of being victimised, following occasions where they believed their colleagues have been victimised. Some managers reported their frustration about senior medical colleagues whom they felt were not responsive towards working with management colleagues.

5.40 We were extremely concerned by the evidence of a breakdown in communication between some senior medical staff and senior managers within the trust. This is a situation which cannot be allowed to continue.

KEY AREAS FOR ACTION – STAFFING AND STAFF MANAGEMENT

Immediate action is required to restore confidence between senior medical staff and senior managers and to restore and develop effective working relationships.

The trust needs to review current management structure and accountabilities clarifying roles and responsibilities of clinical and divisional directors.

The trust must review performance monitoring and assess how this can be fed back into trust development.

Education, training and continuing personal and professional development

There is strategic grasp and substantial implementation in education and continuing professional development with alignment across corporate, divisional and clinical teams.

There is evidence of worthwhile development and commitment to staff education, development and continuing professional development at both a strategic and operational level.

5.41 The trust has a strategy for the continuing professional development of staff and has established links with external education establishments and supports an internal programme of learning.

5.42 The trust was designated as a teaching hospital in 2000 to create a joint medical school with the University of Leicester and the University of Warwick.

5.43 The trust provides clinical placements for trainee medical, nursing, midwifery and allied health professional staff.

5.44 Training opportunities for nursing staff are particularly well developed and supported by a team of committed nurse practice development facilitators. Nurse recruitment and retention is supported by a number of educational programmes and secondment and development opportunities.

5.45 A well equipped postgraduate library and information technology facility has recently opened.

5.46 Six areas have achieved the investors in people award with other areas working towards accreditation. There are opportunities to obtain national vocational qualifications. There is weekly protected learning time for junior medical staff. The trust offers extensive opportunities for experience in specialist clinical areas.

5.47 Systems are in place for mandatory training, some of which is through a cascade system. It is difficult to ascertain who has attended.

5.48 The trust training and development strategy states that all employees including locum medical staff and agency and bank staff attend mandatory training, however, this does not always happen.

5.49 Continuing professional development and training is not always linked to appraisal and personal development planning.

5.50 Some staff have identified a lack of training in research methodologies, risk assessment and risk management, audit, complaints management and information technology.

EXAMPLES OF NOTABLE PRACTICE

Opportunities for experience in specialist clinical areas for trainee doctors and continuing professional development for nursing staff, through education and secondment opportunities, are notable examples of staff development.

KEY AREAS FOR ACTION

The trust needs to coordinate the strategy and programmes for training and continuing professional development to ensure they are linked with appraisal and personal development planning.

Action needs to be taken to ensure systems are in place so that mandatory training requirements for all staff are implemented and validated.

Action is needed to develop and implement a strategy for maintaining accreditation status for placements for medical, nursing and midwifery and allied health professions.

6 | Strategic capacity

This chapter describes the capacity of the trust to implement clinical governance and, through it, improve services for patients.

Strategic capacity

Clinical governance is not integrated well in all areas of the trust and needs to be embedded in the trust culture.

Strategic leadership, focus and planning has been dominated by the development of the new hospital, but the trust also needs to focus on delivering services until the new hospital opens.

Leadership

6.1 Strategic leadership has focused on the development of the new hospital due for completion in 2005 and the development of the medical school due for completion in 2003.

6.2 The designated lead for clinical governance is the medical director who has been supported by the nursing director, with responsibility for some aspects of clinical governance with other executive board members.

6.3 CHI found an absence of any strategic leadership on patient care and service issues across the three existing sites on anything that might arise before the new hospital opens. In particular, capacity planning for both elective and emergency admissions and development of care pathways and A&E services are in disarray.

Accountabilities and structures

6.4 The trust has established a structure for taking forward clinical governance. This includes a quality and standards committee to coordinate clinical governance and quality initiatives throughout the trust. This is supported by a number of sub-committees.

6.5 Clinical governance strategy development and implementation has been devolved to clinical divisions.

6.6 Clinical governance within each clinical division is implemented differently and CHI found no evidence of any monitoring or review for the organisation as a whole.

Patient and public partnerships

6.7 CHI found the trust had difficult relationships with the community health council and that it had little overall involvement in any aspect of clinical governance.

