

HEALTH & WELLBEING BOARD

AGENDA

Wednesday January 8 2014
1.30 pm – 3.30 pm

Committee Room 2, Town Hall

1. **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

2. **APOLOGIES FOR ABSENCE**

(If any) – receive

3. **DISCLOSURE OF PECUNIARY INTERESTS**

Members are invited to disclose any pecuniary interest in any of the items on the agenda at this point of the meeting. Members may still disclose any pecuniary interest in any item at any time prior to the consideration of the matter.

4. **BHRUT - CQC INSPECTION AND SPECIAL MEASURES REPORTS**

Discussion.

5. **SAFEGUARDING UPDATE**

Verbal update presented by Joy Hollister.

6. **INTERIM REPORT ON CHILDHOOD OBESITY**

Presented by Elaine Greenway.

7. **JSNA DEMOGRAPHICS CHAPTER**

The Board are asked to endorse the JSNA Demographics chapter.

8. **ASSISTED TECHNOLOGIES**

Presented by John Green.

9. **UPDATE ON SEN BILL**

Report by Joy Hollister. Presented by Mary Pattinson.

10. **REPORT ON JOINT ASSESSMENT AND DISCHARGE**

Written report by Barbara Nicholls.

11. **DATE OF NEXT MEETING**

Members of the Board are asked to note that there will be a special HWB meeting on January 29 2014 at 1.30 pm.

Barking, Havering and Redbridge University Hospitals NHS Trust

Quality report

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Essex, RM7 0AG
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Date of inspection visit: 14–17 October 2013
Date of publication: December 2013

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

Overall summary

Barking, Havering and Redbridge University Hospitals NHS Trust (the trust) is a large provider of acute services, serving a population of over 750,000 in outer North East London.

The trust has two acute hospitals: Queen's Hospital and King George Hospital. Accident and emergency (A&E) departments operate from both of these hospitals. King George Hospital was built in 1993 and is the main hospital for Barking and Dagenham and Redbridge. Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for Havering.

The trust covers three local authorities: Barking and Dagenham which has very high levels of deprivation, and Havering and Redbridge which are closer to the national average. Havering has a relatively elderly population by London standards.

The purpose of this report is to describe our judgment of the leadership of the trust and its ability to deliver safe, effective, caring, responsive and well led services at each of its locations. Our judgment will refer to key findings at each location, for a more detailed understanding of the hospital findings please refer to the relevant location report.

The trust was included in the first wave of the new CQC hospital inspection programme, as it had been shown to be at 'high risk' on several indicators in the new Intelligent Monitoring tool. Over recent years the trust has faced significant financial challenges and has been a persistent outlier on some key quality of care indicators, including:

- Poor results on the CQC inpatient survey and on the cancer patient experience survey.
- Achievement of the four-hour accident and emergency waiting time standard.
- Poor results on the national staff survey.
- High weekend mortality in some areas.
- Non-compliance with regulations recorded on several CQC inspections since it was registered especially in the A&E departments.

The latest NHS staff survey shows encouraging improvement in key areas, for example, the number of staff having appraisals and staff feeling satisfied with the quality of work and patient care they are able to deliver.

The trust has demonstrated that it can bring about significant changes as in the maternity services which have undergone a huge transformation over the last two years. More importantly they have been able to maintain the improvements.

Summary of findings

Overall summary (continued)

The trust has undergone significant change in recent years and previous cost improvement programmes have significantly reduced key corporate functions such as HR and governance departments. The trust also has a history of frequent changes at executive level which has impacted on its ability to rapidly deliver improvements to quality and safety.

The trust Board is now entering a period of improved stability and is starting to work together as a team to address longstanding significant problems. However many initiatives to improve quality and safety have only started very recently and it is too early to tell if they will deliver the required improvements quickly. Information about patient quality of care and patient safety is reported at trust Board meetings and they are aware of many of the issues highlighted in these reports. There have been attempts to address the problems, particularly in the A&E departments, but they have had little success.

The Chief Operating Officer with support from some senior medical staff is now trying to address these challenges, but progress has been slow mainly due to a lack of engagement and support from all senior clinical staff. The longstanding history of the problems and lack of progress indicates that the leadership is inadequate to address the scale of the challenges that the trust is facing and additional support is required.

The trust must ensure the following actions are taken to improve:

- Ensure the Chief Operating Officer has clinical and management support to deliver improvements to patient safety and quality. The improvement plan should be agreed at Board level with progress monitored at each Board meeting.
- Ownership for improvement must be embedded at every level of the trust and the visibility of the Executive Team at Queens Hospital and King George Hospital must be improved.
- The trust needs to urgently focus on resolving problems in the A&E departments of King George and Queen's Hospitals which are resulting in unsafe care. A clear and unambiguous protocol must be put in place for the transfer of patients between trust locations. All care must be documented.
- The trust must also address its discharge planning and patient flow problems which will require improved working with local partners.
- Infection control procedures must be implemented consistently in every ward and theatre across the trust.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Many of the services are safe but require some improvements to maintain the safety of patient care. The A&E departments are at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with long waiting times for patients to be assessed to be assessed by specialist doctors.

Are services effective?

The trust had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in medicine, end of life care and outpatients. Effective care in the A&E departments is hampered by long waiting times for patients to be seen by a specialist.

Are services caring?

National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. Significant work has been undertaken to improve patient care and many patients and relatives were complimentary about the care they received and the way staff spoke with them. We observed that staff treated patients with dignity and respect. However, more work is required to improve care in the end of life service and ensure improvements in patient care in all services is reflected in national patient surveys.

Are services responsive to people's needs?

The longstanding problem of waiting times in the A&E department at Queen's Hospital has not been addressed. Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments. A lack of effective partnership working with other health and social care partners has contributed to the problems.

Are services well-led?

We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. The trust Executive Team need to be more visible and greater focus is needed at Board level to resolve longstanding quality and patient safety issues.

Summary of findings

What people who use the hospital say

The trust scored low overall on the Friends and Family Test, especially in A&E and Gastroenterology (Clementine B ward). The results over the last four months place the trust in the bottom 10 trusts nationally for the A&E component of the Friends and Family Test.

The key themes in complaints from patient surveys included a lack of privacy, respect, information on discharge, cleanliness, delays in care, positive staff and

nurse attitude, and patient included in care decisions. These views were voiced across the CQC's Adult Inpatient Survey 2012, Cancer Patient Experience Survey, National Bereavement Survey 2011, Patient Opinion, Share Your Experiences, and NHS Choices. In contrast, the trust scored 'Good' or 'Excellent' on the Patient Environment Action Team assessment in privacy, food and environment.

Areas for improvement

Areas where the hospital MUST improve:

- Ensure the Chief Operating Officer has appropriate management support to deliver improvements to patient safety and quality. The improvement plan should be agreed at Board level with progress monitored at each Board meeting.
- Ownership for improvement must be embedded at every level of the trust and the visibility of the Executive Team at Queens Hospital and King George Hospital must be improved.
- The trust needs to urgently focus on resolving problems in the A&E departments of King George and Queens Hospitals which are resulting in unsafe care. Specialist doctors must attend patients in the A&E department within the agreed timescales outlined in the trust's policy.
- A clear and unambiguous protocol must be put in place for the transfer of patients between trust locations. All care must be documented.
- The trust must also address its discharge planning and patient flow problems which will require improved working with local partners.
- Infection control procedures must be implemented consistently in every ward and theatre across the trust.

Good practice

Our inspection team highlighted the following areas of good practice within the hospital:

- The e-handover system in the medical services which allows doctors to manage their workload more effectively.
- Patients were positive about the care they received from staff, many of whom were positive about working for the trust.
- The virtual ward which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- The inspection team was impressed with the care provided to patients who have had a stroke, with the trust performing well against a number of data indicators and was in the first (highest) quartile of all units.

Are services safe?

Summary of findings

Many of the services are safe but require some improvements to maintain their safety. The A&E departments are at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with long waiting times for patients to be assessed and reassessed. Delays in specialist doctors seeing patients in the A&E departments are also impacting on patient safety.

Our findings

Incident reporting/never events

An electronic incident reporting system is in place and incidents are monitored and investigated by ward managers or matrons. Learning was shared through a range of mechanisms: intranet, email and weekly ward/unit meetings, although we were told these did not always take place.

Corporate risk management processes are in place and managers at directorate level are aware of and use risk registers and risk assessments. However more needs to be done to improve understanding of risk as documents reviewed, alongside interviews with staff (managers and Board members) identified.

- Risks are not always clearly defined.
- More needs to be done regarding identifying and recording assurance and control processes on the corporate risk register.
- Quality Impact Assessments of CIPs is in place but lack clearly identified metrics that could be used to monitor whether an identified risk was in fact coming to fruition.

Pre-inspection information showed maternity services accounted for 36 (23%) of the serious incidents reported and 22 of these were classified as 'unplanned admissions of term babies'. The service has carried out an analysis of the number of unplanned admissions and identified cases which represented avoidable harm. The review concluded that the cases of avoidable harm were a small percentage of the overall admissions. Each case has been reviewed and action taken.

Between August 2012 and September 2013 the trust had three never events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken).

Two of these were in maternity and involved swabs being retained inside patients and one was an incidence of wrong site surgery in ophthalmology. The trust has taken action to address the issues and, although never events are not acceptable and trust has not reported more or less incidents than other trusts of a similar size.

To minimise the occurrence of never events, the trust is using the World Health Organisation (WHO) safety checklist in theatres, which is regularly audited.

Cleanliness and infection prevention and control

The trust has improved its arrangements for the prevention and management of infection control. In the 2012 Department of Health NHS Staff Survey, only 52% of staff who responded said that hand-washing materials were always available, which was worse than expected. The trust responded to this by installing hand-washing facilities at the entrance to clinical areas. During our inspection we observed staff washing their hands and that gloves and aprons were available although at times were not used by all staff.

The trust has set its own targets of zero cases of meticillin-resistant staphylococcus aureus (MRSA) and 40 for *Clostridium difficile* (*C. difficile*). Between July 2012 and June 2013 the number of reported patients with *C. difficile* was 56, significantly lower than the expected number of cases taking into account the size of the trust and the number of cases reported nationally. Similarly, the number of patients with MRSA reported during the same period (nine) is within an acceptable range.

All the wards we visited were clean but in the theatres at King George Hospital we observed some poor practice related to staff not washing their hands as required and not using stickers to show when equipment had been cleaned as per trust policy. Some equipment was quite dusty.

Staffing

The trust is aware that staffing is an area for improvement. There are vacancies across many staff groups and recruitment is underway. In the meantime bank and agency staff are used to fill vacancies on shifts, although there were times when they were unavailable.

Are services safe?

The trust faces significant difficulties in recruiting medical staff for A&E, and has done since 2011. The College of Emergency Medicine recommends that, for the number of patients seen in the A&E at Queen's Hospital, it should have 16 consultants to provide cover 16 hours a day, seven days a week. The trust has eight consultants in post out of an establishment of 21 to cover both A&E departments at Queen's and King George Hospitals. The heavy reliance on locum staff is putting patients at risk of receiving suboptimal care. Joint work with other trusts has not achieved the desired results and additional work is underway, including recruiting staff from overseas.

Induction for locum and agency staff is variable and sometimes consisted of being shown around the ward.

Some staff told us there were adequate staff to meet patients' need while others felt staffing levels were at a minimum and unplanned absences were difficult to manage. We did not see any examples of patients not having their needs met through lack of staff. Although staff were able to meet patients' needs, they did not have sufficient time to complete patient records of care. This was a common issue across both medical and surgical wards and both hospitals.

Patients attending the outpatient clinics did not always see their named doctor due to clinics being cancelled when the consultant did not arrive due to other planned activities or leave was required at short notice.

Documentation

Nursing staff at both hospitals were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen's and King George Hospitals with transfer checklists not always completed which meant staff may not be aware of a patient's needs – as in the case of one patient who had diabetes which was not recorded. Staff told us they did not have time to always complete the "paperwork" but knew their patients and the care they required.

Environment

We found problems with the environment in the theatres at King George: the corridors were cluttered with trolleys and equipment due to a lack of available storage space.

The sexual health clinic location at Queen's was unsuitable as the area was not big enough to accommodate patients and staff. Patients had to wait in a narrow corridor used by other staff to transfer medical records on trolleys. The environment did not enable patients to have private consultations, and outpatients frequently had to wait in corridors. Staff, including the General Manager and a consultant, had expressed their concerns, but told us nothing had been done. The clinic also used a former storage cupboard as a treatment room. No review of the decision to move the sexual health clinic was recorded.

Safeguarding vulnerable adults and protecting children

Staff had received training on safeguarding vulnerable adults and child protection. They understood the policies and processes and knew what action to take if they needed to raise an alert. The trust had a safeguarding team if staff needed support.

Are services effective?

(for example, treatment is effective)

Summary of findings

The trust had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in medicine, end of life care and outpatients. Effective care in the A&E departments is hampered by long waiting times for patients to be seen by a specialist.

Our findings

Mortality rates

The trust's clinical staff can access mortality rate information. Each clinical department has access to a specific data review system which provides an early warning of outlier status. The information is included in the department's 'dashboards' (performance reporting and tracking system) and is reported to the Quality and Safety Committee.

The trust was identified as having higher-than-average mortality rates for patients with pneumonia, septicaemia and most cancers and reviews have been carried out. In June 2013, information showed that elective patients who were admitted over the weekend were at a higher risk than those admitted during the week. Actions to improve this include implementation of seven-day working for senior clinical staff, including the critical care outreach service, and better availability of specialist consultant support.

Past CQC inspections noted the trust has received two mortality alerts from the Care Quality Commission (CQC) for Septicaemia Shunting for hydrocephalus procedures and Septicaemia (except in labour). The trust carried out a case note review for the first alert and found "no obvious deficits of clinical or operative quality" and the case has been closed. The second case is currently being reviewed.

NHS Safety Thermometer

The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm: falls, pressure ulcers, catheter related urinary infections and assessment and treatment of venous thromboembolism (VTE). The trust is performing well and has achieved the required target (for May, June and July 2013) for 95% of patients to be free from these areas of harm.

National guidelines

Implementation and monitoring of national guidelines varied. We found a number of services were using national guidelines. The ITUs were providing care in line with national guidelines and submitting data to the Intensive Care National Audit & Research Centre (ICNARC) on outcomes for people using critical care services to monitor its performance compared to others nationally. The data showed that the number of deaths for critical care services at Queen's Hospital was within the expected range and at King George Hospital the number of deaths was lower than expected. In maternity services, women received care according to best practice clinical guidelines.

Prior to the visit we reviewed the log recording the trust's implementation of National Institute for Health and Care Excellence (NICE) guidelines. A number were recorded as "partial compliance" or "awaiting response". The trust's process for ensuring that NICE guidelines were implemented was unclear. The cardiology ward at the King George Hospital had a range of protocols and guidelines for the admission and management of cardiology patients.

Clinical audits

The trust participated in some local and national audits and demonstrated changes as a result, such as recruiting additional bowel cancer specialist nurses. It was noted at the Quality and Safety Committee in August 2013 that the Clinical Audit Committee was "struggling with Directorate engagement" and the committee was due to be reviewed with an audit plan completed by October 2013.

Are services caring?

Summary of findings

Significant work has been undertaken to improve the culture and morale among staff and this has had a positive effect on the patient experience. Many patients and relatives were complimentary about the care they received and the way staff spoke with them. We observed that staff treated patients with dignity and respect. Work needs to continue to ensure that improvements are reflected in future national inpatient surveys.

Our findings

The trust has performed poorly in a range of surveys about people's experience of inpatient care, cancer care and care in the A&E department. Although results improved since 2011, in the CQC's 2012 Adult Inpatient Survey, the trust scored 'worse than other trusts' in six of the 10 areas of questioning, and 'within the expected range' for the remaining four.

The trust also performed badly in the 2012/2013 Cancer Patient Experience Survey and was rated as being in the worst 20% of all trusts nationally for two-thirds of the questions (42 out of 63).

Staff attitude

We saw many examples of staff delivering care in a kind, compassionate manner and most patients felt they were listened to and involved in discussions about their care. Staff were sensitive when giving difficult news to relatives and gave them the privacy and time they needed. Women in the maternity and children's services were positive about the care they received. People used words such as "marvellous" and said "nothing is too much trouble for them".

Involving patients in their care

Many patients said they felt they had been involved in decisions about their care, and staff allowed them time to ask questions. They were satisfied with the level of information they had been given and the next stages of their treatment had been explained to them. In maternity services, women felt involved in developing their birth plans, their partners were made to feel welcome, and they had sufficient information to enable them to make choices about their care and treatment during labour.

Privacy and dignity

Staff maintained people's privacy and dignity by drawing curtains when they were providing personal care. Wards were divided into single-sex bays with bathroom facilities. In the ITUs there was enough space between each bed to allow some degree of privacy. The oncology wards at Queen's Hospital had relative rooms so families could have privacy (although this was not always available in other wards). The palliative care team tried to ensure that all patients on the end of life care pathways were cared for in side rooms.

Nutrition

In the annual Patient Environment Action Team (PEAT) assessment, the trust had scored 'excellent' for food. When patients were admitted, their risk of malnutrition was assessed. The trust had a protected meal times policy and patients who needed assistance received their food on a red tray to ensure staff were aware. We observed staff providing support to patients with their meals as needed and monitoring their fluid intake. Following feedback from patients, the trust had reintroduced hot meals in the evening.

Are services responsive to people's needs?

(for example, to feedback)

Summary of findings

The longstanding problem of waiting times in the A&E department at Queen's Hospital has not been addressed. The trust has not worked as effectively as it could with partner organisations such as the local authority to address these issues to resolve discharge planning and patient flow.

Our findings

The trust's bed occupancy exceeds the national average and at times is at a level that is detrimental to patient care. Between April and June 2013 it was 97% while the national average is 86.5%. Once bed occupancy rates rise above 85%, quality of patient care can be affected.

Waiting times

Data shows that patients often waited more than four hours to be admitted to Queen's Hospital. These delays mean that patients were more likely to have poor outcomes. We also found delays in discharging patients from the ITUs at both hospitals. Between April 2012 and April 2013, 50% of patients experienced a delayed discharge from the ITU and 64 patients were transferred to other hospitals for non-clinical reasons. While these figures were within accepted ranges compared to other units nationally, there were impacts on those who needed access to the service. Medical staff described the situation as "frustrating".

Discharge

At Queen's Hospital on occasion patients having day case surgery had to be nursed in and discharged from the recovery area rather than a ward due to bed shortages. The environment was not designed to accommodate patients who should be cared for on a ward. There was a lack of privacy, insufficient bathroom facilities and patients were served food while others were coming round from their anaesthetic.

Elsewhere in the hospital we were told about delays in patients being discharged. Staff attributed some of this to care packages not being in place, doctors not completing discharge summaries 24 hours in advance and delays in getting medicines for people to take home. Pharmacists told us that they were often informed late in the discharge process which meant medicines weren't ready until late in the afternoon.

Senior nurses had attended training to introduce nurse-led discharge but, as yet, this had not been implemented.

Cancelled operations

Although the trust is performing as expected in relation to cancelled operations, some day-case patients had their surgery cancelled two or three times. All seven people on the day-case list for 17 October 2013 at Queen's Hospital had had their procedure cancelled previously, one to two weeks prior to admission date to accommodate more urgent cancer cases.

Outpatient appointments

Sufficient time was allocated for consultations in the outpatient clinic but this was sometimes reduced due to clinics being delayed or over booked. Appointments were delayed between 50 and 90 minutes. Some of the delays were due to consultants carrying out scheduled ward rounds or other duties at the same time. Other issues included cancelled appointments, missing notes and patients either not receiving or having multiple appointment letters. Complaints about the appointments process and missed appointments were discussed at the trust Board in July 2013 when it was noted that some people only had three days' notice that their appointment had been cancelled. The trust is aware of the problems and has started to take action, but progress is slow.

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

Seven-day working

The trust is in the process of introducing seven-day working to improve patient outcomes by allowing for senior medical review and discharge of patients seven days per week. This needs to be done in partnership with other organisations within the health and social care economy. Although this work is in the early stages in many areas, the Care of the Elderly department is making good progress and providing consultant cover from 9am to 8pm, seven days per week.

Complaints/patient feedback

The trust uses the Friends and Family survey to gather feedback on patients' experience and this is discussed at ward meetings.

In terms of complaints, the trust target for responding to complainants within the agreed timeframe (these are based on the complexity and severity of the complaint and range from 10 days to 80 days) in July 2013 was 85% and the trust achieved 82%. Of the 11 departments, seven achieved the trust target with six achieving 100% response rate. Directorates that did not meet the trust target were Emergency Care, Acute Medicine and Surgery.

The trust was aware that between 15 and 20% of responses did not answer the questions raised in the complainant's original letter and has put a system in place for members of the executive team to check the responses before they are sent out. Work is also being done with managers and clinical staff on how to conduct a thorough investigation and put together a good written response.

Complaints reports are submitted to the trust's Quality and Safety Committee and the Board.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Summary of findings

We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. The trust Executive Team need to be more visible and greater focus is needed at Board level to resolve longstanding and significant quality and patient safety issues.

Our findings

Leadership

The latest NHS staff survey shows encouraging improvement in a number of key findings, including the number of staff feeling able to contribute towards improvements, levels of staff motivation and the number of staff willing to recommend the trust as a place to work or receive treatment. We found that much of this was reflected during our visit.

The 2012 General Medical Council's National Training Survey found the trust performed below the expected range in six areas and better than expected in one area: Emergency Medicine. Junior doctors we met with during the inspection felt that consultant cover and support, along with training, was good but identified staffing levels and the general busyness of the trust as an issue. The number of locums they worked with had an impact on the continuity of care.

Senior nursing and medical staff cover services across both Queen's and King George Hospitals and visit them during the week. A few staff had mixed views about how much attention King George received with some feeling there was more focus on Queen's Hospital.

Senior staff told us that engagement of clinical staff was good, but still in the early stages. They were concerned about further changes at executive level as it "perpetuates the belief that the executive team come and go" so there is little value in engaging in any changes. This was supported by other staff who said "don't change the executive team"

The executive is still coming together as a team and learning how to work effectively. They are aware, along with senior managers and clinicians of the high workload and bed occupancy. They are having difficulties managing the demand on services and transferring and discharging patients, particularly in medical services, in a timely manner. Decision making among senior clinicians and engagement also needs to be improved. Alongside this, plans were being put in place to reconfigure services from King George Hospital to the Queen's Hospital.

Given the scale of the problems and the fact that they are still developing as Board their resource and capability is inadequate in relation to the scale of the problems they face. Additional support will be required to bring about the necessary improvements.

Monitoring quality

The Quality and Safety Committee is the overarching governance committee which all other clinical governance committees report to. This committee, along with the Audit Committee, reports to the trust Board. Many of the problems highlighted in this report have been reported at governance meetings. The trust is aware that it needs to strengthen its committee and governance arrangements and is developing a Quality Strategy which incorporates the findings from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Report) and the NHS Operating Framework which will outline the governance work and direction of travel for the trust until 2018.

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Barking, Havering and Redbridge University Hospitals NHS Trust

King George Hospital

Quality report

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Telephone: 020 8983 8000
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Date of inspection visit: 14–17 October 2013
Date of publication: December 2013

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

Overall summary

Barking, Havering and Redbridge University Hospitals NHS Trust (the trust) is a large provider of acute services, serving a population of over 750,000 in outer North East London the trust has two acute hospitals: Queen's Hospital and King George Hospital. Accident and emergency (A&E) departments operate from both of these hospitals Victoria Centre and Barking Hospital are the other sites. It also provides services from the Victoria Centre and Barking Hospital but does not manage them. King George Hospital was built in 1993 and is the main hospital for Barking and Redbridge. Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for Havering, Dagenham and Brentwood. There are plans to reconfigure services from King George Hospital to Queen's Hospital. The trust covers three local authorities; Barking and Dagenham which has very high levels of deprivation, and Havering and Redbridge which are closer to the national average. Havering has a relatively elderly population by London standards.

This report relates to King George Hospital and there is a separate report for the overall trust.

The findings of the inspection team identified the following areas for improvement:

- The accident and emergency department does not provide safe care all of the time. There is a lack of senior medical staff supported by middle and junior grade doctors, and an over-reliance on locum doctors. Medical staff from other specialities are not reviewing patients within the agreed timescales and are not doing enough to relieve the burden on A&E staff. Patient flow through the trust is poor from when they attend A&E through the Acute Medical Unit and medical wards requires improvement.
- We could not be assured that patients always received safe and effective care on surgical wards, and medical wards. The completion of nursing documentation was inconsistent and if patients were transferred to King George Hospital there were no documented handovers. Delayed discharges and high occupancy rates meant that the service could not be as responsive as required and this put unnecessary pressure on departments and increased the risk of poor outcomes for patients.
- Some aspects of end of life care also need to be improved.
- Administration in the outpatients department is very poor which impacts adversely on patient care.

The maternity and children's care services were good, with no significant areas requiring improvement.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

The A&E department is at times unsafe because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors with on some occasions long waiting times for patients.

Are services effective?

The hospital had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in some of the services we visited. Effective care in the A&E department is hampered by long waiting times for patients to be seen by a specialist.

Are services caring?

National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. Many patients and relatives were complimentary about the care they received and the way staff spoke with them. However, some aspects of the care provided by the end of life need to be improved.

More work is required to ensure that improvements in care provided by all services is reflected in future national inpatients surveys.

Are services responsive to people's needs?

Overall the hospital needs to improve its responsiveness to patients' needs. Although there are some external factors which affect the movement of patients, more work needs to be done to improve discharge planning.

Are services well-led?

Overall the hospital needs to improve its responsiveness to patients' needs. Although there are some external factors which affect the movement of patients, more work needs to be done to improve discharge planning.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The A&E department did not provide safe care all of the time. There is a lack of senior medical staff supported by middle and junior grade doctors at nights and weekends.

Overall we found staff to be caring and people were positive about their experience. The department was responsive and patients were treated appropriately to their needs although some specialities took too long to attend A&E to see patients.

There was good clinical leadership within A&E and staff felt supported by the senior doctors and nurses. However, staff did not have confidence in the trust leadership to make the necessary improvements in A&E.

Medical care (including older people's care)

We found that the service was caring with appropriate staffing levels and skill mix. Most patients told us they felt that staff had been very supportive. However, information about patients' care and treatment was inconsistently recorded. When we looked at patient records we found examples where discharge summaries had not been completed.

Some members of staff were unaware of how to recognise and respond to a patient who had sepsis (blood poisoning). All of the wards we visited were clean and well maintained. We found that staff had access to all the equipment that they required.

Surgery

The Inspection Team could not be assured that patients always received safe care. Nursing documentation was inconsistent and people were put at risk of infection in theatres due to inadequate cleaning and poor practices by staff. Where patients had been transferred from Queen's Hospital, there was no documented handover and staff were not always aware of a patient's medical history.

Delayed discharges and high bed occupancy rates meant that the service could not be as responsive as required. Staff opinion varied on whether the service was well-led. Regular meetings took place to monitor aspects of the service, but, due to the discrepancies we found, we could not be assured that all auditing activity was effective.

Patients told us staff were caring and they felt their needs had been met.

Intensive/critical care

The patients we spoke to in intensive care, and their relatives, felt that they had been well cared for and involved in making decisions about their treatment.

The service was well-led by a team who had identified the risks and challenges the service faced and were monitoring them. However, there was a lack of patient flow in and out of the service due to delayed discharges and high bed occupancy. This affected the service's ability to provide responsive and effective care to all patients requiring intensive care. Once admitted to the intensive care unit patients received safe and effective care from caring, qualified staff.

Maternity and family planning

Maternity and family planning services were safe and effective. Patients reported that midwives were caring and responsive and staff were positive about the service they provided.

Systems were in place for reporting and reviewing incidents to ensure that appropriate action was taken. Midwives used comments and complaints to improve women's experiences of care and had responded proactively to these.

Summary of findings

What we found about each of the main services in the hospital continued

Children's care

Children's care services were safe and caring and patients and parents reported that staff were responsive to their needs. Parents said nurses were very caring and kind, and responded well to their children's needs. They considered that children had received safe and effective treatment and said staff were knowledgeable and helpful. Staff engaged positively with children of different ages and involved them in their care. The facilities for children were good and there was a well-equipped children's play area.

Performance information, and comments and complaints were used to improve the service.

End of life care

Patients received safe and effective end of life care. They had support to make decisions and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patient records for end of life care were completed in a timely fashion. However, patients and families had negative views about some aspects of the end of life care service. Also discharges were not as fast as required due to the length of time taken to complete the referral form.

Outpatients

The outpatient service did not always provide safe and appropriate care. There were instances where patients did not see the correct clinician to deal with their treatment, in some cases because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Most patients found the staff caring, but care was not always responsive. Patients received treatment and follow-up appointments. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed although some patients felt they were not kept informed. Some clinics were not managed efficiently and areas of the service needed to improve. The service had a high number of patients who did not attend their appointment and there were a high number of cancelled and delayed clinics.

Summary of findings

What people who use the hospital say

The trust scored low overall on the Friends and Family Test, especially in accident and emergency.

The trust scored 19 in the July A&E Friends and Family Test with a response rate of 10.2%. Scores over the last four months have ranged from 12 in April and 21 in June,

results which place Barking, Havering & Redbridge in the bottom ten trusts nationally for this component of the test. However, these results should be treated with caution due to the low response rate for the A&E section of the test.

Areas for improvement

Areas where the hospital **MUST** improve:

- Waiting times in the A&E department must be reduced
- Increased number of permanent senior medical staff in the A&E department
- The care provided in the medical, surgical care services and end of life service
- The management of sepsis
- Discharge planning and movement of patients through the hospital to ensure patients are cared for on the appropriate wards and clinical areas and discharged when they are well enough.
- Management of the appointment times in some of the outpatient clinics
- Documentation relating to patient care.
- Sharing information to monitor performance and quality of care
- Cleanliness and infection control in operating theatres
- Job planning for consultants to enable them time to travel between the two hospitals and attend ward rounds and outpatient clinics

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice within the hospital:

- The e-handover system in the medical services which allows doctors to manage their workload more effectively.
- Patients were positive about the care they received from staff, many of whom were positive about working for the trust.
- The virtual ward which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.

King George Hospital

Detailed findings

Services we looked at: Accident and emergency (A&E), Medical Care (including older people), Surgery, Intensive/Critical Care, Maternity, Paediatrics/Children's Care, End of Life Care, Outpatient Services

Our inspection team

Our inspection team was chaired by the Chief Inspector of Hospitals and included a range of specialists: consultant surgeon, consultant haematologist/medical director, junior doctor, senior nurses and a student nurse, midwives, a hospital manager, patients and members of the public.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are introducing our new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care according to our new surveillance model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Barking, Havering and Redbridge University Hospitals NHS Trust was considered to be a high-risk service.

How we carried out this inspection

Prior to the visit we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit from 14–17 October 2013. During the visit we held focus groups with a range of staff in the hospital, nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the trust.

Are services safe?

Summary of findings

The majority of the services we visited were safe but improvements are needed to maintain safety. Insufficient numbers of full-time, permanent medical staff King George Hospitals means that, on occasion, the A&E service is unsafe. The hospital has tried to mitigate some of the risk by employing locum and agency staff but, at times, locums who are new to the trust may be the most senior doctor in the department. This places significant pressure on them and other staff and increases the risk of patients receiving suboptimal care.

There were vacancies in most departments and many wards relied on bank nurses (staff who work in the trust as overtime), agency nurses and locum medical staff who, on occasions, were unavailable.

The hospital is finding it difficult to recruit staff due to national shortages in some specialties and its reputation acquired through negative media reporting of past CQC inspection findings.

Arrangements to minimise risks to patients are in place, including incident reporting, infection prevention and control, child protection and safeguarding vulnerable adults, but some areas, such as the environment and nursing documentation, need to be improved.

Our findings

Incident reporting/never events

An electronic incident reporting system is in place and incidents are monitored and investigated by ward managers or matrons. Learning was shared through a range of mechanisms: intranet, email and weekly ward/unit meetings, although we were told these did not always take place.

To minimise the occurrence of never events, the hospital is using the World Health Organization (WHO) safety checklist in theatres, which is regularly audited.

Cleanliness and infection prevention and control

The trust has improved its arrangements for the prevention and management of infection control. In the 2012 Department of Health NHS Staff Survey, only 52% of staff who responded said that hand-washing materials were always available, which was worse than expected. The trust responded to this by installing hand-washing facilities at the entrance to clinical areas. During our inspection we observed staff washing their hands and that gloves and aprons were available although at times were not used by all staff.

The trust has set its own targets of zero cases of meticillin-resistant staphylococcus aureus (MRSA) and 40 for *Clostridium difficile* (*C. difficile*). Between July 2012 and June 2013 the number of reported patients with *C. difficile* was 56, significantly lower than the expected number of cases taking into account the size of the trust and the number of cases reported nationally. Similarly, the number of patients with MRSA reported during the same period (9) is within an acceptable range.

All the wards we visited were clean but in the theatres we observed some poor practice related to staff not washing their hands as required and not using stickers to show when equipment had been cleaned as per trust policy. Some equipment was quite dusty.

Staffing

The trust is aware that staffing is an area for improvement. There are vacancies across many staff groups and recruitment is underway. In the meantime bank and agency staff are used to fill vacancies on shifts, although there were times when they were unavailable.

The trust faces significant difficulties in recruiting medical staff for A&E, and has done since 2011. The trust has eight consultants in post out of an establishment of 21 to cover both A&E departments at Queen's and King George Hospitals. The heavy reliance on locum staff is putting patients at risk of receiving suboptimal care. Joint work with other trusts has not achieved the desired results and additional work is underway, including recruiting staff from overseas.

Induction for locum and agency staff is variable and sometimes consisted of being shown around the ward.

Are services safe?

Some staff told us there were adequate staff to meet patients' need while others felt staffing levels were at a minimum and unplanned absences were difficult to manage. We did not see any examples of patients not having their needs met through lack of staff. Although staff were able to meet patients' needs, they did not have sufficient time to complete patient records of care. This was a common issue across both medical and surgical wards and both hospitals.

Patients attending the outpatient clinics did not always see their named doctor due to clinics being cancelled when the consultant did not arrive due to other planned activities or leave was required at short notice.

Documentation

Nursing staff on both medical and surgical wards were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen's and King George Hospitals with transfer checklists not always completed which meant staff may not be aware of a patient's needs – as in the case of one patient who had diabetes which was not recorded. Staff told us they did not have time to always complete the "paperwork" but knew their patients and the care they required.

Environment

We found problems with the environment in the theatres: the corridors were cluttered with trolleys and equipment due to a lack of available storage space.

Safeguarding vulnerable adults and protecting children

Staff had received training on safeguarding vulnerable adults and child protection. They understood the policies and processes and knew what action to take if they needed to raise an alert. The trust had a safeguarding team if staff needed support.

Are services effective?

(for example, treatment is effective)

Summary of findings

Many services provided effective care, but some services had better information gathering and monitoring systems in place. Services such as the intensive care units (ITUs) were able to demonstrate they are providing effective care. For other areas it was less clear and some were only just implementing systems to capture information to assess their effectiveness.

Our findings

Mortality rates

They hospital clinical staff can access mortality rate information. Each clinical department has access to a specific data review system which provides an early warning of outlier status. The information is included in the department's 'dashboards' (performance reporting and tracking system) and is reported to the Quality and Safety Committee.

The trust was identified as having higher-than-average mortality rates for patients with pneumonia, septicaemia and most cancers and reviews have been carried out. In June 2013, information showed that elective patients who were admitted over the weekend were at a higher risk than those admitted during the week. Actions to improve this include implementation of seven-day working for senior clinical staff, including the critical care outreach service, and better availability of specialist consultant support.

Past CQC inspections noted the trust has received two mortality alerts from the CQC for septicaemia shunting for hydrocephalus procedures and septicaemia (except in labour). The trust carried out a case note review for the first alert and found "no obvious deficits of clinical or operative quality" and the case has been closed. The second case is currently being reviewed.

National guidelines

Implementation and monitoring of national guidelines varied. We found a number of services were using national guidelines. The ITUs were providing care in line with national guidelines and submitting data to the Intensive Care National Audit & Research Centre (ICNARC) on outcomes for people using critical care services to monitor its performance compared to others nationally. The data showed that the number of deaths for critical care services at King George Hospital was lower than expected. In maternity services, women received care according to best practice clinical guidelines.

Prior to the visit we reviewed the medical services log recording the trust's implementation of National Institute for Health and Care Excellence (NICE) guidelines. A number were recorded as "partial compliance" or "awaiting response". The trust's process for ensuring that NICE guidelines were implemented was unclear. The cardiology ward had a range of protocols and guidelines for the admission and management of cardiology patients.

Clinical audits

The hospital participated in some local and national audits and demonstrated changes as a result, such as recruiting additional bowel cancer specialist nurses.

Are services caring?

Summary of findings

Previous national surveys indicated that patients were unhappy with many aspects of their care. Many patients and relatives we spoke with were positive about the care they received. They said the nurses were “kind” and provided them with support when they needed it. People felt they had been given information when they needed it and most had been involved in discussions about their care. Staff spoke to patients in a caring way and protected their privacy and dignity.

However, some aspects of the care provided by the end of life team need to be improved and work needs to continue to ensure improvements in the care patients receive is reflected in national surveys.

Staff were happy working at the trust and felt things were improving.

Our findings

The trust has performed poorly in a range of surveys about people’s experience of inpatient care, cancer care and care in the A&E department. Although results improved since 2011, in the CQC’s 2012 Adult Inpatient Survey, the trust scored ‘worse than other trusts’ in six of the 10 areas of questioning, and ‘within the expected range’ for the remaining four.

The trust also performed badly in the 2012/2013 Cancer Patient Experience Survey and was rated as being in the worst 20% of all trusts nationally for two-thirds of the questions (42 out of 63).

Staff attitude

We saw many examples of staff delivering care in a kind, compassionate manner and most patients felt they were listened to and involved in discussions about their care. We saw that when patients called for support staff responded promptly. Patients described the staff as “wonderful” and said they could not have received better care. Women in the maternity and children’s services spoke highly of the staff in all areas and said staff made them feel welcome and they felt cared for.

Involving patients in their care

Many patients said they felt they had been involved in decisions about their care, and staff allowed them time to ask questions. They were satisfied with the level of information they had been given and the next stages of their treatment had been explained to them. In maternity services, women felt involved in developing their birth plans, their partners were made to feel welcome, and they had sufficient information to enable them to make choices about their care and treatment during labour.

Privacy and dignity

Staff maintained people’s privacy and dignity by drawing curtains when they were providing personal care. Wards were divided into single-sex bays with bathroom facilities. In the ITU there was enough space between each bed to allow some degree of privacy. The palliative care team tried to ensure that all patients on the end of life care pathways were cared for in side rooms.

Nutrition

The hospital had a protected meal times policy and patients who needed assistance received their food on a red tray to ensure staff were aware. We observed staff providing support to patients with their meals as needed and monitoring their fluid intake. Following feedback from patients, the hospital had reintroduced hot meals in the evening.

Are services responsive to people's needs?

(for example, to feedback)

Summary of findings

The hospital has some arrangements in place to respond to patients' needs – such as the Critical Care Outreach Team. It also responds to patient feedback through the complaints process and the Friends and Family test. (The NHS Friends and Family test introduced in April 2013 allows patients to give feedback on the quality of care.) However, it has a very high bed occupancy compared to the national average, along with longer hospital stays than necessary and delayed discharges.

The hospital is not always meeting the national four hour quality indicator for waiting times in the A&E department.

While some of these issues require the involvement of partner organisations to resolve, there is much the trust can do to improve the flow of patients which would enhance their response to patients' needs and reduce the risk of patients receiving poor care.

Our findings

The trust's bed occupancy exceeds the national average and at times is at a level that is detrimental to patient care. Between April and June 2013 it was 97% while the national average is 86.5%. Once bed occupancy rates rise above 85%, quality of patient care can be affected.

Waiting times

Data shows that on some occasions patients waited more than four hours in the A&E department to be admitted to the hospital and too long to see a specialist doctor. These delays increase the risk of patients having a poor outcome. We also found delays in discharging patients from the ITU due to a lack of available beds on the wards.

Discharge

On medical wards we found that discharge plans had not always been completed and on one day of the inspection four patients were ready to be discharged but were still on the ward. The reasons for the delay had not been recorded.

Outpatient appointments

Sufficient time was allocated for consultations in the outpatient clinic but this was sometimes reduced due to clinics being delayed or over booked. Appointments were delayed between 50 and 90 minutes. Some of the delays were due to consultants carrying out scheduled ward rounds or other duties at the same time. Other issues included cancelled appointments, missing notes and patients either not receiving or having multiple appointment letters. Complaints about the appointments process and missed appointments were discussed at the trust Board in July 2013 when it was noted that some people only had three-days' notice that their appointment had been cancelled. The trust is aware of the problems and has started to take action, but progress is slow.

Seven-day working

The trust is in the process of introducing seven-day working to improve patient outcomes by allowing for senior medical review and discharge of patients seven days per week. Diabetes and endocrinology services have been centralised at King George Hospital. The aim of this is to ensure senior medical staff are on site every day and improve outcomes and discharge planning.

Complaints/Patient feedback

The trust uses the Friends and Family survey to gather feedback on patients' experience and this is discussed at ward meetings.

Work is being undertaken to improve the quality and timeliness of responses to complaints. The surgical services were aware this was an area that needed improvement.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Summary of findings

Overall, staff were positive about their immediate clinical managers but had mixed views about more senior staff and the visibility of the executive team.

Arrangements were in place to monitor the quality and performance of services but these are being reviewed and staff acknowledged that data could be used more effectively.

Our findings

Leadership

The latest NHS staff survey shows encouraging improvement in a number of key findings, including the number of staff feeling able to contribute towards improvements, levels of staff motivation and the number of staff willing to recommend the trust as a place to work or receive treatment. We found that much of this was reflected during our visit.

The 2012 General Medical Council's National Training Survey found the trust performed below the expected range in six areas and better than expected in one area: Emergency Medicine. Junior doctors we met with during the inspection felt that consultant cover and support, along with training, was good but identified staffing levels and the general busyness of the trust as an issue. The number of locums they worked with had an impact on the continuity of care.