Partnerships with other health and social care organisations

6.8 There are examples of effective collaborative working relationships with partner health and social care organisations, working together in the development of the new hospital complex, the achievement of medical school status, within regional specialist services and on nursing projects.

6.9 CHI heard the trust leadership style described by external partners as aggressive with a reluctance to consult. Partner organisations expressed the wish to see a willingness to work differently, to collaborate more across health and social care communities. They would like early involvement in developments, full consultation and a facilitative management style.

KEY AREAS FOR ACTION – STRATEGIC CAPACITY

The trust needs to take immediate action to ensure a focus for strategic direction and service planning now and until the new hospital is open. Patients and carers should play a central role in this process.

Immediate action should be taken to adapt the current leadership style of the trust to facilitate improved working relationships within the organisation and with partner organisations.

7 | Action following the Review

7.1 The trust will now develop objectives in conjunction with CHI to develop those areas of clinical governance that need to be improved, and continue to move forward those areas, which are already of a good standard.

7.2 A published action plan will then be produced in response to the objectives. The regional office responsible for monitoring the action plan is the West Midlands Regional Office, Bartholomew House, Birmingham B16 9PA.

7.3 The action plan will be available from the Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust, Walsgrave Hospital, Clifford Bridge Road, Coventry CV2 2DX. It will also be on the CHI website **www.chi.nhs.uk**

The review team

Helen Chalmers
Nurse Practitioner, Nurse Educationalist
Research Associate University of London

Margaret Dexter
Interim and Project Management Company Director
Ex-Social Services Senior Manager

Marilyn Kent
Senior Physiotherapist
Blackpool, Wyre and Fylde Community NHS Trust

Ed Macalister–Smith
Director of Strategy and Development
Berkshire Health Authority

Ian Stamp
Retired Special Casework Lawyer
Crown Prosecution Service

Andrew Watson
Medical Director/Consultant Paediatrician
Isle of Wight Healthcare NHS Trust

Maureen Burton
CHI Review Manager

Natasha Dorrington
CHI Operations Co-ordinator

Sources of evidence

CHI collected information about the trust and its services from a wide variety of sources including:

- national data about trust activity

- the trust's data about each episode of patient treatment

- the trust's own reports about its clinical governance activity

- reports of other external reviews of the trust, for example made by the Audit Commission and the Royal Medical Colleges

- interviews with patients, trust staff and representatives from local health and social care organisations and

- diaries completed by recent patients

Details of the number of individuals and organisations who provided information are given in the table below.

|	Number
Stakeholders for example, patients, carers, GPs, local public	
■ meetings*	20
■ letters, e-mails and phone calls	38
■ diaries	78
Organisations for example, health authorities, social services, primary care groups, community health council	
■ meetings*	12
■ letters, e-mails and phone calls	0
trust staff	
■ interviews*	68

* These refer to numbers of meetings and interviews held. The numbers of individuals is higher as some stakeholders, organisations and staff were seen in groups.

CHI's assessments of clinical governance

CHI is introducing a systematic framework for assessing clinical governance in trusts so that judgements made in reports of reviews are reliable, fair and consistent. The assessment framework is being developed with the National Clinical Governance Support Team in England and the Clinical Effectiveness Support Unit in Wales. This will ensure that consistent messages are given to trusts about clinical governance.

CHI's model for clinical governance (Figure C.1) illustrates its belief that effective clinical governance depends upon a culture of continuous learning, innovation and development and will improve patients' experience of care and treatment in hospital. Over time, CHI will use the information it accumulates from reviews to help to determine which aspects of clinical governance are the most important for improving patients' experience and outcomes.