Staff told us that engagement of clinical staff was good, but still in the early stages. Senior nursing and medical staff cover services across both Queen's and King George Hospitals and visit them during the week. A few staff had mixed views about how much attention King George Hospital received with some feeling there was more focus on Queen's Hospital. There was also concern about the future reconfiguration of services to Queen's Hospital.

Many staff felt they were supported by their line manager and they were part of a team. They had team meetings and felt there was good communication between different groups of staff. One member of staff said "It's a smaller hospital so things are easier to manage .." Visits to wards by non-executive directors is currently being implemented by the trust.

Capacity

Although there were problems managing capacity and delayed discharges, they were not as severe as at Queen's Hospital. The same senior clinical staff cover both hospitals and in order for improvements to happen they need to improve their decision making and engage in making the necessary improvements.

Monitoring quality

We found many areas had team meetings where they discussed comments, complaints surveys and incidents. However monitoring actions implemented to ensure that changes take place need to be more robust. Many services have, or are in the process of developing, a dashboard (performance reporting and tracking system using a number of quality and safety indicators) to identify and monitor potential risks to patients.

Accident and emergency

Information about the service

The emergency department A&E consists of a separate children's care, resuscitation, observation, major injuries ('Majors') and minor injuries area. Ambulance patients who are unwell and may need admission are assessed and directed through to the 'Majors' area, consisting of 15 bays. Once the hospital has made a decision to admit a patient they should be moved as soon as possible from the A&E to the main hospital wards or to the medical assessment unit (MAU). In the financial year 2012/13 approximately 70,000 patients attended the A&E.

We talked to six patients, three relatives and seven staff, including nurses, doctors, consultants, managers, and paramedics. We observed care and treatment and looked at care records. We received comments at our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The A&E department did not provide safe care all of the time. There is a lack of senior medical staff supported by middle and junior grade doctors at nights and weekends.

Overall we found staff to be caring and people were positive about their experience. The department was responsive and patients were treated appropriately to their needs although some specialities took too long to attend A&E to see patients.

There was good clinical leadership within A&E and staff felt supported by the senior doctors and nurses. However, staff did not have confidence in the trust leadership to make the necessary improvements in A&E.

Are accident and emergency services safe?

Most of the senior medical staff we spoke to told us they did not think A&E was safe all of the time. One consultant told us, "We work with locums to ensure we have enough staff but they do not always know our policies and procedures. We try to stick with the same people. The locums are of various quality which gives me concerns."

Nights and weekends

Patients could potentially be placed at risk of receiving unsafe medical care by the lack of senior medical staff available at nights and weekends. The medical cover is provided by middle-grade and junior doctors with an on-call consultant covering both Queen's and King George Hospital. The Clinical Director, all of the consultants we spoke to and nursing staff expressed their concerns about this. There was a consultant on duty from Monday to Friday between 8am and 10pm. At weekends there are six hours of consultant cover on each day. During our inspection we found a patient who had been admitted after 10pm the previous night and did not appear to have received optimal care from the A&E and specialist doctors.

During one visit to the A&E we observed a patient in the resuscitation area who had possibly had suboptimal management overnight and was subsequently admitted directly to ITU approximately 12 hours after arriving in the A&E.

Staffing levels

The A&E at King George has an establishment of 76 nurses of which 66 posts are filled. Staff told us they are able to ensure there is sufficient nursing cover by using agency and in-house bank staff (who work overtime in the hospital). We examined the nursing rotas and observed the actual number of nurses on duty. We found that there were always three nurses on duty in the 'Majors' area which, for the number of patients, meant their ratio ranged from one registered nurse to four patients to one registered nurse for six patients. Staff told us they were able to provide good patient care most of the time. A senior nurse told us, "I think we could do with one more nurse on each shift, we only have one nurse for the observation area covering six patients but I would prefer two."

Accident and emergency

In addition the A&E employs two accident department assistants (ADAs) who provide cover during the day. Their primary role is to record patient indicators such as blood pressure and also take blood samples. However, when they are not undertaking these tasks, they are expected to ensure patients are supported with nutritional and personal care needs. This means that the nurses are able to focus on providing specific nursing care to patients.

The A&E at King George is under-resourced for consultants. The College of Emergency Medicine recommends that the A&E at King George Hospital should provide consultant cover 16 hours a day, seven days a week. The trust has eight consultants in post out of an establishment of 21 to cover both the A&Es at Queen's and King George Hospitals. The A&E makes up for the shortage of full-time consultants by employing locums and has a consultant working between 8am and 10pm. Staff told us that consultants do not finish their shift at 10pm unless they are happy it is "safe" to do so. After 10pm there is a consultant available on call for both hospital sites. The number of consultants in post has been decreasing over the last few years, and when we last inspected in May 2013 there were 10 consultants in post.

Consultants need to be supported by middle- and junior-grade doctors. The A&E at King George is under resourced for middle grade doctors. Of the 28 posts for middle-grade doctors, 10 are filled by permanent staff, and the trust relies on locums to make up the additional numbers. We examined the rotas for medical staff and found that, on some occasions, the most senior doctor on duty at King George was a locum. When we last inspected in May 2013 there were 13 middle-grade doctors in post.

Selection and supervision of locum doctors

Because of the low number of permanent staff, many of the doctors in A&E are locums supplied by agencies. We examined the staff rotas and found that, on many occasions, about half of the middle-grade and junior doctors at any given time were locums. Staff told us they would usually be able to employ locum staff they had previously worked with and who they trusted to deliver good and safe care. However, they said that occasionally other locums would turn up for shifts and they felt this created a risk to patients.

Are accident and emergency services effective?

Patient flow

We found that there is usually good patient movement between A&E and the rest of the hospital and patients can get to wards suitable for their conditions.

On some occasions, we found that patients are waiting too long to see a specialist doctor when they have been referred by an A&E doctor. Although, one patient said, "I haven't waited that long at all, they seem very good." There is generally good patient movement from the A&E into the rest of the hospital.

Managing patient care

On the day of our inspection at 11.14am there were 17 patients in the whole A&E, nine of whom were in the 'Majors' area. For only one person, a decision to admit had been made and they were waiting for an intensive care bed to become available. The nurse in charge advised us that the MAU had spare beds if patients needed to be transferred. Two of the patients had been in the A&E for more than four hours.

The trust's policy is that all patients should be seen by a specialist doctor within 30 minutes of referral by an A&E clinician. We examined the medical notes of the three patients who had been referred to a specialist and found that the waiting time to see a specialist doctor had been just under four hours, one-and-a-half hours, and 10 minutes respectively. Staff told us it is much more difficult to get a referral at night. This means that specialist diagnosis and treatment are delayed, putting patients at risk. One consultant told us, "Children's care are good at responding when we call them, medicine and urology are much slower".

Patient movement to other parts of the hospital

Staff told us that patient movement gets much worse in the winter as the number of attendances increases. One member of staff told us, "The trouble is when it gets very busy they put too much pressure on wards to discharge people, who end up coming back into the emergency department anyway." A senior nurse told us, "We are

Accident and emergency

usually fine until we get more than 50 patients in the emergency department; from this point things start to grind to a halt." We examined the trust's performance for unplanned readmissions where it has set a target of no more than 4.9%, and found that it performed significantly worse than this with 8.7%.

Staff told us that the decision making between the high dependency unit, intensive care unit and the A&E was not always clear. We were told that, on a number of occasions, patients would be accepted by these or other specialities but would remain in A&E for a number of hours. This created the risk of patients being overlooked and medical reviews not being conducted, which could lead to poor outcomes for patients.

Are accident and emergency services caring?

Staff were caring and sensitive to patient's physical and emotional needs.

The vast majority of patients we talked with were complimentary about staff in the A&E. One patient said, "I have no complaints thank you." Another person said, "yes they have looked after me just fine, they have given me a drink and now I am waiting for them to come and take a blood sample".

We observed that the staff treated people with respect and kindness, talking to them in a soft and responsive way. We observed that, when people called for support, a member of staff would respond efficiently.

Patients' privacy and rights

Patients were given appropriate information and support regarding their care or treatment. Patients told us they had been involved in decisions about their care and treatment. Staff respected patients' rights to make choices about their care. We saw staff explaining treatment options to patients to make sure they fully understood the treatment and choices available. All the people we spoke to told us that staff had kept them up to date on what was happening with their treatment

Food and drink

Patients received adequate nutrition and hydration while they were in A&E. Although the department does not have dedicated staff, we found that patients are offered food and drink. We observed that most patients had water, tea or coffee cups by their beds. The patients we spoke to said they had been offered drinks. We visited in the late morning and found that patients who had been there for a number of hours had been offered breakfast.

Are accident and emergency services responsive to people's needs?

Waiting times

Nationally agreed emergency department quality indicators state that 95% of patients should be seen within four hours and no patient should be in the department for more than 12 hours. The emergency department at King George does not always reach this target but performs in line with most other emergency departments and better than Queen's Hospital.

Working with the ambulance service

Information provided to us by the London Ambulance Service (LAS) indicated that King George had not closed or diverted any ambulances in 2013.

The LAS also records "black breaches" (those cases where it has taken over 60 minutes from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place). Data provided by the LAS shows that throughout 2013, King George had 32 "black breaches", which compares favourably with Queen's Hospital where, for the same period, there were 222 "black breaches". However this does not reconcile with information provided by the trust which shows that for year 2013 there has only been one breach involving four patients.

We spoke to two paramedics who told us they felt valued by the doctors and nurses in A&E. One of them told us, "They are good here; they all go quiet when we are doing a patient handover and pay attention."

Accident and emergency

Working with partners

Partners we spoke to said that the trust was not always responsive to people's needs and that it could improve the way it works with partners. One local authority member told us, "the trust remains inward looking and is not yet fully engaging with local partners."

Caring for children

We found there were always trained paediatric A&E nurses on duty within the paediatric area, except at night when the area is covered by general A&E nurses. Senior staff told us that the trust was currently recruiting additional paediatric nurses to provide 24-hour cover. Staff had training and understood safeguarding, child protection and reporting procedures. The paediatric unit worked well with the paediatric ward, which always had a middle-grade and junior doctor allocated to the A&E paediatric area.

Are accident and emergency services well-led?

A&E clinical leadership

A&E has good clinical leadership. We spoke to the clinical director who had a good understanding of the risks and issues the department faces. We observed that consultants and senior nurses gave clear guidance and support to junior staff. Staff are motivated and there was good team working and communication between all grades of staff and they said they felt well supported by managers. One member of staff told us, "It's a smaller hospital so things are easier to manage; we have good staff and work very well as a team."

Staff had less confidence in the trust's management to address the fundamental issues of staffing and patient flow.

Trust support for A&E

There was widespread concern from staff that the trust has not fully supported A&E when concerns are raised. One member of staff said, "We never see any of the management over here and all the important meetings are held at Queen's." Staff also felt they were not kept up-to-date on the planned closure of the A&E at King George Hospital by senior management in the trust. One nurse told us, "There is a lot of unrest about the closure; we feel they are doing it by the back door. It makes it more difficult to recruit and keep staff."

Managing quality and performance

The trust has a system in place for recording and analysing clinical incidents. We examined summaries of all incidents for a three-month period prior to our inspection. We found that incidents were being properly reported but many of the records we examined were unclear about how the trust would make future changes. We also found that a number of the incident reports indicated difficulties in getting specialist doctors to attend A&E.

Medical care (including older people's care)

Information about the service

Medical services at King George Hospital include a range of inpatient wards including an Acute Elderly Unit and two wards which provide post operative care following orthopaedic surgery and a discharge lounge.

Summary of findings

We found that the service was caring with appropriate staffing levels and skill mix. Most patients told us they felt that staff had been very supportive. However, information about patients' care and treatment was inconsistently recorded. When we looked at patient records we found examples where discharge summaries had not been completed.

Some members of staff were unaware of how to recognise and respond to a patient who had sepsis (blood poisoning). All of the wards we visited were clean and well maintained. We found that staff had access to all the equipment that they required.

Are medical care services safe?

Incident reporting

We spoke with a wide range of staff. They knew how to report a concern about care and treatment on wards and about the management of wards. We were told that, following an adverse incident, they would usually get feedback from their manager.

Staffing levels and skill mix

On all the wards we visited staff told us they felt they had sufficient staff to enable them to meet the needs of patients.

When we visited the 28-bed MAU, a unit where patients stay for up to 48 hours while a decision is taken on the best place for them to be cared in, we were told they had five trained nurses in the morning and three healthcare assistants. This had recently been increased as a result of extra funding for winter. At night there were three trained nurses on duty. Staff said they felt this was adequate to meet the needs of patients on the unit.

We visited Gardenia ward, which had 25 beds and treated cardiology patients. During the day there were five trained nurses and two healthcare assistants. At night there were three trained nurses and one healthcare assistant. The staff told us they felt this was sufficient to meet the needs of their patients.

The trust was in the process of recruiting extra consultants in the medical division to ensure that they were able to meet the needs of seven day working.

In most of the areas we visited nursing staff told us that, when they needed support from doctors, they received this promptly. Junior doctors told us that senior colleagues were usually available. However, some staff on surgical wards reported that there were sometimes delays in getting support with medical patients who were on their ward because there were no beds available

Documentation

We looked at the documentation of care in patient notes. We noted that there were a number of gaps in the completion of nursing records and that nursing notes were not up to date. For example, discharge plans had not always been completed. Nurses told us they did not always have time to complete the paperwork for patients, but they felt they knew their patients and were delivering good care. Senior nursing staff told us they were aware of the need to improve nursing documentation.

Environment

In general, the accommodation at King George Hospital was very good for meeting patients' needs. The wards were spacious and clutter free. Patients told us they thought it was a good environment.

We saw that single-sex accommodation was provided in all the areas we visited.

Infection control

Wards were clean and well-maintained. Hand-washing facilities and hand gels were available in most areas. We saw that personal protective equipment, including gloves and aprons, was usually available.

Staff told us they had infection control 'link' nurses on the wards. These staff linked with the trust infection control team and provided guidance and support to ensure good practice was maintained in managing the risk of infections.

Medical care (including older people's care)

Medicines/emergency equipment

On Gardenia Ward we checked storage of medications, including controlled drugs. We found that medicines were stored appropriately and, where required, had been appropriately signed for. We saw that medicine record cards had been completed and allergies recorded where appropriate.

We checked the crash trolleys (used to transport emergency medication) in a number of wards, including on Gardenia Ward, and found they had been checked regularly by the staff. All of the medication was within expiry dates and all the appropriate equipment was arranged according to the checklist.

Patients on the wrong ward

During our inspection there were a number of patients who were 'outliers'. This means they were on wards that were not the correct speciality for their needs. We visited these patients to see how they were being managed and if they were getting the support they needed. We visited Heather Ward and looked at the care of three outlier medical patients. We saw evidence they were having their care managed appropriately by the correct medical team. When we visited Iris Ward we were shown that patients had a named consultant whose contact details were recorded on the ward board. Nurses told us that the nursing paperwork was the same, so this made managing patients easier.

Sepsis

The trust needs to ensure that staff are aware of how to recognise when patients may be developing sepsis (blood poisoning) and know how to respond appropriately.

When we visited we asked staff on Heather and Gardenia wards how they would recognise sepsis and how they would respond to this. None of the nurses we asked knew about guideline to use if they suspected sepsis or were able to clearly define what sepsis was. They were not aware of any specific training available on the management of sepsis. Some said that they thought a sepsis care pathway was available on the intranet but no one was able to locate it.

Are medical care services effective?

Assessments

Patients' notes included initial assessments of their needs. Where required, pain scores were calculated and Braden scale scores (which identify patients at risk of pressure ulcers) had been completed appropriately. The trust had an early warning score system to highlight when patients' health condition was deteriorating. If a patient's score increased the medical team was alerted. We saw recorded observations of this being completed.

Capacity assessments

In order to identify patients who may be confused, mini mental tests involving a number of short tasks were used to identify patients who needed extra help if suffering from confusion. The September 2013 performance report for the acute medical division records showed that 94% of patients over 75 had a test score recorded. Staff were able to describe the action they would take if a patient did not have capacity to make decisions.

Multidisciplinary working

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement for doctors, nurses and therapists in patients' care. We saw that, when patients were identified as requiring support from specialist teams, (such as tissue viability), they received this.

Delays in discharge

On Ash Ward we looked at the records for nine patients and found that only one of them had a clear discharge plan. In four cases the discharge plan had been started and recorded that the patients were ready to be discharged home but they were still on the ward. There was no information to explain why this had not happened.

We asked staff across the trust what happened when there was a 'black' alert (a severe lack of beds and patients waiting in A&E to be admitted). They told us they would receive an email but did not explain any action they would take to speed up patient discharge where possible.

Medical care (including older people's care)

Are medical care services caring?

Patients' view of care

Most patients were very positive about their care. Some told us they felt they were "extremely well cared for". On the MAU patients told us the nurses had been checking to see if they were comfortable.

We saw that staff treated people in a kind and caring manner. For example, when we were on Beech Ward we observed a sister taking time to engage with a patient and comfort them.

Are medical care services responsive to people's needs?

Seven-day consultant cover

The trust was introducing seven-day consultant cover. Diabetes and endocrinology services were now centralised at King George Hospital. The aim was to improve patient outcomes by ensuring senior medical staff were on site every day, and also to improve arrangements for discharge planning, to help reduce length of stays and prevent patients having to spend longer in hospital than necessary. At the time of the inspection we were told that the new arrangements had been implemented, although formal job planning had not yet taken place to enable a consultant to be on site seven days per week.

Do not attempt resuscitation recording

We saw six patient records that were marked DNA CPR ('do not attempt cardio-pulmonary resuscitation') Only two records showed that the decision had been discussed with the person or their relatives.

Support for people whose first language is not English

We asked staff how they would support someone whose first language was not English. They were able to explain how they would ask for an interpreter and told us they had never had any problems in securing one.

Virtual Ward

Since 2009, the Virtual Ward has managed patients from eight clearly defined ambulatory care pathways, allowing patients to receive care at home. Patients are identified by their consultant as medically suitable for ambulatory therapy according to strict criteria. The Virtual Ward nurses collect referral forms from MAU and arranges all tests and investigations, ensuring they happen in a timely manner. Patients can have follow-up care in the community or at the hospital. Patient satisfaction surveys for the service showed that patients valued the support and management they received. Staff told us they hoped the service could be further developed and utilised for other conditions.

Are medical care services well-led?

Staff morale

Most staff told us they felt their morale was good. On all the wards we went to, most expressed a general sense of being well supported by peers and management and that team-spirit was high.

Training

Staff they told us they felt they had good opportunities to undertake training. They told us they felt they were supported in their roles and had regular appraisals of their performance. Junior doctors told us that in general they had good support from senior doctors.

Monitoring quality

During the inspection we saw many examples of information being gathered on the performance of wards. However, this information was not currently being collated in one place to allow for the easy recognition of themes. Actions identified were not always monitored in a robust manner to ensure that changes were made. For example, there was no central log to ensure that learning actions identified from complaints had been implemented.

Surgery

Information about the service

Surgery at Barking, Havering and Redbridge University Trust is provided across its two main sites; Queen's Hospital and King George Hospital. Queen's Hospital provides acute surgical procedures, while King George Hospital undertakes more elective procedures. Patients are also transferred from Queen's Hospital to King George Hospital for rehabilitation. Orthopaedic surgery is carried out at King George Hospital, and there are four surgical wards.

People can access the surgical services at King George Hospital via the hospital's A&E department, their GP or referral from Queen's Hospital.

We talked to patients and staff, including healthcare assistants, nurses, doctors, consultants, senior managers and therapists. We visited all four surgical wards and the operating theatres at King George Hospital. We observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance about the trust.

Summary of findings

The Inspection Team could not be assured that patients always received safe care. Nursing documentation was inconsistent and people were put at risk of infection in theatres due to inadequate cleaning and poor practices by staff. Where patients had been transferred from Queen's Hospital, there was no documented handover and staff were not always aware of a patient's medical history.

Delayed discharges and high bed occupancy rates meant that the service could not be as responsive as required. Staff opinion varied on whether the service was well-led. Regular meetings took place to monitor aspects of the service, but, due to the discrepancies we found, we could not be assured that all auditing activity was effective.

Patients told us staff were caring and they felt their needs had been met.

Are surgery services safe?

We could not be assured that all patients received care that ensured their safety and welfare.

Documentation

When a patient was initially admitted, nursing staff completed an assessment of their needs. This included assessing the risk of the person developing pressure ulcers, having a fall, their risk of malnutrition and their mobility requirements. Where risks had been identified, there were specific 'care bundles' (additional assessment and monitoring documents) to ensure each identified risk was managed appropriately. On some wards we visited this documentation had been fully completed and was up to date. However, on other areas we found examples of where the assessment had identified risks, but the relevant care bundles had not been completed. In one patient's record, a falls assessment had been completed on 8 September 2013, but had not been updated since. The documentation stated that it should be completed weekly, or if a patient's condition changed. We also found examples of where patients were on fluid balance charts and the total inputs and outputs had not been recorded.