Figure C.1: CHI's model for clinical governance
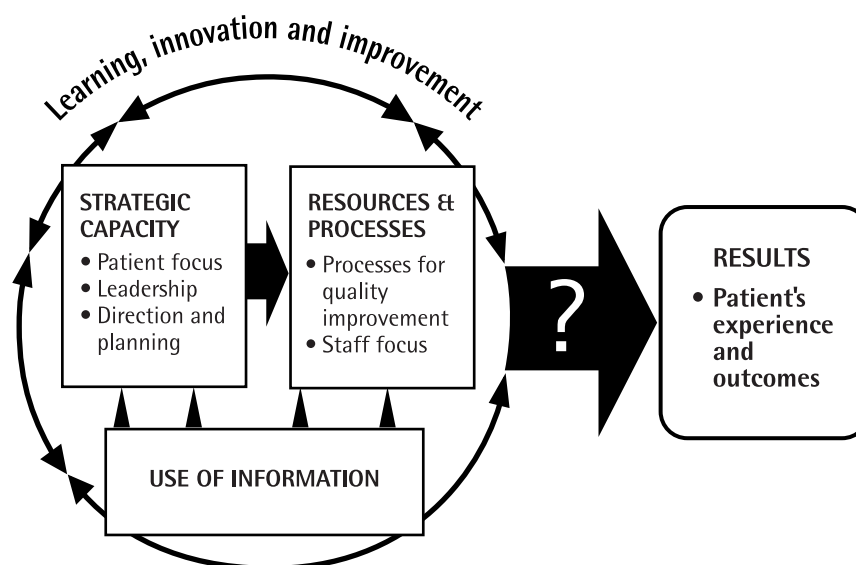
Work is in progress to identify the dimensions of the **patients' experience and outcomes** under the 'RESULTS' part of the model so that CHI can assess the information it collects about what it is like to be a patient and interpret information about clinical processes and care outcomes.

CHI evaluates clinical governance by exploring three key, interlinked areas identified in the model:

■ **strategic capacity:** how far does the trust's leadership set a clear overall direction that focuses on patients? How well is it integrated throughout the trust?

- **resources and processes:** how robust are its processes for achieving quality improvement, such as consultation and patient involvement and clinical audit? How effective are the trust's arrangements for staff management and development?

- **information:** what information is available on patients' experience, outcomes, processes and resources, and how does the trust use it strategically and at the level of patient care?

Each of these areas comprises a number of components that CHI examines in every trust. CHI has so far identified seven components of 'RESOURCES AND PROCESSES' and 'INFORMATION' (Figure C.2). Work is being carried out to identify the components of 'STRATEGIC CAPACITY'.

Figure C.2: Components of clinical governance – resources and processes and information

Resources and processes	Component
(i) processes for quality improvement	Consultation and patient involvement
	Clinical audit
	Clinical risk management
	Research and effectiveness
(ii) staff focus	Staffing and staff management
	Education, training and continuing professional and personal development
Information	Use of information about patients' experience, outcomes and processes

CHI's review teams assess how well clinical governance is working throughout the trust by making enquiries about each of these seven components at corporate and directorate levels and in clinical teams. This involves collecting information systematically about review issues that have been defined for each component. CHI will introduce similar methods to assess information collected about components of STRATEGIC CAPACITY in future rounds of reviews.

On the basis of the evidence collected, CHI's reviewers assess each component of clinical governance against a four-point scale:

I. little or no progress at strategic and planning

II. worthwhile progress and development at strategic and planning levels or at operational level, but not at both

III. good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust

IV. excellence - co-ordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development

There is wide variation within trusts in progress made developing the component parts of clinical governance. At this stage of development, CHI believes it is most useful to trusts to assess each component separately to help them prioritise their development of clinical governance and will not make judgements to produce an overall rating for a trust. Assessments at level I require urgent action, and at level II, action. When the assessment is level III or IV, trusts are already making good or excellent progress; CHI will encourage these trusts to continue to make improvements to achieve the next stage of clinical governance.

Glossary

A&E Accident and emergency, that is, the part of the hospital concerned with the immediate treatment of patients who have had an accident or who require medical or surgical emergency care.

Accountability Responsibility, in the sense of being called to account for something.

Action plan An agreed plan of action and timetable that makes improvements to services, following a clinical governance review.

Acute – care / trust / hospital Acute means short-term (as opposed to chronic, which means long term) Acute care is the term used for medical and surgical treatment involving doctors and other medical staff in a hospital setting. Acute hospital - provides surgery, investigations, operations, serious and other treatments, usually in a hospital setting.

Anaesthetics The study and practice of a branch of medicine that controls a patient's consciousness during an operation. It may also deal with intensive care and pain control.

Appraisal An assessment or estimate of the worth, value or quality of a person or service or thing.

Audit A review that establishes how well a service meets pre-determined standards or criteria.

Cardiac, cardiology To do with the heart, the branch of medicine concerned with the heart and its diseases.

Care pathway Most simply, this is seen as a description of the journey taken (or intended to be taken) through a clinical service. Some have defined it as a defined set of treatment and care steps designed to meet the particular need of each patient.

Care process The description of what happens to a patient.

Carers People who look after their relatives and friends for no pay, often in place of a nurse.

CCU Coronary care unit - this has special equipment and highly trained staff to care for very sick people with heart disease. Typically used for the first few days after a heart attack.

CHI Commission for Health Improvement (for England and Wales).

Clinical Clinical means any treatment provided by a healthcare professional. This will include, doctors, nurses, therapists etc. Non-clinical is management, administration, catering, portering etc.

Clinical audit The continual evaluation and measurement by health professionals of how far they are meeting standards that have been set for their service. Standards can be set by health professionals themselves, or others. Successful clinical audit also involves changing practice to meet the standards.

Clinical director The clinician (often a doctor) who is accountable for clinical and sometimes management elements of service delivery.

Clinical effectiveness For individuals, this means the degree to which a treatment achieves the health improvement for a patient that it is designed to achieve. For whole organisations it means the degree to which the organisation is ensuring that 'best practice' is used whenever possible.

Clinical governance Refers to the quality of health care offered within an organisation. The Department of Health document *A First Class Service* defines clinical governance as a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish. It's about making sure that health services provide patients with high quality care.

Clinical governance review A review of the policies, systems and processes used by an organisation to deliver high quality health care to patients. The review looks at the way these policies work in practice.

Clinical governance review report An objective description of the policies in place and how they work to ensure good quality patient care. The purpose is to identify areas for improvement and to encourage the spread of good ideas. It does not cast judgment on members of staff, and it does not classify the quality of care provided.

Clinical incident An incident (usually an error) which occurs in a hospital or in the community where actual or potential harm may have been experienced by patients or the public.

Clinical indicators Selected measurements of clinical care which help NHS staff to judge how well they are doing. Government publishes some of these annually.

Clinical information Information about treatments given to a patient by a health professional. Could also mean information collected by the organisation about clinical practice (of individuals or teams).

Clinical networks A group of services which work together across organisational boundaries to provide better patient care. For example, in cancer services where the cancer unit and the cancer centre work together to care for patients. Similarly a group of surgeons may work together across a district to provide a full service to a number of hospitals. A cancer centre is a major provider of (usually) specialised cancer services, and is at the 'hub' of the cancer network. A cancer unit is (usually) a district general hospital (at a 'spoke') which deals with most patients, but refers specific cases to the cancer centre.

Clinical outcome The impact effect of a treatment on the health or well being of an individual.

Clinical practice Methods of delivering health care.

Clinical risk Risks associated with various health care treatments.

Clinical risk management Understanding the various levels of risk attached to each form of treatment and systematically taking steps to ensure that the risks are minimised.

Clinician / clinical staff A fully trained health professional - doctor, nurse, therapist, technician etc.

CNST Clinical Negligence Scheme for trusts. This is an 'insurance' scheme for assessing a trust's arrangements to minimise clinical risk which can offset costs of insurance against claims of negligence. Successfully gaining CNST 'standards' (to level one, two, three) reduces the premium that the trust must pay.

Commission for Health Improvement (CHI) Independent national body (covering England and Wales) to support and oversee the quality of clinical governance in NHS clinical services.

Community care Health and social care provided by health care professionals, usually outside hospital and often in the patient's own homes.

Community Health Council (CHC) A statutory body sometimes referred to as the "patients' friend". CHCs represent the public interest in the NHS and have a statutory right to be consulted on health service changes in their area.

Consent Permission to allow a health treatment or investigation to happen.

Core income Money that is given to an organisation by the government to provide healthcare services for local people.

Coronary heart disease Any heart disorder caused by disease of the coronary arteries which supply blood to the heart (coronary means 'of the heart').

CPR Cardio pulmonary resuscitation - the technical term for resuscitating a patient who has collapsed (usually unconscious) in which the underlying cause is severe illness with circulatory or breathing failure.