Patients were often transferred between Queen's Hospital and King George Hospital. For example, patients who had undergone a complex orthopaedic surgical procedure at Queen's Hospital were transferred to King George for rehabilitation. Staff told us that patient handovers were conducted over the telephone. At King George Hospital we looked at the nursing notes for patients who had recently been transferred from Queen's Hospital. There was a transfer checklist available, but these had not been completed. One nurse was not aware that a patient had diabetes.

There was a lack of documented guidance in patients' records about the care they needed in relation to their medical and psychological needs. When we asked staff how they planned a patient's care, they told us they used the "evaluation" sheets in their nursing notes. However, the notes we saw documented the care that had been provided on that shift and were task-orientated rather than including how a patient liked to be cared for or

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how best to support them. We were told that staff were informed of any outstanding care needs during the handover. We looked at examples of handover sheets and saw no evidence that these included how to meet patients' psychological needs. Due to the inconsistencies in the nursing documentation and lack of recorded care planning, we could not be assured that all patients received care that ensured their safety and welfare.

Patients' medical records had evidence of multidisciplinary input from the medical team, physiotherapists, dieticians and occupational therapists, where necessary.

Managing risk

We observed a theatre team at King George Hospital. People were protected from avoidable harm through the use of "five steps to safer surgery" procedures. This included the use of the World Health Organization (WHO) safety checklist to ensure that people had consented to the procedure and that the necessary checks were completed before, during and after surgery.

There were systems in place to deal with medical emergencies. The trust had a Critical Care Outreach Team who reviewed patients on wards whose condition may be deteriorating. Staff on the wards told us that the team were quick to respond when they required advice or assistance. All wards used the early warning score observational chart to ensure that patients who may be becoming unwell were quickly identified and their condition escalated to the outreach team or the night time on-call team. In addition, there was one resuscitation trolley available on each ward and we saw that these were checked daily by staff.

The surgical department had learned from some mistakes. A never event (a serious, largely preventable patient safety incident), occurred at Queen's Hospital in 2013, where a patient had a different surgical procedure to the one they had consented to. Categorized as a "wrong site surgery". To reduce the risk of this happening again, patients were not draped in surgical gowns until final checks had been completed, including checking the person's consent form.

In 2012 the trust was a mortality outlier for septicaemia, meaning there were more deaths than expected. However, no staff we spoke with had undertaken sepsis training while working for the trust, nor did the trust use a best practice tool such as Sepsis Six, which is a series of life-saving

interventions. In addition, we noticed that the observational charts used to respond to a patient's deteriorating condition did not prompt staff to consider sepsis.

There was an electronic incident reporting system in place. Incidents were monitored and investigated by ward managers and/or matrons. We were told that learning from incidents was shared with staff during weekly ward meetings and via the trust's intranet and email messages. However, on some wards, staff told us that these meetings did not routinely take place.

Hospital infections and hygiene

The trust infection control rates for *Clostridium difficile* (*C.difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were within the expected ranges. There were signs and information leaflets for patients and visitors on how to prevent infections and when to avoid coming to hospital.

According to the NHS Staff Survey (2012), only 52% of staff said that hand-washing materials were available. Hand gel was available at the end of each bed and by the entrance to each ward or bay area. As a result of the staff survey, hand-washing sinks had also been placed by the entrance of each ward. The most recent Friends and Family test for some surgical wards had raised concerns about doctors not washing their hands. We were told that monthly hand hygiene audits were undertaken and staff were encouraged to challenge their colleagues. Most people had seen doctors using the hand gel to clean their hands between seeing patients.

At the time of our inspection the ward areas were clean. We observed domestic staff cleaning the wards and people told us that they had no concerns about the cleanliness of the hospital. We looked at equipment, including commodes, and saw that these were visibly clean and had a sticker applied with the date they were cleaned by staff.

However, we visited the operating theatres at the hospital and found the corridors were cluttered with trollies and equipment due to a lack of available storage space. When we checked the trollies and drawers, which contained theatre items, they were visibly dirty. Some equipment which would be used by theatre staff was also dusty. Staff had not used stickers (which was trust policy) to show when equipment had been cleaned. Staff were not clear about who was responsible for ensuring the corridor was clean. We were told that infection control checklists were

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completed monthly or weekly if concerns were identified. We looked at these for the three months preceding our inspection and saw that the equipment and trollies had been marked as visibly clean.

We also observed poor practice during a surgical procedure. Two members of staff answered the telephone in theatre, but did not wash their hands afterwards. Another member of staff removed dirty swabs and instruments from a trolley inside the operating theatre and did not clean their hands before moving into a sterile area. Therefore, there was a risk of cross-contamination. Hand hygiene audits were completed weekly. While we were told that all infection control audits were sent to the trust's infection control team, there was no evidence of any feedback when audits fell below 100%. Therefore, current audits were not effective in ensuring high standards of infection control.

Staffing

We were told that staffing levels were determined by the number of beds on the ward. Most staff said that, if there was a full complement of staff on each shift, they could manage to provide all the care patients needed. On the general surgical wards, nurses told us they usually cared for between eight and 10 patients each, but sometimes more. However, all staff said the number of staff scheduled to work each shift was the minimum required and, if there were unexpected absences, then it was challenging. Staffing levels were not adjusted to the medical conditions of people using the service. On one ward, staff told us they thought staffing levels were "unsafe" at night, particularly if they had patients who required closer observation.

The staff electronic rota system did not show where shifts had been covered by bank (in-house staff working overtime) or agency staff. We asked to see the rotas on two wards for the month preceding our inspection. On one day it showed that no nurses had been scheduled to work. We followed this up and found that bank and agency nurses had worked that day and this had been recorded in a book which was kept only on the ward. This made it difficult for senior management to monitor staffing levels and how often shifts had been short-staffed. A senior manager for the service told us there was an over-reliance on locum and agency staff.

Are surgery services effective?

Monitoring quality

The trust used the nationally recognised Enhanced Recovery Programme for urology, colorectal and orthopaedic patients. The aim of the programme was to speed up a patient's recovery following surgery and lead to improved outcomes. In May 2013 the department audited 200 patients on the programme. The sample was evenly split between Queen's Hospital and King George Hospital. 80% of patients said they were involved as much as they wanted to be in their care. Pain management was better, and patients were mobilising earlier. While the length of stay for patients was higher than its target, there had been a gradual reduction between January 2013 and April 2013, some of which may be attributable to the programme.

According to the June 2013 performance dashboard, 96.7% of surgical patients were risk assessed for venous thromboembolism (VTE). This was above the target of 90%. In addition, there had been no reported grade 3 or 4 pressure ulcers. There were skin care information bundles in place for when staff identified people who may be a risk of developing pressure ulcers and input was sought from the Tissue Viability team.

Audits

The hospital participated in a variety of clinical audits. The audit for bowel cancer found that only 50% of patients were seen by a clinical nurse specialist. As a result the trust had recruited more bowel cancer nurses so there were two nurse specialists at both hospital sites. Specialties within the department reviewed particular cases at their clinical governance meetings and participated in research.

Staff from the day case surgery team were unable to tell us how they were performing as a unit compared to others. Senior management told us that data was being collected on the performance of individual surgeons, but was not formally published by the trust.

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Are surgery services caring?

Dignity and respect

People were treated with dignity and respect. We observed staff closing curtains when providing care and talking to people about their care discreetly. Wards were divided into single-sex bays and there were designated male and female toilet facilities. Interpreter services were available if required and staff were required to attend mandatory training on caring for people with dementia. People who were confused or who had been diagnosed with dementia were discretely identified on the boards in the ward area so that staff were aware.

People were complimentary about the staff caring for them. Everyone we spoke with felt the staff were caring. People described staff as “wonderful” and “very kind”. One person said that they could not have received better care.

Nutrition

When people were first admitted, their risk of malnutrition was assessed. Staff also monitored fluid intake. Staff on each ward were responsible for serving drinks and food. We observed that people had drinks within easy reach. The July 2013 Friends and Family survey had indicated that people were not satisfied with the quality of food. We were told that the trust had reinstated hot meals in the evening time, which had been received well by patients and staff. Red trays were provided to people who needed support with eating and drinking so that staff could prioritise assisting during meal times.

On one ward at King George Hospital staff told us that nutritional drinks were not always easily accessible and that this would be raised with the dietician.

Comfort rounds were conducted on each ward to ensure that people were comfortable and not in pain. However, in some records we reviewed the comfort round charts had not been completed. There was no system in place for people who had undergone a day case procedure to receive a follow-up phone call the next day to check that they were not in pain or experiencing any adverse reactions.

Are surgery services responsive to people's needs?

Discharge planning

There was a dedicated emergency theatre list 365 days of the year, but no dedicated day case theatre list. At the time of our inspection, the day case ward at King George Hospital was being used as an over-flow area for when other surgical wards were full. People were also being nursed in the theatre recovery area and discharged home from there. Staff told us this was commonplace due to a shortage of beds elsewhere in the trust.

We were told that people were not discharged home until they were well enough and arrangements had been made with other relevant services (where necessary). There was a dedicated discharge team to assist with this process, but nursing staff were able to describe the procedure should a referral need to be made to social services.

There were delays with patient discharges. Staff said this was caused by waiting for care packages to be confirmed by social services, bed shortages in the community and discharge summaries not being completed by doctors 24 hours in advance. Senior nurses told us they had attended training to enable nurse-led discharges, but this had not been implemented by the trust. The average length of stay for surgical patients was 4.5 days, with a target of 4.45 days. This was lower than the trust's average of 7.05 days.

Feedback from patients

According to the July 2013 Friends and Family survey, overall, the trust performed worse than expected for how caring staff were. However, during our inspection of the surgical services, most people felt that staff were very caring.

According to the survey, people felt they had not been given enough notice when they were to be discharged or told what to expect. People at King George Hospital felt that staff had explained the process well and they knew what to expect. However, one person had been told that it was not safe for them to be discharged, but no other alternatives had been suggested, which was worrying them.

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We were told that, following the results of the July 2013 Friends and Family survey, nursing staff and doctors were encouraged to spend more time with people to discuss any of their fears or concerns. People we spoke with were positive about staff communication. One person told us they understood their plan of care and felt “well-informed”. Another person told us staff “provided reassurance”.

The most recent Friends and Family survey results were on display in the ward areas with details of action taken.

In April 2013, only 67% of complaints from surgical patients had been responded to in line with the trust’s policy. The Clinical Director for surgery acknowledged that the complaint’s procedure was poor as there was no consultant lead for it.

Are surgery services well-led?

Leadership

Staff views on whether they felt the surgical department was well-led varied between wards and staff grades at King George Hospital. All staff were proud of their job. One member of staff described it as an “excellent place to work” whereas another felt that their manager did not escalate concerns upwards. All staff were aware of the trust’s whistle-blowing policy and said they would feel comfortable using it.

Management arrangements

The matrons and medical staff worked across both sites. The matrons visited King George Hospital about once a week as the majority of surgical services were provided at Queen’s Hospital. Some ward staff felt that the senior staff focused on Queen’s Hospital. One person told us that King George Hospital “feels like a different trust”. Theatre teams met for an hour once a week and this time was protected. We looked at the meeting minutes and saw that clinical governance and training were discussed.

Ward managers told us they felt well supported by management and confirmed that they met weekly with their matron and colleagues. At these meetings they discussed incidents, complaints and quality of care audits. We were told that the trust’s executive team disseminated information via newsletters and emails and that staff were able to contact the Chief Executive directly. Some staff told us they did not have time to read these and relied on their ward manager to pass on key messages. Others told us these messages were sent once decisions had been made and that they did not feel involved in the changes affecting the organisation.

Monitoring quality

Clinical governance meetings took place monthly. Specialties also held their own governance meetings. We looked at the minutes for some of these and saw that they discussed deaths, patient surveys and complaints. However, a senior manager for the service told us the department needed to make better use of the data available.

A variety of audits were carried out to monitor the quality of care provided and to inform the performance dashboard. Weekly quality audits took place on each ward and involved looking at records, incidents, training and talking to patients. However, these audits had not identified the gaps we found in documentation. Furthermore, according to the June 2013 performance dashboard 100% of procedures had a completed WHO checklist. We were told that, each month, the first 100 cases were audited. However, we looked at five, none of which were fully completed. Therefore, we were not assured that the provider’s monitoring systems were accurate or effective.

Intensive/critical care

Information about the service

Barking Havering and Redbridge University Trust has a total of 40 beds in the intensive care unit (ITU). These are split across the two hospital sites of Queen's Hospital and King George Hospital. There are eight ITU beds at King George delivering care to patients, except children, with serious life-threatening illness. A Critical Care Outreach Team assists in the management of critically ill patients on wards across the trust during the day. At night, cover is provided by the on-call team.

We visited the ITU ward at King George Hospital, observed care and treatment and looked at care records. We talked with two relatives and five staff, including nurses, doctors and consultants. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The patients we spoke to in intensive care, and their relatives, felt that they had been well cared for and involved in making decisions about their treatment.

The service was well-led by a team who had identified the risks and challenges the service faced and were monitoring them. However, there was a lack of patient flow in and out of the service due to delayed discharges and high bed occupancy. This affected the service's ability to provide responsive and effective care to all patients requiring intensive care. Once admitted to a critical care ward, patients received safe and effective care from caring, qualified staff.

Are intensive/critical care services safe?

Environment

At the time of our inspection, the ITU ward area and equipment were visibly clean. There were adequate hand-washing facilities with hand gel dispensers at the end of each bed and by each ward entrance. We observed staff cleaning their hands between attending to patients. The ITU was spacious and there was enough room around each bed for equipment and for staff to provide care safely. Resuscitation

trolleys were available on each ward and these were checked daily. Staff told us that there was enough equipment available for each bed area.

Documentation

We looked at documentation on the critical care wards and found people's needs had been assessed and that observations were recorded in a timely manner. Where people had been identified as being at risk of developing a pressure ulcer, they had been put on a skin care pathway which ensured that the condition of their skin was monitored regularly.

Staffing levels and skill mix

At the time of our inspection, all eight beds were occupied, but there was not the full, planned complement of nurses working and the ward manager had been unable to arrange for additional nurses to cover. Therefore, nurses were having to care for two level 3 patients (the most seriously ill, requiring advanced respiratory support or with multi-organ failure) each when they would usually provide one-to-one care. However, there was good medical cover as one consultant was based on each intensive care ward throughout the trust during the day so a person's medical condition could be responded to rapidly. Comprehensive handovers took place twice daily between shifts and were attended by consultants, junior doctors and nurses to ensure that all staff were aware of the person's plan of care and treatment.

Staff working on the unit had the necessary skills and experience. All staff were trained in intensive care and had their competency checked before they worked alone. One nurse told us that they had been supernumerary for the first six weeks they worked on the unit. There was a preceptorship programme of clinical supervision experience, mentoring and training, designed to support newly qualified nursing staff for the first six to 12 months of their roles.

Critical care outreach team

The department provided a Critical Care Outreach Team during the day, which responded to deteriorating patients elsewhere in the hospital, triggered by an alert from the early warning score observational chart used by all wards. Staff on the wards said the outreach team were usually quick to respond. We spoke to the outreach team and they told us that response times were usually 30 minutes. At night, wards were instructed to call the on-site manager who would call for medical support.

Intensive/critical care

We received mixed views from staff on the response from the hospital-at-night team and the trust was in the process of recruiting to the outreach team so that it could provide cover 24 hours a day, seven days a week.

Safeguarding

There were systems in place to protect people from the risk of abuse. Safeguarding training was mandatory for all staff. Staff were able to describe the safeguarding process and some were able to provide examples of where they had made a referral to social services. Staff also showed an awareness of the Mental Capacity Act 2005.

Are intensive/critical care services effective?

National guidance

People received care in line with national guidelines.

There was a set criteria for patients who should be admitted to the unit and the Critical Care Outreach Team were responsible for reviewing each patient referred to the unit to determine if it was appropriate or not.

Patient outcomes

The trust submitted data to the Intensive Care National Audit & Research Centre (ICNARC) on the outcomes for people using critical care services to monitor its performance compared to others nationally. We looked at the data and saw that the number of deaths for the ITU at King George was lower than expected, indicating there were good clinical outcomes for people once they were admitted to the unit.

Transfer/discharge of patients

Transfer of patients to wards once they are well enough needs to be improved. On the day of our inspection, three people were ready to be discharged to a ward, but they were unable to be transferred due to bed shortages. This was not an effective use of the service as patients who needed to be admitted to the unit were being nursed on the wards. It also presented a potential patient safety risk should additional equipment be required.

Are intensive/critical care services caring?

Dignity and respect

People were treated with dignity and respect. There was enough space between each bed to provide people and visitors to the ward with some degree of privacy.

Staff acknowledged that the ward could be noisy because of the equipment, but said that most people were understanding of this. We observed staff talking to people kindly and having a good rapport with them.

Involvement of patients in decision about their care

Patients and their relatives were involved in decisions about their care. People were positive about the staff caring for them. One person's relative described the nursing staff as "marvellous" and told us that "nothing is too much trouble for them". They told us they understood the care their relative was receiving and found staff to be supportive and approachable. One member of staff told us they felt the team as a whole "give good care".

Are intensive/critical care services responsive to people's needs?

Capacity

The service was not always able to meet demand due to the high level of bed occupancy on the wards and delayed discharges throughout the hospital. Bed occupancy rates in the ITU at King George were 82% between April 2012 and April 2013. In the same time period, about 50% of patients experienced a delayed discharge from the ITU and 64 people were transferred from ITU to other hospitals for non-clinical reasons which impacted on those who needed to access the service. Medical staff described the situation as "frustrating". In order to mitigate the risks associated with transferring acutely unwell patients, a consultant would transfer the patient and provide a face-to-face handover to the receiving service. However, this was only where the patient was transferred during the day and some people were being transferred after 10pm. The fact that patients were being transferred to wards late at night when staffing levels were reduced had been identified as a risk and was on the risk register.

Intensive/critical care

Feedback

People were encouraged to give feedback about their experience and we saw that the Friends and Family survey results were on display. We looked at the trust's patient experience report which covered the period between April and June 2013. There were no reports of any concerns being raised in relation to the ITU at King George Hospital.

Are intensive/critical care services well-led?

Leadership

Intensive care was a consultant-led service and staff told us they felt part of a supportive team. The senior managers and clinicians had a good understanding of the department's performance.

Monitoring quality

They had identified the risks within their service and were able to demonstrate how they were attempting to mitigate these. For example, by recruiting to increase the Critical Care Outreach Team and ensuring consultants led transfers of patients to other units during the day. Where risks had been identified, these had been placed on the risk register.

Staff told us they had regular team meetings to discuss any issues that may have arisen, such as incidents and complaints. All staff we spoke with enjoyed working on the ITU.

Senior nursing staff conducted weekly quality audits, looking at the quality of nursing documentation and feedback from people. Weekly hand hygiene audits were also undertaken.

Maternity and family planning

Information about the service

The labour ward was closed at the end of March 2013 but antenatal and postnatal clinics are still provided at King George Hospital from Monday to Friday between 8.30am and 4.30pm. If a woman requires inpatient antenatal care, this is provided at Queen's Hospital. The full range of diagnostic facilities are available, along with specialist clinics for women with diabetes and mental health problems. We visited the antenatal clinic and spoke with three members of staff. We spoke to two mothers who attended clinics at the hospital.

No sexual health or family planning services are provided at King George Hospital.

Summary of findings

Maternity and family planning services were safe and effective. Patients reported that midwives were caring and responsive and staff were positive about the service they provided.

Systems were in place for reporting and reviewing incidents to ensure that appropriate action was taken. Midwives used comments and complaints to improve women's experiences of care and had responded proactively to these.

Are maternity and family planning services safe?

Managing risks

Mothers were risk assessed when they first registered, and then reassessed as their pregnancy progressed. If maternal risk factors such as diabetes were identified, women were referred to specialist multidisciplinary clinics and extra care or monitoring was provided as appropriate, including screening for foetal abnormalities.

The maternity service monitored the quality and safety of care provided to women and their families. A maternity dashboard (a performance reporting and tracking system using a number of quality and safety indicators) was

used to identify and monitor potential risks to patients. The dashboard was reviewed monthly and concerns were escalated. Not all staff were aware of this valuable tool.

Safety incidents were followed up, discussed widely and lessons learned disseminated to staff. An example was the recent training for all staff on using and interpreting cardiotocography (CTG) which monitors the heartbeat of the baby and the mother's contractions to identify potential foetal distress.

A named midwife carried out a regular programme of audits as well as spot checks. Audits covered topics such as care given to pre-existing diabetic women, a patient satisfaction survey for the perinatal mental health clinic, antenatal care and antenatal referrals. The findings of audits were followed up. For example, the audit for care of diabetic women revealed a need for more dietician involvement and more frequent antenatal appointments for women who were less compliant with monitoring their glucose. Findings were presented to dieticians and the Clinical Commissioning Group. Documentation has improved and more referrals were now being made to the dietician.

Safeguarding patients

We spoke to staff about safeguarding for vulnerable women. Staff were aware of safeguarding and child protection policies, and what to do if they suspected abuse. Social workers were involved and we were told that they were sometimes instrumental in encouraging women to attend specialist antenatal clinics. Hospital staff could contact social workers from two of the three boroughs at Queen's Hospital. There was a named maternity safeguarding lead.