Day case patient A patient who is admitted to hospital for treatment but does not need to stay overnight. Usually offered to patients requiring minor surgery.

Defibrillator A piece of equipment which sends an electric current through the heart to restore the heart beat.

Discharge planning A thorough assessment of the needs of the patient when they leave hospital and return to their home, or another place. It often includes joint work between the hospital and social services to plan how patients can leave hospital as soon as possible to continue their rehabilitation in the community.

District Auditors District Audit, the external auditors for some NHS Trusts, local authorities and other bodies. DA is the local arm of the Audit Commission.

DNR Do not resuscitate. This is an instruction, agreed between doctor, patient and/or relatives, about a patient which says that if their health suddenly deteriorates to near-death, no special measures will be taken to revive them.

Elective This refers to a planned hospital procedure as opposed to one carried out in an emergency.

Emergency admissions An unplanned admission to hospital as a result of an emergency such as an accident or a sudden illness. This is usually through A&E department or through a GP organising an immediate admission.

Evidence based clinical guidelines Guidelines (drawn up to assist clinician-patient decisions in specific clinical circumstances) that have been produced from a sound research base.

Evidence based practice A series of practices and disciplines in clinical fields in which clinical staff are enabled to make the best use of available evidence in establishing common practice. These practices include asking the best question for a particular patient, searching for evidence to answer the question, critically appraising the evidence to make sure that it applies to the patient in question, applying it and auditing success. The application of clinical guidelines is also encompassed by this term.

FCE Finished consultant episode. A period of continuous consultant treatment under a specific consultant. If a patient is transferred from one consultant to another it will be counted as two FCEs.

General medicine The branch of medicine that is concerned with a variety of medical disorders.

General surgery The branch of surgery (involving an operation) which covers a broad range of conditions which are not handed by specialists (for example cardiologist (heart) and urologist (prostate, bladder and kidney).)

Governance Assessment, control, monitoring.

Health authority (HA) Statutory NHS body responsible for assessing the health needs of the local population, commissioning health services to meet those needs and working with other organisations to build healthy local communities.

Health community or health economy All NHS organisations in one area, also including the community health councils, and voluntary and statutory organisations with an interest in health.

ICU/ITU See intensive care.

IM&T Information management and technology.

Incident reporting system A system which requires clinical staff to report all matters relating to patient care where there has been a special problem.

Incidents Something which has happened that is out of the ordinary which may be harmful to patients.

Independent review This is stage two of the formal NHS complaints procedure. It consists of a panel, usually with three members, who look at the issues surrounding a complaint.

Infection control A set of procedures to prevent the spread of infection. This will include washing of hands, use of sterile equipment etc.

Inpatient A patient who stays overnight in hospital.

Integrated care pathway See care pathway above.

Intensive care Treatment and care for the sickest patients, usually carried out in a special ward called the intensive care or therapy unit - the ICU or ITU.

Intervention A treatment given to a patient by a health care professional.

Investors in People Investors in People is a national quality standard which sets a level of good practice for improving an organisation's performance through its people.

IPR Individual performance review - a, usually, annual process to look at staff performance against previously agreed objectives.

Lay member A person from outside the NHS who brings an independent voice to CHI's work.

Locum A temporary doctor who stands in for the permanent doctor.

Medical The branches of medicine concerned with treatment through careful use of drugs as opposed to (surgical) operations.

Medical admissions unit An area where patients can go after they have been admitted via A&E which allows the patient's assessment and treatment to begin immediately. Patients may be discharged directly from an admissions unit, or may be transferred to a ward for longer-term care (i.e. usually more than a day).

Medical director The term usually used for a doctor at trust board level (a statutory post) responsible for all issues relating to doctors and medical and surgical issues throughout the trust.

Mortality rate The number of deaths in a given period and for a given size of population.

Multidisciplinary A group of health care workers who are members of different disciplines.

National data set A standard set of data items (statistical evidence), concepts and definitions to enable the production of national and nationally comparable data.

National indicators Statistics recorded by the Department of Health on a range of specific treatments to allow comparison and measurement of NHS organisations.

National targets A nationally agreed target that all NHS organisations must achieve. It includes waiting times for appointments.