Staffing levels

There were sufficient numbers of staff to run the clinics and associated classes. We were told that staff turnover and sickness was low. There were both midwife and consultant-led clinics. Other specialists attended some clinics – for example, a psychiatrist attended the clinic for women with mental health problems and a diabetic specialist doctor and a dietician diabetic nurse attended clinics for people with diabetes. Child protection teams were involved in clinics for women who misused substances or alcohol.

Maternity and family planning

Are maternity and family planning services effective?

Benchmarking and national guidelines

Women received care according to best practice clinical guidelines as set out by the National Institute for Health and Care Excellence (NICE). Audits were undertaken to ensure that the clinic was performing in line with similar clinics – for example, in the care of women with pre-existing diabetes, antenatal referrals to consultants and the antenatal booking process. The audit of diabetes had revealed good aspects of care in relation to being booked early by diabetes midwives, education, scans and retinal screening. It also identified a need to inform GPs of some women whose diabetes was poorly controlled. A presentation had been made to the GP forum about the results of the audit.

Supervision of midwives

Midwives had access to a supervisor of midwives for advice and support and supervision of their practice. An audit of midwives' views on supervision between November 2012 and January 2013 showed that supervision was valued by 99% of the midwives sampled and found it supportive, informative and helpful in assisting with statement writing and birth plans. Midwives told us they were supported to attend four days mandatory training a year and in accessing professional development opportunities.

Are maternity and family planning services caring?

Support for women

Many women and their families spoke very highly of staff in the clinics and praised the support and reassurance they had received from staff. They were able to obtain the information they needed.

Patient involvement

Women felt involved in developing their birth plans and were given sufficient information to enable them to make choices about giving birth. The antenatal clinic offered classes in the last trimester of pregnancy which were run by midwives.

Are maternity and family planning services responsive to people's needs?

Referrals

Women said the antenatal service was responsive to their needs. They were able refer themselves to the maternity service online. If people didn't want to have to come to a hospital, they could attend clinics at Children's Centres. Women said it was easy to change appointments and people felt they had plenty of time to ask questions. One woman who had been identified as 'high risk' and been referred to a consultant had mentioned to the midwife that she felt she was missing out on general advice on diet and other aspects of pregnancy because she was no longer seeing a midwife. In response to this, arrangements were put in place to ensure all mothers had the chance to develop a birth plan with a midwife and attend antenatal classes.

Patients' feedback and complaints

Women's experiences of care obtained through patient surveys, complaints and comments were used to improve care. Complaints had fallen over the past year. A change in the management of staff breaks so that midwives took shorter breaks at times of high activity had improved women's experiences. Women praised staff for taking time to listen when they had concerns.

Information

Information leaflets about various topics, including tests and screening, breastfeeding and other sources of support were available in clinical areas.

Are maternity and family planning services well-led?

Leadership

The Director of Midwifery had oversight of the service. The staff thought the unit was well-led, although following the closure of the delivery unit at King George, some staff had some concerns about how long the clinics would continue to run.

Maternity and family planning

Managers were based at Queen's Hospital but visit the King George site as the antenatal clinics on both sites are regarded as a single service. Staff said that communication with Queen's Hospital was good with information cascaded by email and The Link magazine which went to all staff.

Managing quality

The trust has a Maternity Risk Management Strategy and the Director of Nursing is the named executive responsible for Maternity at the trust Board. A number of sub-groups feed into the Maternity Quality and Safety Committee, which reports through the Women's Board to the Trust Quality and Safety Committee and to the trust Board. Local meetings include staff at all levels, including junior and senior nursing and medical staff.

Staff monitored the quality and safety of care across the maternity service through a range of audits and spot checks. Some of these had been introduced recently and time was needed to assess their value in prompting change. We saw presentations that communicated the findings of audits as well as action plans to respond to identified concerns. Both email and face-to-face meetings were used to disseminate lessons learned and these were also incorporated in training. The unit reported performance indicators on the maternity dashboard and monitored incidents, complaints and patient feedback. A Maternity Message of the Week communicated key issues to all staff.

Staff told us they felt supported by senior managers and could escalate concerns if needed.

Children's care

Information about the service

King George Hospital children's services consists of two distinct units:

- The special care baby unit (SCBU) in Jasmine Ward has 12 cots and provides care for babies who require less intensive care before going home. Most babies have been transferred from the neonatal intensive care unit (NICU) at Queen's Hospital.
- The children's ward in Clover Ward has its own staff (although there was a policy that newly recruited children's nurses would work on this ward as well as in the paediatric service at Queen's Hospital).

Both units are led by matrons who are based at Queen's Hospital where there are related services.

The general paediatric service has a dedicated children's outpatient clinic for urology, diabetes, respiratory and other conditions. An 18-bed ward takes inpatients as well as day patients coming into hospital for surgery or for assessment. The ward has two six-bed bays and six cubicles for patients with infectious diseases. Most children are admitted after coming to the A&E service at King George.

We talked with staff in the SCBU and two staff and parents or relatives of children in the children's ward. We observed care and treatment and looked at six care records. We also reviewed performance information about the trust.

Summary of findings

Children's care services were safe and caring and patients and parents reported that staff were responsive to their needs. Parents said nurses were very caring and kind, and responded well to their children's needs. They considered that children had received safe and effective treatment and said staff were knowledgeable and helpful. Staff engaged positively with children of different ages and involved them in their care. The facilities for children were good and there was a well-equipped children's play area.

Performance information, and comments and complaints were used to improve the service.

Are children's care services safe?

Special Care Baby Unit (SCBU)

Admission criteria

The SCBU was a specialist care unit for babies who needed minimal additional support and monitoring of their breathing or heart rate, support with feeding or recovery and convalescence from other care. One mother said she was impressed with the skills and kindness of the staff and the reassurance they gave mothers.

The neonatologists were required to use clear criteria for deciding to admit a baby to or discharge a baby from the SCBU. Most babies did not stay more than a week or two in this unit. The unit was fully equipped with new-born resuscitation drugs and equipment to help babies with breathing. In the event of deterioration, a baby would be stabilised and taken back to the NICU at Queen's Hospital.

Children's care

Staffing levels

The ratio of nurses to babies was generally 1:4 including a neonatal and special care nurse. As babies in the SCBU required minimal care and treatment, (mainly oversight of feeding and weight), staff thought this staffing level was sufficient. Consultants did ward rounds seven days a week.

Capacity

The cot occupancy in the SCBU was monitored daily and throughout the shift alongside the monitoring of cot occupancy in the NICU. Baby transfers between the two hospitals were co-ordinated by neonatologists and ward co-ordinators. A nurse escorted babies being transferred.

Paediatrics

Admissions

Most children who were admitted to the paediatric ward at King George had been brought to A&E by their families. Children's risks were assessed on admission and care planned accordingly. We looked at the records of six babies and children and saw that all the relevant information had been recorded.

The parents on the paediatric ward were very complimentary about the care provided by nursing staff and were confident in the expertise of the staff. The parent of one child who had frequent admissions to the ward was unhappy that she received different advice from different doctors.

Staffing

There were sufficient numbers of nursing staff to meet the needs of children on the inpatient wards. The ratio of nurses to children was 1:5 unless a child needed one-to-one care.

The trust had a full complement of paediatricians. Consultant paediatricians were on call at night and during the weekend. Junior doctors said consultants were accessible and supportive.

Safeguarding children

All nurses on the ward had attended mandatory safeguarding training to Level 3. There was a named nurse and consultant responsible for safeguarding of children and young adults, both based at Queen's Hospital. There were weekly multidisciplinary meetings about children of concern.

Patient safety and environment

All nurses we spoke with understood the process for reporting incidents and explained how they learned from these.

All areas in the children's unit were visibly clean. Hand hygiene gel was available and used by staff, parents and visitors on the ward.

Staff told us they had access to the equipment they needed. The environment was well maintained with toys and activities suitable for different age groups. Toys were clean and in good condition.

Resuscitation equipment and drugs for babies and children were available on the ward.

Are children's care services effective?

Special Care Baby Unit (SCBU)

Discharge

Most babies spent only a short time on the SCBU before being able to go home. Each baby had a clear care plan and risk assessment on admission to SCBU, which often involved gradual weaning off oxygen to prepare for discharge. There were protocols for staff responsibilities including transport arrangements for babies, sharing information and learning lessons from admissions, and these processes were audited.

Some babies who had been discharged would continue to receive support at home from the children's community service. Doctors said staff worked hard to encourage relevant parents to bring their babies back for check-ups and had improved the rate of clinic attendance.

Staffing levels and skills

In the SCBU staff were either neonatal doctors or nurses trained in neonatal nursing. There was a national shortage of such nurses and the trust had sent some of its own staff on training to help remedy this. Agency and bank nurses (trust nurses working overtime) were sometimes used and there were clear induction checklists for such staff. There was a mechanism for permanent staff to report unsatisfactory agency or bank staff.

Children's care

Paediatrics

The parents and children we talked to in the paediatric wards said they were looked after well and said their children had prompt and effective pain relief. Parents were aware of their children's care and treatment plans and said they had been able to contribute to them. The length of stay depended on the condition of a child but the hospital's aim was always to discharge young people back home as soon as possible. Sometimes family care was supported by the children's community service.

Children were discharged with medical notes sent out to GPs or others and staff said there were rarely delays in discharging children. There was a home care team to support discharge.

Staffing levels and skills

Children on the paediatric ward were cared for by nurses trained to care for and treat children. Medical staff were also paediatricians. The trust had its full complement of paediatric doctors. Some nurses on the ward had recently been promoted and the trust would be reviewing the need for replacements.

The paediatric outpatient area was not busy at the time of our visit, although we were told there were 40 appointments a day. There were two consulting rooms. We were told 30% of patients did not attend for their diabetic appointments. The nurse said that the receptionist was sometimes directed to work at Queen's Hospital and that meant they had to take on reception as well. It was not always possible to guide patients to the consulting room when this happened, and there was no way of verifying children's hand hygiene.

There was a senior house officer based at King George. Consultants and registrars rotated between children's services at King George and Queen's Hospital.

Are children's care services caring?

Special Care Baby Unit (SCBU)

Staff tried to minimise the time mother and baby were apart. In the SCBU mothers were often able to be more involved in the care of their baby and staff were there to support them. One mother spoke highly of the "wonderful helpfulness of staff". Parents felt that doctors communicated well with them. There was a nursery nurse who was able to give advice, guidance and support for parents on all aspects of baby care, including breastfeeding and milk feed preparation.

Paediatrics

Parents said staff cared for their children well and that their child's treatment was explained to them in a way they could understand. They felt able to raise any concerns with staff. Parents said their children received pain medication quickly when they arrived on the children's wards and they were given information about their child's medication.

Parents were able to stay with their children overnight so children felt less anxious about being in hospital. There were toys and books for children of all ages.

Are children's care services responsive to people's needs?

Paediatrics

Support for parents

Parents were pleased that beds were available for them to stay with their children on the ward. They also welcomed the availability of toys to keep children occupied during their stay.

Feedback

Staff encouraged parents to give feedback when their child was discharged and staff said they learned from feedback and used it to improve their interaction with parents and children.

Children's care

Staff told us the bed base could be adjusted to cope with seasonal vacancies. More beds were likely to be needed in winter.

Staff mentioned that the ward could not easily take children with challenging behaviour because they were not staffed for this. Such children went to the Brookside child and adolescent specialist inpatient unit.

Are children's care services well-led?

Special care baby unit (SCBU)

Management

The SCBU was closely integrated with the neonatal intensive care unit (NICU) and doctors and nursing staff rotated between the units on the two sites. Nursing staff were managed by a newly appointed matron, who had established himself quickly in his role. Although managers were based at Queen's they also worked at King George Hospital.

Doctors and nurses said they worked as an effective team.

Safety and quality of care was monitored and action taken to respond to concerns. This included reporting on performance indicators through a range of audits and monitoring risks through the risk register.

Paediatrics

Management

The matron was visible to her staff and nurses and the healthcare assistant considered they worked together as a team and with medical staff. Two staff said the ward was very well run. The matron told us that, when she first joined, there were a lot of management changes but that the structure now seemed fairly stable.

Senior managers within the paediatric service had a clear vision for developing aspects of the children's service. There were plans to rotate paediatric nurses through A&E which was intended to help liaison between that service and the ward. A meeting to discuss this was to be held shortly after our visit.

Monitoring quality

Staff told us they had regular supervision and appraisal and that there were regular training opportunities. They mentioned that management communications had improved but they sometimes felt staff at King George Hospital "got left out of the loop".

Staff said that the hospital was slow at managing poor staff performance. Quicker processes would be better for all staff because nurses who were not performing well became supernumerary.

End of life care

Information about the service

The palliative care team is based at Queen's Hospital. The team provides end of life care directly to patients throughout the trust where appropriate as well as supporting and training staff on the wards. One member of staff is based at King George Hospital Mondays and Fridays. They receive over 1,000 referrals every year. The trust offers a bereavement service between 8am and 5pm.

We spoke with a patient, families of patients and five members of staff, including staff nurses, bereavement service officers, mortuary officers and ward sisters. We observed care and treatment and looked at two patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients received safe and effective end of life care. They had support to make decisions and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patient records for end of life care were completed in a timely fashion. However, patients and families had some negative views about the end of life care service. Also discharges were not as fast as required due to the length of time taken to complete the referral form.

Are end of life care services safe?

Documentation

The records of two patients who had received palliative care or end of life care demonstrated that they had received appropriate care for their condition. Pain relief, nutrition and hydration were provided according to their needs. Their wishes for their end of life care were also clearly documented including if they wanted to be resuscitated. Mental capacity assessments were in place where required and patients or their next of kin signed these plans as accurate.

Staffing

The palliative care team included specialists who understood their role and were passionate about ensuring patients received good end of life care. The team was fully staffed, although they wanted further staff seconded to the service which had not been fully successful. The service had one consultant lead. The trust had an end of life co-ordinator who trained staff on the wards in end of life care.

Are end of life care services effective?

Patient's end of life care was managed effectively. Patients received effective support from a multidisciplinary palliative care team. The team, including a consultant, a lead nurse, clinical nurse specialists and a social worker, responded swiftly to referrals to ensure that patients received an effective service. An end of life care co-ordinator provided support to all patients and staff across the trust. A chaplaincy and bereavement service was also available. Links with community services and hospices had been made to ensure families had support out of hours. All staff in the palliative team were trained to provide specialist care and expertise in palliative and end of life care.

Multidisciplinary working

Ward staff were aware of end of life pathways, although different wards told us they would request support from the palliative team for different aspects of a patient's end of life care. Some staff were reluctant to involve the palliative care team, whereas others would ask them to provide all end of life care. All staff we spoke with felt well supported by the palliative care team, although some acknowledged that it was easier for the team to support patients at Queen's rather than King George due to being located there.

National guidelines

The end of life care team followed government guidelines. In response to the national independent review More Care, Less Pathway: A Review of the Liverpool Care Pathway, July 2013, the Department of Health recently asked all acute hospital trusts to undertake an immediate clinical review of patients on end of life care pathways. The trust had undertaken this review and had an interim policy on end of life care which replaced the Liverpool Care Pathway.

End of life care

Training

The palliative care team supported ward staff to ensure continuity with end of life care when there was no direct palliative clinical support. All clinical staff had mandatory training in basic end of life every two years and more comprehensive training was also available to staff.

However, some staff felt end of life training was not flexible enough and take up of training ranged between ward areas. This meant that care could fluctuate depending on which staff looked after a patient.

Staff informed us that the trust had introduced the Gold Standards Framework on two wards in the trust for end of life care. The National Gold Standards Framework Centre in End of Life Care is the national training and co-ordinating centre, providing a gold standard of care for people nearing the end of their life.

Quality monitoring

Although the trust was in the bottom 20 percent in the National Bereavement Survey in 2011 in three of six quality indicators, the trust met their Commissioning for Quality and Innovation (CQUIN) targets for end of life in 2012/13 and were on course to meet higher standards in 2013/14. The trust had carried out their own bereavement survey in the last year with positive results.

Are end of life care services caring?

Patient and relatives experience

Patients and families had negative views about the end of life care service. Only some wards had relative rooms so families could have privacy. The palliative care team tried to ensure all patients on end of life pathways were in side rooms and we observed that this had been arranged.

Families of patients receiving end of life care had dedicated parking and their visiting hours were not restricted. The bereavement service had private and comfortable relative rooms. The mortuary had a viewing area that was dignified and viewing could be arranged before a post mortem was started. A multi-faith service was available for patients and their relatives.

Although they felt everything was dealt with sensitively, some patients and families felt they had not had enough input from the palliative care team and had not been fully involved in end of life arrangements. One family told us they always had to escalate their concerns to enable their relatives' needs to be addressed and had been unable to contact the palliative team directly at times. They also felt that staff treated their concerns differently as the patient was receiving end of life care; they felt staff were more concerned about making the patient comfortable rather than addressing their health needs. Another patient told us that they had been waiting to be discharged for three weeks but had not been told why there was a delay. We found that the nurse covering King George Hospital that week was on leave one of the days and the lead nurse was covering their normal palliative team duties as well as those at King George. This meant requests for patient and relatives to have face-to-face contact with a member of the palliative care team at King George was not always possible.

Information

The bereavement service had a number of leaflets to support relatives, including contacts of support organisations and networks such as counsellors as well as a step-by-step guide of what a family needs to do when a relative has died.

Are end of life care services responsive to people's needs?

Referrals

We saw examples of referrals to the palliative team late on Fridays and Mondays. Due to the service being Monday to Friday, this led to delays with palliative team input as no referrals could be completed over the weekend and there was a backlog of referrals on a Monday. We were told this was due to consultants not completing the necessary paperwork in a timely manner.

If the palliative team were not on site during their opening hours, a telephone advice service was available to patients, families and ward staff.

End of life care

Discharge

Patients were discharged safely with the right care and support. We listened to some palliative care patient consultations with the end of life consultant, end of life nurse and ward nurses. The patient's palliative care needs were discussed in-depth, including end of life care. This included making sure support services were in place so that the patient could return home safely, psychological and religious support and a review of the patient's pain relief needs.

Although patients were fast-tracked to get immediate funding to facilitate the right home care package or nursing home depending on their wishes, this was not always done as efficiently as it could be. Staff reported that fast-track discharges were delayed due to the length of time it took to complete the referral form. This resulted in delays with arranging social care in the community due to limited providers being available through the local authorities and referrals to the palliative team being rejected for not having enough information to show that fast-track discharge was required.

Are end of life care services well-led?

Leadership

All staff were positive about their work and wanted to provide a high quality service. While many aspects of the service are good action needs to be taken to improve some aspects of the care provided to patients and outstanding issues related to referrals and fast-track discharges.

Outpatients

Information about the service

Outpatient services are located in one area at King George Hospital. The clinics run from Monday to Friday 9am to 5pm. The trust offers outpatient appointments for all its specialties where assessment, treatment, monitoring and follow up are required. During our inspections, there were separate outpatient clinics for neurology, trauma, cardiology, chest, geriatric, pain, general medicine, epilepsy, hepatology, orthodontics, dermatology, vascular, ear, nose and throat (ENT), ophthalmology, stroke, chiropody, orthopaedic, urology, endocrinology, rheumatology, maxillofacial, anaesthetics, breast, general surgery, paediatrics, obstetrics and anti-coagulation.

During the inspection we talked with eight patients and five members of staff, including booking and clerking staff, doctors and consultants. We observed care and treatment. We received comments from our listening event, from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The outpatient service did not always provide safe and appropriate care. There were instances where patients did not see the correct clinician to deal with their treatment, in some cases because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Most patients found the staff caring, but care was not always responsive. Patients received treatment and follow-up appointments. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed although some patients felt they were not kept informed. Some clinics were not managed efficiently and areas of the service needed to improve. The service had a high number of patients who did not attend their appointment and there were a high number of cancelled and delayed clinics.

Are outpatients services safe?

Staffing

Patients had consultation, diagnostic tests and assessment and consultations with appropriately qualified staff and advice was sought from other healthcare professionals, where necessary. However, sometimes patients did not see the correct clinician to deal with their treatment, in some cases because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Environment

Some of the outpatient services were provided in a clean, safe and accessible environment. However, staff reported to us that patients had to frequently wait in corridors.

Infection control

One hand hygiene gel was empty in outpatients. However, we observed staff always following infection control guidelines such as not having any clothes or jewellery below the elbow.

Accessibility

All clinics were on the ground floor, making access safe and easier for patients with mobility difficulties. There were wheelchairs in the outpatient areas for use if needed.

Safeguarding

Staff understood safeguarding processes and what to do if they needed to raise an alert. Staff told us that they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. The trust had a safeguarding team if staff needed support.

Outpatients

Are outpatients services effective?

Quality and monitoring

The trust had recently started auditing their appointment times to ensure the time was spent efficiently and obtaining feedback from patients about their appointments. We were told that, in the first month, patient feedback had been positive and meetings with a patient representative were being held in the outpatients department.

Team working

Some staff told us that frontline staff worked as a team and staff moved between Queen's and King George hospitals if there was a shortage of staff that could not be covered.

Are outpatients services caring?

Staff attitude

Most patients told us they found the staff caring. They said staff were reassuring and explained their current treatment and next steps, including the risks and benefits. When we observed patient consultations, staff were friendly, explained the next stages of their treatment and gave patients contact details if they needed further support after they were discharged.

If a patient did not see their usual doctor, patients told us they felt the doctor was informed about their condition and background.

Information was available in all outpatient clinics informing patients of any delays and most patients told us they felt informed about appointments at both hospitals.

Information desks were available in public areas so patients could be assisted to find their outpatient appointment.

Are outpatients services responsive to people's needs?

Appointment times

Although patients were allocated sufficient time with staff when they attended clinics, in some clinics, this time was sometimes reduced due to delays or overbooking. A text reminder system was in place for all outpatient clinics, but staff and patients told us they had experienced some difficulties using the system. The trust is taking action to address the problems. Staff in the outpatient area felt that call centre staff had not been adequately trained due to the amount of errors that were occurring: an average of 40 percent of appointments not being booked correctly causing more delays. Call centre staff had recently been undertaking work at the weekends to help with the introduction of a new IT system.

Some patients told us that appointments were sometimes delayed and staff told us delays could go up to 90 minutes for scheduled appointments. We observed patients waiting up to 50 minutes. Staff told us these delays were due to a number of factors, including consultants being scheduled to conduct ward rounds or other duties at the same time as scheduled clinics, patients and staff having to wait for parking spaces, staff travelling from other trust sites without enough time allocated, patients not receiving appointment letters or receiving multiple appointment letters, or lost medical notes.

It was estimated that around 10 percent of medical notes were missing for each clinic, equating to around 200 a week. This was due to staff not tracking notes correctly. It was also reported that doctors completed administration work during clinics that was not linked to the clinic and this was also causing delays. At a focus group with nurses they told us that this was due to a lack of specialist doctors. Those clinics that were either directly referred to an emergency clinic by their GP or their follow up was booked directly with the consultant were less affected by these issues. An audit by the trust in May 2013, the Chief Operating Officer and complaints data confirmed these issues were being experienced and an action plan was in place to address them, but we did not find evidence of any improvements during our visit.

Outpatients

Privacy and dignity

The general outpatients' areas had private consultation rooms and we observed one patient being treated with dignity and respect, including being examined in private.

Vulnerable patients and patients needing support

Staff were aware of how to support vulnerable patients, although we were told that no patient had required a chaperone as they always attended with a carer. All outpatient areas had a telephone system that enabled staff to speak to patients in up to 60 languages without an interpreter. The trust also had an interpreter service if patients needed it.

Are outpatients services well-led?

Management

Most of the senior staff, matrons and general managers felt supported by their colleagues and their line management. Staff were briefed by senior staff in the trust and trust-wide messages and updates were cascaded by email and by managers or clinical leads in team meetings. The outpatient department had an item on the risk register since 2008 regarding waiting times being longer than 18 weeks for new patients. This was reviewed in 2012 and the manager who was responsible for the area was unable to tell us what was being done to reduce the risk.


Staff told us that they escalated issues and complaints to their line management and via a daily issues logbook but, other than one example regarding dictaphones, we were told nothing had been done or staff had not had any feedback. Some staff told us that they tried to contact managers when there was an issue but had been unable to get hold of them. One senior member of staff told us they were unable to be as visible as they had been previously due to a lack of staff.

Good practice and areas for improvement

Introduction


The inspection has identified many areas that require improvement notably in the domains of effectiveness and responsiveness and a few that were inadequate in the safety domain. However, one area that is a key strength is in the domain of caring.

Areas of good practice

- The e-Handover system in the medical services which allowed doctors to manage their workload more effectively. 
- The virtual ward, in medical services, which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- Patients were positive about the care they received from staff, many of whom were positive about working for the trust.

Areas for improvement

Areas where the hospital MUST improve:

- Waiting times in the A&E department must be reduced 
- Increased number of permanent senior medical staff in the A&E department
- The care provided in the medical, surgical care services and end of life service
- The management of sepsis
- Discharge planning and movement of patients through the hospital to ensure patients are cared for on the appropriate wards and clinical areas and discharged when they are well enough.
- Management of the appointment times in some of the outpatient clinics
- Documentation relating to patient care.
- Sharing information to monitor performance and quality of care
- Cleanliness and infection control in operating theatres
- Job planning for consultants to enable them time to travel between the two hospitals and attend ward rounds and outpatient clinics

This section is primarily information for the provider.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010: Care and welfare of patients</p> <p>People who use the service were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by ensuring the welfare and safety of the service user.</p> <p>Improvements are needed in respect of:</p> <ul style="list-style-type: none">• The care they receive in the A&E department and medical services• Discharge planning and ensuring patients are cared on the appropriate wards/clinical areas• Management of the appointment times in some of the outpatient clinics• Regulation 9 (1)(b)(i), Regulation 9 (1)(b)(ii) and Regulation 9 (1)(b) (iii)

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</p> <p>Records</p> <p>Improvements are needed in respect of nursing documenting all appropriate documentation relating to patient care. Regulation 20 (1)(a)</p>

This section is primarily information for the provider.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not enough qualified, skilled and experienced staff to meet the needs of patients. There are insufficient permanent medical staff employed in the A&E department.
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Service user were not protected from the risk of a health care associated infection because staff in the operating theatre did not follow infection prevention and control procedures
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The provider did not have effective systems in place to monitor the quality of the services provided. Regulation 10 (1)(a) 2 (b)(i)

Barking, Havering and Redbridge University Hospitals NHS Trust

Queen's Hospital

Quality report

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

Overall summary

Barking, Havering and Redbridge University Hospitals NHS Trust (the trust) is a large provider of acute services, serving a population of over 750,000 in outer North East London. The trust has two acute hospitals: Queen's Hospital and King George Hospital. Accident and emergency (A&E) departments operated from both of these hospitals. It also provides services from the Victoria Centre and Barking Hospital but does not manage them. King George Hospital was built in 1993 and is the main hospital for Barking and Redbridge. Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for Havering, Dagenham and Brentwood. There are plans to reconfigure services from King George Hospital to Queen's Hospital.

The trust covers three local authorities; Barking & Dagenham which has very high levels of deprivation, and Havering and Redbridge which are closer to the national average. Havering has a relatively elderly population by London standards.

This report relates to Queen's Hospital and there is a separate report for the overall trust. Queen's Hospital is the larger of the two hospitals and provides acute care.

The inspection team identified the following areas for improvement:

- The A&E department does not provide safe care all of the time. On some nights there are too few full-time doctors on duty, and at other times there are too many patients in the department. Patients were also not seen and treated effectively by specialist doctors, and were waiting too long to be either admitted or discharged. Staff were caring and were doing their best given the high demand and limited staffing cover.
- We could not be assured that patients always received safe and effective care on surgical wards, and medical wards. The completion of nursing documentation was inconsistent and if patients were transferred to King George Hospital there were no documented handovers. Delayed discharges, particularly in medical services and high occupancy rates meant that the service could not be as responsive as required and this put unnecessary pressure on departments and increased the risk of poor outcomes for patients.
- The outpatient service did not always provide safe and effective care. Patients received treatment and follow-up appointments, although these were not always held in appropriate private locations. The service had a high number of patients who did not attend their appointment and there was a high number of cancelled and delayed clinics.

Summary of findings

Overall summary (continued)

- Some aspects of end of life care also need to be improved.
- The inspection team was impressed with the care provided to patients who have had a stroke, with the trust performing well against a number of data indicators and was in the first (highest) quartile of all units.

Many initiatives to improve quality and safety have only started very recently. We particularly commend the work being led by the Director of Nursing, Chief Operating Officer and the Director of Midwifery. Despite this, the trust management (Board and executives) recognises the need for both managerial and clinical leadership to be strengthened and would welcome further support. The trust continues to face huge problems both in bringing about change and improving practice at Queen's Hospital in planning for reconfiguration of services from King George Hospital.

The maternity services, which have undergone a huge transformation over the last two years have maintained the improvements following the transfer of the delivery unit from King George Hospital earlier this year.

Summary of findings

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?

Some of the services we visited were safe but required some improvements, but the A&E department at Queen's Hospital is at times unsafe. This is because of the lack of full-time consultant and middle-grade doctors. There is an over-reliance on locum doctors, with long waiting times for patients to be assessed and reassessed. Other services such as medicine and surgery require improvements.

Are services effective?

The hospital had some arrangements in place to manage quality and ensure patients receive effective care, but more work is needed in some of the services we visited. Effective care in the A&E department is hampered by long waiting times for patients to be seen by a specialist.

Are services caring?

National inpatient surveys have highlighted many areas of care that need improvement and work has been undertaken to improve the patient experience. Many patients and relatives were complimentary about the care they received and the way staff spoke with them. However, more work is required to ensure that these improvements are reflected in future national inpatients surveys.

Are services responsive to people's needs?

Overall the hospital needs to improve its responsiveness to patients' needs. Some improvements have been made to help people access care more quickly, but the longstanding problem of waiting times in the A&E department at Queen's Hospital has not been addressed. There are also problems with the paediatric waiting times: the current process does not meet their needs and causes unnecessary delays with the initial assessment. Although there are some external factors which affect the movement of patients in the hospital, more work needs to be done to improve discharge planning. The hospital has not worked as effectively as it could with partner organisations such as the local authority to address some of these issues.

Are services well-led?

We found examples of good clinical leadership at service level and staff were positive about their immediate line managers. Leadership at a more senior level was good, but given that there are a number of longstanding problems which have not been resolved, some aspects of the leadership need to be strengthened.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

The A&E department does not provide safe care all of the time. On some nights there are too few full-time doctors on duty, and at other times there are too many patients in the department. This increases the risk of errors being made in clinical judgements or people not being assessed or reassessed in a timely manner, which means they may not get the right treatment when it is needed. Staff were caring and were doing their best given the high demand and limited staffing cover.

The department is not responsive to people's needs. People experienced excessive delays in being assessed, reviewed, and treated. While staff were positive about the leadership and felt supported by senior doctors and nurses, they do not feel supported by the management of the trust.

Medical care (including older people's care)

Medical services are safe although there are a number of areas which require improvements, including documentation. Patients felt they received good care but there were delays in discharging patients who were well enough to go home and learning from incidents needs to be improved.

The trust was implementing changes to try and improve the patient experience and ensure patients were admitted to the correct ward and discharged as soon as they were well enough. Patients told us they felt the care they had received was very good and that the staff were responsive and caring.

All of the wards we visited were clean and well maintained. We saw some instances of nurses not using barrier aprons and gloves as well as occasional empty hand-wash gel canisters. These standards need to be constantly maintained to minimise cross-infection risks.

Surgery

Patients on the surgical wards told us staff were caring and they felt their needs had been met. The service used comments and complaints to improve, and there was some evidence of learning from incidents. However, although the service was safe some aspects of care require improvement. The completion of nursing documentation was inconsistent and if patients were transferred to King George Hospital there were no documented handovers. Delayed discharges and high occupancy rates meant that the service could not be as responsive as required.

Intensive/critical care

The patients and relatives we spoke to in the intensive care unit (ITU) felt that they had been well cared for and involved in making decisions about their treatment. The service was well-led by a team who had identified the risks and challenges the service faced and were monitoring them. However, there was a lack of patient flow in and out of the service due to delayed discharges and high bed occupancy in other parts of the hospital. This affected the service's ability to provide responsive and effective care to all patients. Once admitted to an intensive care ward, patients received safe and effective care from caring, qualified staff.

Summary of findings

What we found about each of the main services in the hospital continued

Maternity and family planning

Most of the patients that we spoke to were pleased with the antenatal and maternity care they received, and said that they had found midwives to be sensitive and supportive and had received clear information from doctors. The staff we talked to were positive about working at the hospital.

Most areas in the maternity unit were clean, but not all medicines had been locked away and we found some out-of-date items which indicated poor stock control.

All safety incidents were followed up, discussed widely and lessons learned were disseminated to staff.

Although staffing levels were good, some staff told us they felt under pressure and consideration needs to be given to how support roles can be used more effectively. The consultant cover was lower than in some similar services and, given the number of deliveries, cover should be in line with the Royal College of Obstetricians and Gynaecologists recommendation.

Children's care

Parents told us they were happy with the services provided for new-born babies and that staff listened to their concerns and answered their questions. The standard of hygiene was high, and all babies were routinely swabbed to identify any colonisation of bacteria and preventative treatment was given if needed.

Parents of children and young people using the children's care services said that staff were caring and kind, responded well to people's needs, and considered that their children had received safe and effective treatment.

The facilities on the ward were good and included indoor and outdoor play areas, a sensory room and a tuition service. We also saw evidence that performance information, comments and complaints were used to improve the service.

End of life care

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service. Records regarding end of life care were completed in a timely fashion. However discharges were not as fast as required and the level of care could fluctuate depending on which member of staff was looking after a patient as a consequence of variable take-up of training between ward areas.

Outpatients

The outpatient service did not always provide safe and effective care. Patients received treatment and follow-up appointments, although these were not always held in appropriate private locations. Patients were able to ask questions to help understand their treatment and monitoring plans but sometimes this could be rushed. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed, although some patients felt they were not kept informed. Some clinics were not managed efficiently and areas of the service needed to improve. On average, between 10-12% of patients do not attend their appointment (the national average is 10%) and there were a high number of cancelled and delayed clinics.

Summary of findings

What people who use the hospital say

The trust scored low overall on the Friends and Family Test, especially in accident and emergency and Gastroenterology (Clementine B ward).

The trust scored 19 in the July A&E Friends and Family Test with a response rate of 10.2%. Recent scores have

ranged from 12 in April and 21 in June; results which place Barking, Havering & Redbridge in the bottom 10 trusts nationally for this component of the test. However, these results should be treated with caution due to the low response rate for the A&E section of the test.

Areas for improvement

Action the hospital MUST take to improve

- Waiting times in the A&E department must be reduced.
- Increased number of permanent senior medical staff in the A&E department.
- The care provided in the medical and surgical care services.
- The management of sepsis.
- Discharge planning and movement of patients through the hospital to ensure patients are cared for on the appropriate wards and clinical areas.
- Management of the appointment times in some of the outpatient clinics.
- Environment in the sexual health clinic.
- Documentation relating to patient care.
- Job planning for consultants to enable them time to travel between the two hospitals and attend ward rounds and outpatient clinics.
- Sharing information to monitor performance and quality of care.

Good practice

Our inspection team highlighted the following areas of good practice:

- The e-handover system in the medical services which allows doctors to manage their workload more effectively.
- Patients were positive about the care they received from staff, many of whom were positive about working for the trust.
- The virtual ward which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- The inspection team was impressed with the care provided to patients who have had a stroke, with the trust performing well against a number of data indicators, and was in the first (highest) quartile of all units.

Queen's Hospital

Detailed findings

Services we looked at: Accident and emergency (A&E); Medical care (including older people); Surgery; Intensive/critical care; Maternity and family planning; Paediatrics/children's care; End of life care; Outpatient services

Our inspection team

Our inspection team was chaired by the Chief Inspector of Hospitals and included a range of specialists: consultant surgeon, consultant haematologist/medical director, junior doctor, senior nurses and a student nurse, midwives, a hospital manager, patients and members of the public.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. Between September and December 2013 we are introducing our new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care according to our new surveillance model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. Using this model, Barking, Havering and Redbridge University Hospitals NHS Trust was considered to be a high-risk service.

How we carried out this inspection

Prior to the visit we reviewed a range of information we hold about the trust and asked other organisations to share what they knew about the trust. We carried out an announced visit from 14–17 October 2013. During the visit we held focus groups with a range of staff in the hospital, nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the trust.

Are services safe?

Summary of findings

The majority of the services we visited were safe but improvements are needed to maintain safety. Insufficient numbers of full-time, permanent medical staff means that, on occasion, the A&E service is unsafe. The hospital has tried to mitigate some of the risk by employing locum and agency staff but, at times, locums who are new to the trust may be the most senior doctor in the department. This places significant pressure on them and other staff and increases the risk of patients receiving suboptimal care.

There were vacancies in most departments and many wards relied on bank nurses (staff who work in the trust as overtime), agency nurses and locum medical staff who, on occasions, were unavailable.

The hospital is finding it difficult to recruit staff due to national shortages in some specialties and its reputation acquired through negative media reporting of past CQC inspection findings.

Arrangements to minimise risks to patients are in place, including incident reporting, infection prevention and control, child protection and safeguarding vulnerable adults, but some areas, such as the environment and nursing documentation, need to be improved.

Our findings

Incident reporting/never events

An electronic incident reporting system is in place and incidents are monitored and investigated by ward managers or matrons. Learning was shared through a range of mechanisms: intranet, email and weekly ward/unit meetings, although we were told these did not always take place.

Pre-inspection information showed maternity services accounted for 36 (23%) of the serious incidents reported and 22 of these were classified as 'unplanned admissions of term babies'. The service has carried out an analysis of the number of unplanned admissions and identified cases which represented avoidable harm. The review concluded

that the cases of avoidable harm were a small percentage of the overall admissions. Each case has been reviewed and action taken.

Between August 2012 and September 2013 the trust had three never events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken).

Two of these were in maternity and involved swabs being retained inside patients and one was an incidence of wrong site surgery in ophthalmology. The trust has taken action to address the issues and, although never events are not acceptable, the trust has not reported more or less incidents than other trusts of a similar size.

To minimise the occurrence of never events, the hospital is using the World Health Organisation (WHO) safety checklist in theatres, which is regularly audited.

Cleanliness and infection prevention and control

The trust has improved its arrangements for the prevention and management of infection control. In the 2012 Department of Health NHS Staff Survey, only 52% of staff who responded said that hand-washing materials were always available, which was worse than expected. The trust responded to this by installing hand-washing facilities at the entrance to clinical areas. During our inspection we observed staff washing their hands and that gloves and aprons were available, although at times not all staff used them.

Staffing

The trust is aware that staffing is an area for improvement. There are vacancies across many staff groups and recruitment is underway. In the meantime bank and agency staff are used to fill vacancies on shifts, although there were times when they were unavailable.

The trust faces significant difficulties in recruiting medical staff for A&E, and has done since 2011. The trust has eight consultants in post out of an establishment of 21 to cover both A&E departments at Queen's and King George Hospitals. The heavy reliance on locum staff is putting patients at risk of receiving suboptimal care. Joint work with other trusts has not achieved the desired results and additional work is underway, including recruiting staff from overseas.

Are services safe?

Induction for locum and agency staff is variable and sometimes consisted of being shown around the ward.

Some staff told us there were adequate staff to meet patients' needs while others felt staffing levels were at a minimum and unplanned absences were difficult to manage. We did not see any examples of patients not having their needs met through lack of staff. Although staff were able to meet patients' needs, they did not have sufficient time to complete patient records of care. This was a common issue across both medical and surgical wards.

Patients attending the outpatient clinics did not always see their named doctor due to clinics being cancelled when the consultant did not arrive due to other planned activities or leave was required at short notice.

Documentation

Nursing staff on both medical and surgical wards were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen's and King George Hospitals with transfer checklists not always completed, which meant staff may not be aware

of a patient's needs – as in the case of one patient who had diabetes which was not recorded. Staff told us they did not have time to always complete the "paperwork" but knew their patients and the care they required.

Environment

The sexual health clinic location at Queen's Hospital was unsuitable as the area was not big enough to accommodate patients and staff. Patients had to wait in a narrow corridor used by other staff to transfer medical records on trolleys. Staff, including the General Manager and a consultant, had expressed their concerns, but told us nothing had been done. The clinic also used a former storage cupboard as a treatment room. No review of the decision to move the sexual health clinic was recorded.

Safeguarding vulnerable adults and protecting children

Staff had received training on safeguarding vulnerable adults and child protection. They understood the policies and processes and knew what action to take if they needed to raise an alert. The trust had a safeguarding team if staff needed support.

Are services effective?

(for example, treatment is effective)

Summary of findings

Many services provided effective care, but some services had better information gathering and monitoring systems in place. Services such as the intensive care unit (ITU) were able to demonstrate they are providing effective care. For other areas it was less clear and some were only just implementing systems to capture information to assess their effectiveness.

Our findings

Mortality rates

They hospital's clinical staff can access mortality rate information. Each clinical department has access to a specific data review system which provides an early warning of outlier status. The information is included in the department's 'dashboards' (performance reporting and tracking system) and is reported to the Quality and Safety Committee.

The trust was identified as having higher-than-average mortality rates for patients with pneumonia, septicaemia and most cancers and reviews have been carried out. In June 2013, information showed that elective patients who were admitted over the weekend were at a higher risk than those admitted during the week. Actions to improve this include implementation of seven-day working for senior clinical staff, including the critical care outreach service, and better availability of specialist consultant support.

Past CQC inspections noted the trust has received two mortality alerts from the Care Quality Commission (CQC) for septicaemia shunting for hydrocephalus procedures and septicaemia (except in labour). The trust carried out a case note review for the first alert and found "no obvious deficits of clinical or operative quality" and the case has been closed. The second case is currently being reviewed.

NHS Safety Thermometer

There is a national target that 95% of patients should have a venous thromboembolism (VTE) risk assessment. The medical services had not achieved this target. In an audit in August 2013, only 88% of patients in MAU A and 92% of patients in MAU B received this assessment. There is a VTE support member of staff who checks all acute admissions on the MAU to make sure they have been VTE assessed, and speaks to the doctors on the ward if the assessment has not been done. However, this service was only Monday to Friday and was not available at the weekend.