NCEPOD or CEPOD The national confidential enquiry into peri-operative deaths. The NCEPOD is concerned with maintaining high standards of clinical practice in anaesthesia and surgery, through audit of hospital deaths which occur within 30 days of any operation. This activity has resulted in the production of guidance for NHS hospitals about how to run some elements of surgical practice (e.g. the provision of adequate facilities out of hours). Generally, hospitals are expected to comply with these standards.

Neurology The branch of medicine concerned with medical treatment of disorders of the nervous system.

Neurosciences All branches of medicine concerned with disorders of the nervous system.

NHS Regional Office, NHSE There are eight regional offices of the NHS executive in England. They are responsible for the strategic management of the NHS and monitor the performance of health authorities, trusts and primary care trusts. They are part of the Department of Health and the people who work there are civil servants.

NHS Trust A self governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.
Acute trust -provides medical and surgical services usually in hospital.
Community trust - provides local health services, usually in the community, e.g. district nurses, chiropodists etc.
Combined trust - community and acute trust services under one management.
Primary care trust - new organisations that will be able to provide care usually available from general practitioners and their teams.

NICE National Institute of Clinical Excellence.

Nursing director or chief nurse or chief nursing officer The term usually used for a nurse at trust board level responsible for the professional lead on all issues relating to nurses and nursing throughout the trust.

Outcome All the possible results that may occur from a treatment, service or prevention programme.

Outcomes of patient care The end result of a patient's treatment (can be interpreted widely or narrowly).

Outpatient Services provided for patients who do not stay overnight in hospital.

Paediatric services Medical services for children.

PAS Patient Administration System - a networked information system used in NHS Trusts to record information about inpatient and outpatient activity.

Patient centred care A system of care or treatment is organised around the needs of the patient.

Patient diaries The organisation being reviewed by CHI randomly selects patients who have been treated over the past two months. Diaries are sent to them to complete about the care they received. The patient returns the completed diary to CHI.

Patient involvement The amount of participation that a patient (or patients) can have in their care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

Patient pathway or journey See care pathway above.

performance indicators Nationally agreed measures to indicate how well an organisation is performing.

Performance monitoring A permanent, on-going system which records how a particular service or procedure is carried out and how well it meets targets or standards.

Peri operative Literally, "around the time of the operation". In the context of a CEPOD-defined peri operative death, this occurs within the period of 30 days after an operation, including the operation day.

Primary care Family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Primary care groups (PCG) Group of GPs, nurses and other health professionals working together to improve the health of local people, develop primary and community services and to contract secondary care. Primary care groups are formally constituted sub committees of the health authority.

Primary care trust (PCT) Primary care trusts are evolving from primary care groups. They will have the same functions as primary care groups but will also commission some secondary health care services for their population and directly provide some community health services.

Profession allied to medicine (PAM) (allied health professional) A trained health care professional - therapists (physiotherapist, occupational, speech & language) chiropodist, dietician, psychologies, pharmacist etc.

Qualitative Data that cannot be expressed using numbers such as interview statements, diagrams or documents.

Quantitative Data which can be measured in terms of numbers.

Readmission rates The rate at which patients have to go back to hospital as inpatients for treatment related to a recent admission for the same condition.

Regional office See NHS regional office above.

Resuscitation A range of procedures used when someone has suddenly become seriously ill in a way that threatens their life.

Review team A group of about six people from a range of backgrounds who conduct the review visit.

Risk assessment An examination of the risks associated with a particular service or procedure.

Stakeholders This term is used to cover a whole range of people and organisations that are affected by, or have an interest in, the services offered by the organisation. It includes patients, carers, staff, unions, voluntary organisations, community health councils, social services, health authority, GPs, primary care groups and trusts in England, local health groups in Wales.

Trauma A powerful shock, injury or wound to the body that may have long lasting effects.

Trauma service A service that provides care for the treatment. of injuries. Often associated with accident and emergency departments, and sometimes linked to orthopaedics.

Trust board A group of about 12 people who are responsible for major strategy and policy decisions in each NHS trust. Typically comprises a lay chairman, five lay members, the trust chief executive and directors.

Waiting lists The number of people waiting for a planned procedure at an acute or community hospital.

Report of a clinical governance review at **The University Hospitals Coventry and Warwickshire NHS Trust – September 2001**