National guidelines

Implementation and monitoring of national guidelines varied. We found a number of services were using national guidelines. The ITU was providing care in line with national guidelines and submitting data to the Intensive Care National Audit & Research Centre (ICNARC) on outcomes for people using critical care services to monitor its performance compared to others nationally. The data showed that the number of deaths for critical care services at Queen's Hospital was within the expected range. In maternity services, women received care according to best practice clinical guidelines.

Prior to the visit we reviewed the log recording the medical services implementation of National Institute for Health and Care Excellence (NICE) guidelines. A number were recorded as "partial compliance" or "awaiting response".

Clinical audits

The hospital has participated in some local and national audits and demonstrated changes as a result, such as recruiting additional bowel cancer specialist nurses.

Are services caring?

Summary of findings

National inpatient surveys indicated that patients were unhappy with many aspects of their care. However, many patients and relatives we spoke with were positive about the care they received. They said the nurses were “kind” and provided them with support when they needed it. People felt they had been given information when they needed it and most had been involved in discussions about their care.

Work needs to continue to ensure improvements made to improve caring are reflected in national surveys.

Staff were happy working at the hospital and felt things were improving.

Our findings

The trust has performed poorly in a range of surveys about people’s experience of inpatient care, cancer care and care in the A&E department. Although results improved since 2011, in the CQC’s 2012 Adult Inpatient Survey, the trust scored ‘worse than other trusts’ in six of the 10 areas of questioning, and ‘within the expected range’ for the remaining four.

The trust also performed badly in the 2012/2013 Cancer Patient Experience Survey and was rated as being in the worst 20% of all trusts nationally for two-thirds of the questions (42 out of 63).

Staff attitude

We saw many examples of staff delivering care in a kind, compassionate manner and most patients felt they were listened to and involved in discussions about their care.

Staff were sensitive when giving difficult news to relatives and gave them the privacy and time they needed. Women in the maternity and children’s services spoke highly of the staff in all areas and said staff made them feel welcome and they felt cared for. People used words such as “marvellous” and said “nothing is too much trouble for them”.

Involving patients in their care

Many patients said they felt they had been involved in decisions about their care, and staff allowed them time to ask questions. They were satisfied with the level of information they had been given and the next stages of their treatment had been explained to them. In maternity services, women felt involved in developing their birth plans, their partners were made to feel welcome, and they had sufficient information to enable them to make choices about their care and treatment during labour.

Privacy and dignity

Staff maintained people’s privacy and dignity by drawing curtains when they were providing personal care. Wards were divided into single-sex bays with bathroom facilities. In the ITU there was enough space between each bed to allow some degree of privacy. The oncology wards at Queen’s Hospital had relative rooms so families could have privacy (although this was not always available in other wards). The palliative care team tried to ensure that all patients on the end of life care pathways were cared for in side rooms.

Nutrition

The hospital had a protected meal times policy and patients who needed assistance received their food on a red tray to ensure staff were aware. We observed staff providing support to patients with their meals as needed and monitoring their fluid intake.

Are services responsive to people's needs?

(for example, to feedback)

Summary of findings

The hospital has some arrangements in place to respond to patients' needs – such as the Critical Care Outreach Team and the introduction of surgical 'hot clinics', designed to provide rapid access to medical assessment and care to prevent admission to hospital and to reduce the pressure on the A&E department at Queen's Hospital. It also responds to patient feedback through the complaints process and the Friends and Family test. (The NHS Friends and Family test introduced in April 2013 allows patients to give feedback on the quality of care.) However, it has a very high bed occupancy compared to the national average, along with longer hospital stays than necessary and delayed discharges.

The A&E department is not meeting the national four hour quality indicator for waiting times in the A&E department.

While some of these issues require the involvement of partner organisations to resolve, there is much the trust can do to improve the flow of patients which would enhance their response to patients' needs and reduce the risk of patients receiving poor care.

Our findings

The trust's bed occupancy exceeds the national average and at times is at a level that is detrimental to patient care. Between April and June 2013 it was 97% while the national average is 86.5%. Once bed occupancy rates rise above 85%, quality of patient care can be affected.

Waiting times

Data shows that some patients often waited more than four hours for a decision to be made about whether they should be admitted to Queen's Hospital. These delays mean that patients were more likely to have poor outcomes. We also found delays in discharging patients from the ITUs at both hospitals. Between April 2012 and April 2013, 50% of patients experienced a delayed discharge from the ITU and 64 patients were transferred to other hospitals for non-clinical reasons. While these figures were within accepted ranges compared to other units nationally, there were impacts on those who needed access to the service. Medical staff described the situation as "frustrating".

Discharge

At Queen's Hospital on occasion patients having day case surgery had to be nursed in and discharged from the recovery area rather than a ward due to bed shortages. The environment was not designed to accommodate patients who should be cared for on a ward. There was a lack of privacy, insufficient bathroom facilities and patients were served food while others were coming round from their anaesthetic.

Elsewhere in the hospital we were told about delays in patients being discharged. Staff attributed some of this to care packages not being in place, doctors not completing discharge summaries 24 hours in advance and delays in getting medicines for people to take home. Pharmacists told us that they were often informed late in the discharge process which meant medicines weren't ready until late in the afternoon.

Senior nurses had attended training to introduce nurse-led discharge but, as yet, this had not been implemented.

Cancelled operations

Although the trust is performing as expected in relation to cancelled operations, some day-case patients at Queen's Hospital had their surgery cancelled two or three times. All seven people on the day-case list for 17 October 2013 at Queen's Hospital had had their procedure cancelled previously, one to two weeks prior to admission date to accommodate more urgent cancer cases.

Outpatient appointments

Sufficient time was allocated for consultations in the outpatient clinic but this was sometimes reduced due to clinics being delayed or over booked. Appointments were delayed between 50 and 90 minutes. Some of the delays were due to consultants carrying out scheduled ward rounds or other duties at the same time. Other issues included cancelled appointments, missing notes and patients either not receiving or having multiple appointment letters. Complaints about the appointments process and missed appointments were discussed at the trust Board in July 2013 when it was noted that some people only had three-days' notice that their appointment had been cancelled. The trust is aware of the problems and has started to take action, but progress is slow.

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

Seven-day working

The hospital is in the process of introducing seven-day working to improve patient outcomes by allowing for senior medical review and discharge of patients seven days a week. This needs to be done in partnership with other organisations within the health and social care economy. Although this work is in the early stages in many areas, the Care of the Elderly department is making good progress and providing consultant cover from 9am to 8pm, seven days a week.

All respiratory and gastroenterology inpatient services have been centralised at Queen's Hospital with the aim of ensuring senior medical staff cover and improving patient outcomes and discharge planning.

Complaints/patient feedback

The hospital uses the Friends and Family survey to gather feedback on patients' experience and this is discussed at ward meetings.

Work is being undertaken to improve the quality and timeliness of responses to complaints. The surgery services were aware this was an area that needed improvement.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Summary of findings

Overall, staff were positive about their immediate clinical managers but had mixed views about more senior staff and the visibility of the executive team.

Much of the hospital's focus has been on trying to resolve the problems in the A&E department but some of the problems, such as discharge planning and patient flow, have not been addressed. If these issues were addressed it would take some of the pressure of the A&E department and other areas such as the ITU. Although some of the improvement is reliant on good partnership working with local health and social care organisations, there has been a significant lack of progress due to poor engagement from senior clinical staff.

Arrangements were in place to monitor the quality and performance of services but these are being reviewed and staff acknowledged that data could be used more effectively.

Our findings

Leadership

The latest NHS staff survey shows encouraging improvement in a number of key findings, including the number of staff feeling able to contribute towards improvements, levels of staff motivation and the number of staff willing to recommend the trust as a place to work or receive treatment. We found that much of this was reflected during our visit.

The 2012 General Medical Council's National Training Survey found the trust performed below the expected range in six areas and better than expected in one area: Emergency Medicine. Junior doctors we met with during the inspection felt that consultant cover and support, along with training, was good but identified staffing levels and the general business of the trust as an issue. The number of locums they worked with had an impact on the continuity of care.

Staff told us that engagement of clinical staff was good, but still in the early stages. They were concerned about further changes at executive level as it "perpetuates the belief that

the executive team come and go" so there is little value in engaging in any changes. This was supported by other staff who said "don't change the executive team".

Senior nursing and medical staff cover services across both Queen's and King George Hospitals and visit them during the week.

Many staff felt they were supported by their line manager and they were part of a team. One person described it as an "excellent place to work". Some staff said they felt involved in changes being made in the trust while a few did not feel so involved. Other staff wanted the executive team to be more visible. Visits to wards by non-executive directors is currently being implemented by the trust.

Capacity

Senior doctors and managers and the executive team are concerned about the high workload and bed occupancy. The hospital has long standing problems in managing the demand on services and transferring and discharging patients in a timely manner. Patient flow through the hospital, models of patient care and particularly the discharge function needs a whole system review. Progress with this work is slow due to a lack of engagement by senior clinical staff. This is causing unnecessary pressure in some areas and increasing the risk that patients will receive poor care.

Some areas such as Care of the Elderly have made improvements to patient flow with the introduction of the short-stay ward and the elderly care liaison nurses. Others, including the medical admissions unit, were aware that more work was required. Many staff had concerns about how the hospital was going to manage capacity during the forthcoming winter as the hospital was described as "bursting at the seams" and on some wards they had already converted treatment rooms to accommodate patients.

Monitoring quality

We found many areas had team meetings where they discussed comments, complaints surveys and incidents. However monitoring actions implemented to ensure that changes take place need to be more robust. Many services have, or are introducing a performance dashboard (performance reporting and tracking system using a number of quality and safety indicators) to identify and monitor potential risks to patients.

Accident and emergency

Information about the service

We visited the A&E at Queen's Hospital in May 2013 and found that patients were not always receiving timely and proper care because of major delays in their assessment and treatment. There were not enough full-time doctors working in the department. We issued a warning notice, giving the trust until September 2013 to become compliant with the regulations.

The A&E consists of a separate paediatrics, resuscitation, rapid assessment and treatment, major and minor injuries area, which is co-located with the urgent care area. Ambulance patients who are unwell and may need admission are assessed and directed through to the 'Majors' area, consisting of 25 bays, 23 for beds with two used as a seating area with eight seats; it also includes the five rapid assessment and treatment cubicles. Once the hospital has made a decision to admit a patient they should be moved as soon as possible from the A&E to the main hospital wards or to the medical assessment unit. The A&E is subject to high levels of demand; it was originally built to deal with up to 90,000 patients, and in the financial year 2012/13 about 140,000 patients attended.

We talked to patients, relatives and staff, including nurses, doctors, consultants, managers, support staff and paramedics. We observed care and treatment and looked at care records. We received comments at our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The A&E department does not provide safe care all of the time. On some nights there are too few full-time doctors on duty, and at other times there are too many patients in the department. This increases the risk of errors being made in clinical judgements or people not being assessed or reassessed in a timely manner, which means they may not get the right treatment when it is needed. Staff were caring and were doing their best given the high demand and limited staffing cover.

The department is not responsive to people's needs. People experienced excessive delays in being assessed, reviewed, and treated. There is good clinical leadership within the A&E department and staff feel supported by senior doctors and nurses, although they do not feel supported by the management of the trust.

Are accident and emergency services safe?

Most of the senior medical staff we spoke to told us they did not think that the A&E department was safe all of the time. One A&E consultant told us, "When we get very busy, there is a worry that we will miss things, or that someone will deteriorate before we have the chance to assess them." We found that there are not enough full-time doctors on duty at night and weekends in particular to keep people safe. People who are spending too long in A&E are not being reassessed to identify if their condition has deteriorated.

Nights and weekends

Patients could potentially be at risk of receiving unsafe medical care by the lack of senior medical staff available at nights and weekends. The medical cover is provided by middle-grade and junior doctors with an on-call consultant covering both Queen's and King George Hospital. The Clinical Director, all of the consultants we spoke to and nursing staff expressed their concerns about this. Between 8am and 8pm on weekdays all patients arriving by ambulance are assessed by a consultant in the rapid

Accident and emergency

assessment and treatment area of A&E. This means that the most seriously ill patients can be quickly diagnosed and treatment started. Outside of these hours the initial assessment is undertaken by a more junior doctor or nurse. During our listening event, one person felt that one of the reasons their relative had suffered a poor outcome was because she had arrived in the department at 5am and had not been properly assessed.

Staffing levels

The Emergency department A&E at Queen's has 135 nursing posts, of which 98 are filled. Staff told us they are able to ensure there is sufficient nursing cover by using agency and in-house bank staff (staff who work overtime in the trust). We reviewed the number of nurses in the A&E department, which was busy during our inspection. We examined the nursing rotas and observed the actual number of nurses on duty. We found that there were always five nurses on duty in the 'Majors' area which, for the number of patients they had to look after, meant their ratio ranged from one registered nurse to four patients to one registered nurse for seven patients. We were informed that the set ratio for 'Majors' was one registered nurse to five patients but the trust was planning to reduce this to one to four.

There were two healthcare assistants to provide cover 24 hours a day, seven days per week, ensuring that patients are properly supported with nutritional and personal care needs. Nurses are able to focus on providing nursing care to patients. We spoke to three nurses who told us that it can become very busy in the Majors area but, with the support of the healthcare assistants, they are able to cope. One nurse told us, "It's not always this busy, we do have quieter times and quieter days, but when it's like this we are stretched."

The A&E at Queen's is under-resourced for consultants. When we last inspected in May 2013, there were 10 consultants in post. The College of Emergency Medicine recommends that, for the number of patients seen in the A&E at Queen's Hospital, it should have 16 consultants to provide cover 16 hours a day, seven days a week. The trust has 21 posts available but only eight consultants in post out to cover both the A&Es at Queen's and King George Hospitals. The A&E makes up for the shortage of full-time

consultants by employing locums. Queen's A&E has a number of consultants working between 8am and 5pm, but after 5pm there is often only one consultant available until 10pm. Staff told us that consultants do not finish their shift at 10pm unless they are happy it is "safe" to do so. After 10pm there is a consultant available on call for both hospital sites.

Consultants need to be supported by middle- and junior-grade doctors. Of the 28 posts for middle-grade doctors 10 are filled by permanent staff, the trust relies on locums to make up the additional numbers. When we last inspected in May 2013 there were 12 middle-grade doctors in post. We examined the rotas for medical staff and found that, on some occasions, junior doctor shifts had not been filled in the Urgent Care Centre. The A&E at Queen's is under-resourced for middle-grade doctors.

Selection and supervision of locum doctors

Because of the low number of permanent staff, many of the doctors in A&E are locums supplied by agencies. We examined the staff rotas and found that on many occasions about a third of the middle-grade and junior doctors at any given time are locums. Staff told us they could usually employ locum staff who had previously worked at the hospitals. However, staff told us that occasionally locums who had not worked there before would turn up for shifts and they felt this created a risk to patients. One senior nurse told us, "Every now and then a new doctor might turn up. I try to keep an eye on them as they are not always up on how we do things here".

Are accident and emergency services effective?

Patients were not seen and treated effectively by appropriate staff. We found that patients are waiting too long to see a specialist doctor when they have been referred by an A&E clinician.

One patient said, "They told me I need to stay for a while, but there isn't a bed at the moment." There is very poor patient movement from A&E to the rest of the hospital. This means that patients who need to be admitted to the hospital for treatment remain in A&E which is not equipped as a main hospital ward.

Accident and emergency

Managing patient care

People were in A&E for too long, when they should have been transferred to specialist wards for treatment. At one inspection there were 39 patients in the Majors area. For 11 people, a decision to admit to a ward had been made and 14 had been in A&E for more than four hours. One of the patients had been in A&E for 18 hours.

The trust's policy is that all patients should be seen by a specialist doctor within 30 minutes of referral by an A&E clinician. We examined the medical notes of 14 patients who had been referred and found that the average waiting time to see a specialist doctor was just under four-and-a-half hours; one patient had waited nearly 10 hours. This means that specialist diagnosis and treatment are delayed, putting patients at risk.

At another inspection, there were 24 patients in the 'Majors' area. Nine people received a decision to admit and 13 had been in the A&E for more than four hours. One of the patients had been in the A&E for almost 17 hours.

We examined the medical notes of 13 patients who had been referred to a specialist and found that the average wait to see a specialist doctor was just over four-and-a-half hours; one patient had waited just over six hours. Specialist diagnosis and treatment are delayed, putting patients at risk.

Patient movement from the A&E to other parts of the hospital

We found that patients with a decision to admit who should have been admitted to the main hospital's wards were spending too long waiting for a bed in A&E. A senior nurse told us, "As far as I can remember, the flow has only worked properly for two weeks in the last 100 days." Staff told us that these patients are not normally reviewed by A&E doctors unless their condition is observed to have deteriorated. We examined a number of patient notes and found that patients had rarely been reviewed once a decision to admit had been made. This creates a risk that a patient's condition might deteriorate without it being noticed.

Are accident and emergency services caring?

Adult Inpatient Survey

In the 2012 Adult Inpatient Survey there was little improvement since 2011 in the areas that focused on the A&E department. Privacy when being examined was an issue along with patients not being given enough information about their condition.

Comments/observations

The vast majority of patients we talked with at the hospital were complimentary about staff in A&E. One patient said, "It's fine here, they have looked after me well." Another person said, "They have done lots of tests and I am just waiting for the results. I can't complain." We observed that people had been moved to a more comfortable hospital bed instead of a trolley if they needed to be in the hospital for a long period.

We saw that staff treated people with respect and kindness, talking to them in a soft and responsive way. When people called for support, a member of staff would respond promptly. One member of staff put her arm around a bereaved relative and walked her to the family room, talking in a caring manner.

Involving patients in decisions about their care

Patients who use the service were given appropriate information and support regarding their care or treatment. Patients told us they had been involved in decisions about their care and treatment. One patient said, "They have told me what's wrong and that I need to take these tablets and then I will be OK to go home." All the people we spoke to told us that staff had kept them up to date on what was happening with their treatment.

Staff respected patients' rights to make choices about their care. We saw staff explaining treatment options to patients to make sure they fully understood the treatment and choices available.

Food and drink

Patients received adequate nutrition and hydration while they were in A&E. We saw a drinks trolley regularly moving around the Majors area ensuring that people were offered hot and cold drinks. People in A&E for an extended period were offered a hot meal.

We also saw that healthcare assistants and nurses assisted people who needed support with eating and drinking.

Accident and emergency

Are accident and emergency services responsive to people's needs?

The service is not responsive enough to people's needs. People were waiting too long to be either discharged or admitted. The trust is not dealing with enough people within the national four-hour target. The initial care pathway for children does not meet their needs, and unnecessarily delays their initial assessment.

Waiting times

Queen's Hospital has consistently failed to achieve the 95% NHS target for the number of attendees that were discharged, admitted or transferred within four hours of arrival. Between the 1 April 2013 and 8 September 2013, 9,359 (84%) out of 59,038 patients were not seen within four hours of arrival. The department struggles to meet the target at all times, however, Mondays and Sundays provide the greatest difficulties. The A&E at Queen's Hospital performs significantly worse than at King George Hospital. These delays mean that patients are more likely to have poor outcomes.

Caring for children

We found that there were always trained paediatric A&E nurses on duty within the paediatric area. Staff had training and understood safeguarding, child protection and reporting procedures. The paediatric unit worked well with the paediatric ward, which always had a middle-grade and junior doctor allocated to the A&E paediatric area.

Children and their parents who attended A&E had to wait in the general waiting area and, after seeing the general screening nurse, were directed to the paediatric waiting area, where they would have to wait to register with the receptionist and then wait to see the paediatric screening nurse. We found that this pathway was not responsive to the needs of patients and unnecessarily meant they had to wait three times before seeing a nurse for a proper assessment. The current pathway delays the initial time to assessment by a paediatric nurse, thus increasing the risk of a poor outcome. We are also concerned that, due to the extended delay in registration, children's waiting times were not being properly recorded.

Working with the ambulance service

During our last inspection in May 2013, we reviewed information provided by the London Ambulance Service (LAS) for the period January to April 2013 relating to Queen's Hospital. The report showed that Queen's A&E was responsible for most of the ambulance diverts (when an A&E has to close and non-life-threatening admissions and ambulances are diverted to other hospitals) in the North East London region. For this four-month period, ambulances were diverted to other hospitals on 23 occasions. More recent information shows a decrease in the number of ambulance diverts. In the four months of May to August 2013 there were 10.

The LAS also records 'black breaches' (those cases where it has taken over one hour from the time the ambulance arrives at a hospital, until the clinical and patient handovers have taken place). Data provided by the LAS shows that at the time of our last inspection in May 2013, the number of black breaches at Queen's Hospital for the four months from January to April 2013 was 155. In the four months from May to August 2013 there were 51. These delays can increase patient risk. However, this does not reconcile with the number of 'black breaches' reported by the trust. From January to April 2013, five breaches were reported, and from May to August, one breach involving four patients was reported.

We spoke to a number of paramedics who told us they did not always feel valued by the doctors and nurses at Queen's. One of them told us, "They don't always listen to what we have to say about the people we bring in." Paramedics can hold information that is vital to a patient's ongoing care. If information is overlooked by A&E staff then it may result in poorer outcomes for the patient.

Working with partners

Partners we spoke to said that the trust was not always responsive to people's needs and that it could improve the way it works with partners. One local authority member told us, "the trust remains inward looking and is not yet fully engaging with local partners." A representative from a local Clinical Commissioning Group told us that patients did not want to come to the A&E at Queen's hospital. They said patients had told them that staff could be rude. They also told us, "We don't always get the information we need to know when people are discharged home."

Accident and emergency

Are accident and emergency services well-led?

A&E clinical leadership

The A&E has good clinical leadership. We spoke to the Clinical Director who had a good understanding of the risks and issues the department faces. Consultants and senior nurses gave clear guidance and support to junior staff. One patient told us, "I have been watching the matron for the last three hours and she never stops making sure that everything is working as it should be, I am very impressed." We observed that staff are motivated, with good team working and communication between all grades of staff. Staff said they felt well supported by A&E managers.

Trust support for the A&E

There was widespread concern from staff that the trust has not fully supported the A&E in dealing with the major issue of patient flow and staffing levels. Many staff in A&E felt that more could be done by other departments to reduce patients attending A&E or to increase the number

of beds available within the rest of the hospital. Three of the staff we spoke to said they intended to leave A&E and find work elsewhere. Two of these staff said this was because they had lost confidence in the leadership of the trust to make the necessary improvements.

Managing quality and performance

The trust has a system in place for recording and analysing clinical incidents. We examined summaries of all incidents for a three-month period prior to our inspection. Incidents were being properly reported but many of the records we examined were unclear about how the trust would make future changes.

The trust has established an Emergency Care Improvement Programme with workstreams covering seven-day/continuity of care, ambulatory care, urgent care, A&E improvement, recruitment and retention, discharge care planning and frail elderly care. Senior managers at the trust acknowledge that most work is still in progress and some areas, such as recruitment and retention of medical staff, have deteriorated.

Medical care (including older people's care)

Information about the service

Medical services (including frail elderly) includes a number of inpatient wards providing general and specialist medical care to patients such as those with respiratory illness and those who have diabetes

We visited the medical assessment unit (MAU), six wards (including respiratory, gastroenterology, care of the elderly and stroke wards) and the discharge lounge. As well as observing care, we spoke to staff from a range of specialities and grades, many patients and relatives.

Summary of findings

Medical services are safe although there are a number of areas which require improvements, including documentation. Patients felt they received good care but there were delays in discharging patients who were well enough to go home and learning from incidents needs to be improved.

The trust was implementing changes to try and improve the patient experience and ensure patients were admitted to the correct ward and discharged as soon as they were well enough. These have included moving towards a system of seven-day consultant cover on specialty wards and the establishment of an Elderly Receiving Unit on the MAU. Despite these positive developments, it is too early to assess their success.

We saw evidence of action plans being put in place after learning points had been identified from complaints or adverse incidents. However, some of these did not have clear target dates and evaluation processes. The trust needs to ensure that changes are made following any learning from audits, complaints and incidents.

Patients told us they felt the care they had received was very good and that the staff were responsive and caring. Many also told us they felt staff were under pressure due to insufficient cover. When we observed staff we saw them acting in a caring manner towards patients and responding to their needs. However, we noted that staff did not always record the patient care they provided.

We found there were patients who had been assessed as fit for discharge but were delayed due to a lack of capacity in community rehabilitation care or delays in arranging support for them. Some staff also told us that discharges could be delayed due to other factors, such as transport delays or long waits for final prescriptions.

Although staff morale was good, aspects of the leadership need to be improved in order for some of the long standing problems around discharge planning to be addressed.

All of the wards we visited were clean and well maintained. We saw some instances of nurses not using barrier aprons and gloves as well as occasional empty hand-wash gel canisters. These standards need to be constantly maintained to minimise cross-infection risks.

Medical care (including older people's care)

Are medical care services safe?

Incident reporting

We spoke with a wide range of staff. They knew about ward management and how to report a concern about care and treatment if needed. We were told that, following an adverse incident, they would usually get feedback from their manager. In the MAU, staff were able to articulate learning identified from previous incidents and changes that had been made. For example, one of the reasons for the Elderly Receiving Unit being opened recently was to intend to reduce the risk of patients suffering falls.

Falls

Information about falls was being collected on wards and appropriately displayed. We noted that the number of falls on the wards was high. In September 2013, for the year to date there had been 7.3 falls per 1000 bed days. We saw some examples of emerging plans to map and pinpoint where falls occurred. On Harvest A (the elderly care unit) patients identified as being at risk of falls were all nursed on one bay with an extra member of staff to support them. However, staff were not able to show or describe a central plan that all areas were working towards to ensure a consistent approach to reducing falls.

Staffing levels and skill mix

Most wards had sufficient staff to meet patients' needs. For example during the day, Ward Harvest A has a Sister, three staff nurses and four healthcare assistants (two of whom were staff specifically employed to care for patients at high risk of falls) for 31 beds.

In general, staff told us they found the staffing numbers "tight" and "minimal", but felt they were able to adequately meet patients' needs. They told us sometimes it was difficult to fill shifts and agency staff had to be used. In September 2013 the trust had a vacancy rate of 11.7% for acute medicine. The full-time equivalent use of agency staff was 4.3% (Just over 46 out of a funded establishment of just over 1073). Trust staff told us that an over-reliance on agency staff was stressful, especially if there was lack of consistency in the individuals available.

In many wards we visited, staff explained that frequently bank members of staff undertake shifts regularly on the same ward. However, staff also told us they had to use agency staff to ensure they met their required staffing levels.

The September performance report for the year to date showed that 18.97% of medical staffing was temporary. The trust was in the process of recruiting extra consultants in the medical division to ensure that they were able to meet the needs of seven-day working.

We asked locum doctors and agency nursing staff what form of induction they had received on the ward. Some told us they had not received any form of induction apart from being shown around the ward.

In most of the areas we visited, nursing staff told us that doctors supported them promptly and appropriately. In turn, junior doctors said senior colleagues were usually available to help and guide them.

Safeguarding

Staff were able to describe the different types of abuse and how to raise concerns. We saw an example of an appropriate alert being made promptly for a patient who had been admitted with a pressure ulcer. Staff were able to describe how they would access information on safeguarding and were aware of the trust's policy.

Documentation

Initial assessments of patients' needs had been recorded and where required, pain scores were calculated and Braden scale scores, used to identify patients at risk of pressure ulcers, had been completed appropriately. Other documentation we reviewed showed a number of gaps in the completion of nursing forms and nursing notes. For example, discharge plans were not always completed. On ward Clementine B we noted that whether a person required assistance with eating had not been recorded in the patient's notes. Nurses told us they did not always have time to complete paper work immediately, but they felt they knew their patients and their needs and were delivering good care. We observed handovers between the day and night shift on two wards. We saw that staff were aware of the needs of their patients and explained what assistance they required. Senior nursing staff said they were aware of the need to improve nursing documentation.

Environment

In general, the environment was very good for meeting patients' needs. However, on a number of the medical wards, an extra bed space had been created – room 12a, in a former treatment room. This room was small and had no windows.

Medical care (including older people's care)

Sepsis

We asked staff how they would recognise sepsis and how they would respond to this. None of the nurses we asked knew if a guideline was available to use or were able to clearly define what sepsis was. They were not aware of any specific training available on the management of sepsis. Some said they thought a sepsis care pathway was available on the intranet but none of them were able to locate it.

Patients on the wrong ward

During our inspection we noted that there were a number of patients who were 'outliers' – on wards not the correct speciality for their needs. We visited these patients to see how they were being managed. We saw their care was appropriate and well-managed by the appropriate medical team.

Emergency equipment/medicines

We checked the 'crash trolleys' (used when there is a medical emergency such as a cardiac arrest) in a number of wards, including on the MAU and Harvest A, and found they had been checked regularly by the staff. All of the medication was within their expiry dates and all the appropriate equipment was arranged according to the checklist. Medicines were stored appropriately and medication trolleys were kept closed.

Infection control

Visited wards appeared clean, hygienic and well-maintained. Hand-washing facilities and hand gels were available in most areas. Personal protective equipment, including gloves and aprons, was usually available and regularly used. However, we noted examples where some staff did not wear aprons when going to assist patients with personal care. Patients told us they saw staff wash their hands regularly and felt safe as a result.

The trust has conducted a number of hand-washing audits. The results from these identified a number of areas needing improvement. For example, on 2 September 2013 in the MAU only 50% compliance had been achieved. After re-audit a week later, there was 100% compliance.

Staff told us they had infection control 'link' nurses on the wards. These staff linked with the trust infection control team and provided guidance and support to other staff to ensure good practice was maintained in managing the risks of infections.

Data for the medical division in the September performance report indicated there had been no hospital acquired cases of meticillin resistant staphylococcus aureus (MRSA) so far this year.

Are medical care services effective?

NHS Safety Thermometer

There is a national target that 95% of patients should have a venous thromboembolism (VTE) risk assessment. The medical services had not achieved this target. In an audit in August 2013, only 88% of patients in MAU A and 92% of patients in MAU B received this assessment. There is a VTE support member of staff who checks all acute admissions on the MAU to make sure they have been VTE assessed, and speaks to the doctors on the ward if the assessment has not been done. However, this service was only Monday to Friday and was not available at the weekend.

The trust had an "early warning score system" to highlight when a patient's health condition was deteriorating. If a patient's score increased the medical team was alerted. We saw recorded observations of this being completed.

Capacity assessments

In order to identify patients who may be confused, mini mental tests were being undertaken. These involve a number of short tasks undertaken by patients with staff, with the aim of identifying patients who may need extra help if suffering from confusion. The September performance report for the acute medical division showed that 94% of patients over 75 had a mini mental score recorded.

We asked staff how they would support patients who may not have the capacity to make decisions. Many were able to describe how they would conduct capacity assessments and, if required, hold best interest meetings.

Multidisciplinary working

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement for doctors, nurses and therapists in patients' care. Patients identified as needing support from specialist teams, such as tissue viability, received this. There had been recent improvements in the number of physiotherapists in the team on MAU, which was a positive development. Physiotherapists and occupational therapists told us they thought there was good team working and that "things were improving".

Medical care (including older people's care)

National guidance

It was not clear if the processes the trust had in place ensured that relevant National Institute for Health and Care Excellence (NICE) guidance (recommendations on the appropriate treatment and care of people with specific diseases and conditions) were always and consistently applied. The medical log shows there were a number recorded 'partial compliance' or 'awaiting response'. We noted that this had been raised as a concern in recent clinical governance meetings.

Cardiology protocols

There were clear and comprehensive guidelines (that were used by both hospitals) about how to care for patients who had heart failure, acute coronary syndrome and a variety of acute and chronic cardiology conditions for both. Staff were aware of these protocols and how to follow them. Working with other local providers, the unit also had clear restrictions on the type of patients to accept and those that could have their needs better met elsewhere.

Performance for patients who have had a stroke

The National Sentinel Stroke Audit collects data on the performance of trusts in delivering care for patients who have had a potential stroke. Data (from October to December 2012) shows the trust performed well for a number of indicators and was in the first (highest) quartile of all units. For example, the percentage of patients scanned within one hour is 60% compared to the national average of 40%. Overall, for the 12 indicators used, the trust had an average score of 84.8% compared to the national average of 74.7%.

Delays in discharge

Many staff reported they felt that the management of patient movement from admission to discharge could be significantly improved.

On ward Harvest A (elderly care), doctors had identified up to 50% of patients (on the day of the inspection) who were well enough to be discharged once appropriate support had been put in place. Nursing and other staff said delays were often due to arranging care packages for people or delays in arranging final take-home pharmacy items.

In the acute medical division report for September 2013 the average length of stay was recorded as 7.32 days.

This was higher than the trust target, which was 7 days. The 30-day Emergency readmission rate was 11.85% for the year to date. This was higher than the trust target of 6.2%.

The overall length of stay was being monitored. There was some evidence of plans to reduce length of stays, e.g. the move to seven-day consultant cover. However, there appears to be no clear monitoring to identify specific blockages, when and why they occur, where changes needed to be made, or what the impact of changes had been.

Are medical care services caring?

Patients' view of care

In the July 2013 Family and Friends Test, 18 wards scored below the trust's average of 39 and Clementine B ward scored the lowest of all wards.

Most patients and relatives were very positive and complimentary about their care. Many told us they thought the nurses, healthcare assistants and other support staff were exceptionally kind, and that many often went the "extra distance" to support them.

Generally, patients felt involved in appropriate decisions about their care and could identify by name the nurses, doctors and other team members responsible for their care. For example, one patient told us, "I feel my consultant knows me and has a rapport with me."

Observations of care

We observed many examples of staff being caring towards patients. We saw nurses and healthcare assistants taking time to interact with patients. We saw that staff respected patient privacy and dignity by ensuring curtains were closed before they delivered personal care. All the wards we visited maintained single-sex facilities.

Staff ensured that all call bells were left within reach of the patients. During the times we were on the wards we saw most requests were answered very promptly and courteously.

Meals

We observed patients being supported with meals on the MAU. We saw that patients were helped when they needed it. A red tray was used to identify patients who may require assistance.

Medical care (including older people's care)

Are medical care services responsive to people's needs?

Feedback from patients

We saw examples of patients' views being sought. For example, when patients were discharged from the MAU they were given a survey to complete. We also saw evidence that the trust was monitoring responses from the Friends and Family test scores of wards to assess the quality of care provided. Recent test results showed variation between the scores on different wards. When a ward received a poor score, we were told it was monitored to ensure it improved.

Seven-day consultant cover

The trust has recently re-organised to provide seven-day consultant cover. All respiratory and gastroenterology inpatient wards are now centralised at Queen's Hospital. The aim of this project was to improve patient outcomes by ensuring senior medical staff were on site every day, and also to improve arrangements for discharge planning, to help reduce length of stays and prevent patients having to spend longer in hospital than necessary. At the time of the inspection, we were told that seven-day cover had begun to be implemented, although formal job planning had not yet taken place to enable a consultant to be on site seven days per week.

When we visited the MAU we observed there were a number of recent changes to try and improve patient flow and care. An Elderly Receiving unit had been established. This purpose of the unit was to receive patients who were identified at the triage stage in the A&E. This meant these patients would receive quicker access to the care they need. The unit had involvement from the elderly care team at the trust and had a lower ratio of patients to nursing staff.

A number of pilots were being undertaken by the trust to try and reduce unnecessary delays that may increase patients' length of stay. For example, a service to enable staff to request imaging reports from Australia out-of-hours was now being trialled. This would allow full reports to be provided 24 hours a day.

Medical handover

The hospital was using an electronic handover (e-Handover) system for all acute admissions and the handover of current inpatients out of hours (5-9pm). This is a system that gives doctors working in the trust admissions team and the on call team an overview of patients in the hospital, clearly highlighting patient and workload priorities.

Virtual Ward

Established in 2009, the Virtual Ward manages patients from eight clearly defined ambulatory care pathways, allowing outpatients to receive care at home. Patients are identified by their consultant as medically suitable for ambulatory therapy according to strict criteria. The nurses on the Virtual Ward collect referral forms from MAU and arranges all tests and investigations, ensuring they happen in a timely manner. Patients can have follow-up care in the community or at the hospital. Patient satisfaction surveys for the service showed that patients valued the support and management they received. Staff told us they hoped the service could be further developed and used for other conditions.

Do not attempt resuscitation recording

Patient records were marked DNA CPR ('do not attempt cardio-pulmonary resuscitation') when appropriate, with evidence of senior reviews of decision and after discussions with relatives. One patient's relative confirmed that a doctor had discussed this end of life process in an appropriate way.

Medical care (including older people's care)

Are medical care services well-led?

Staff morale

Most of the staff told us their morale was good. On all the wards we went to, most staff expressed a general sense of being well supported by peers and management and that team spirit was high. However, all senior clinical staff need to engage in addressing the problems related to patient movement through the hospital.

Training

Staff felt they had good opportunities to undertake training. They told us they felt they were supported in their roles and had regular performance appraisals. Junior doctors told us that, in general, they had good support from senior doctors.

Monitoring of quality

Medical staff, when assessing the quality of their care, said that mortality information was available through a healthcare information system. However, some said this may not be used regularly. Staff also acknowledged there was potential to develop the robustness of the information and methods they used to judge whether they were delivering high quality care.

During the inspection we saw many examples of information being gathered on the performance of wards. However, this information was not currently being collated in one place to allow for the easy recognition of themes. Actions identified were not always monitored in a robust manner to ensure that changes were made. For example, there was no central log to ensure that learning actions identified from complaints had been implemented.

Surgery

Information about the service

Surgery at the trust is provided at Queen's Hospital and King George Hospital. Queen's provides acute surgical procedures, while King George Hospital undertakes more minor procedures. Patients are also transferred from Queen's to King George Hospital for rehabilitation. At Queen's there are six surgical wards and 12 operating theatres. The hospital has a range of surgical specialties, including colorectal, oral and maxillofacial, orthopaedic, ear, nose and throat (ENT), vascular and neurosurgery.

Patients can be referred to a surgical assessment unit (SAU) at Queen's Hospital by their GP, the A&E department or a consultant if they are having a planned procedure. The SAU was opened to reduce the pressure on A&E for people who required a surgical review. Staff on the SAU assess whether a person needs to be admitted to a ward or seen as an outpatient in a doctor-led 'hot clinic', designed to provide rapid access to medical assessment and care to prevent admission to hospital.

We talked to patients and staff, including healthcare assistants, nurses, doctors, consultants, senior managers and therapists. We visited all six surgical wards, the SAU, the discharge lounge and the operating theatres at Queen's Hospital. We observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance about the trust.

Summary of findings

Patients on the surgical wards told us staff were caring and they felt their needs had been met. The service used comments and complaints to improve the service and there was some evidence of learning from incidents. However, we could not be assured that patients always received safe and responsive care. The completion of nursing documentation was inconsistent and if patients were transferred to King George Hospital there were no documented handovers. Delayed discharges and high occupancy rates meant that the service could not be as responsive as required. However, initiatives such as the SAU and 'hot clinics' had been implemented in an attempt to reduce admissions and increase patient flow.

Are surgery services safe?

Documentation

When a patient was initially admitted, nursing staff completed an assessment of their needs. This included their risk of developing pressure ulcers, having a fall, the possibility of malnutrition and their mobility requirements. Where risks were identified, there were specific 'care bundles' (additional assessment and monitoring documents) to ensure appropriate management.

The documentation should be completed weekly, or if a patient's condition changed. On some wards this documentation was fully completed and up to date. However, in other areas we found that relevant care bundles had not been completed. In one patient's record, a falls assessment had not been updated since 8 September 2013. We also found examples of patients on fluid balance charts where the total inputs and outputs had not been recorded.

On the neurosurgical ward one person had had their intravenous catheter removed, but their notes did not document why and there was no use of the Visual Infusion Phlebitis (VIP) score, the recommended way to monitor catheter sites to help prevent infections and identify when the catheter line may have been dislodged.

Patients were often transferred from Queen's to King

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George Hospital, including for rehabilitation. Staff told us that patient handovers were conducted by telephone. The nursing notes for transferred patients included a transfer checklist, but these were not completed. One nurse was not aware that a patient had diabetes.

There was a lack of documented guidance in patients' records on the care they required in relation to their medical and psychological needs. Staff told us they planned a patient's care by using the 'evaluation' sheets in their nursing notes. However, the notes we saw documented the care provided on that shift and were task orientated rather than including how a patient liked to receive care or how best to support them. We were told that staff were informed of any outstanding care needs during the handover. We looked at examples of handover sheets and saw no evidence that these included how to meet patients' psychological needs.

We looked at patients' medical records and saw evidence of multidisciplinary input from the medical team, physiotherapists, dieticians and occupational therapists, where necessary but not from nursing staff.

Managing risk

We observed theatre teams at Queen's Hospital. People were protected from avoidable harm through the use of the Patient Safety First 'five steps to safer surgery' procedures. This included the use of the World Health Organization (WHO) safety checklist to ensure that people had consented to the procedure and that the necessary checks were completed before, during and after surgery. We saw that the safety check of an anaesthetic machine had identified a fault. This machine was removed from the operating theatre and replaced.

There were systems in place to deal with medical emergencies. The trust had a Critical Care Outreach Team responsible for reviewing patients on wards whose condition may be deteriorating. Staff on the wards told us that the team were quick to respond when they needed advice or assistance.

All wards used the early warning score (EWS) observational chart to ensure that patients who may be becoming unwell were quickly identified and their condition escalated to the team or the night on-call team. There was also one resuscitation trolley available on each

ward and we saw that these were checked daily by staff.

The surgical department had learned from some mistakes. A Never Event (a serious, largely preventable patient safety incident) had occurred in 2013. This incident involved a person undergoing a different surgical procedure to the one they had consented to, categorised as a "wrong site surgery" which had occurred in ophthalmology. To reduce the risk of this happening again, patients were not draped in surgical gowns until final checks had been completed, including checking the person's consent form.

In 2012 the trust was a mortality outlier for septicæmia, meaning there were more deaths than expected. However, no staff we spoke with had undertaken training in how to recognise and manage sepsis while working for the trust, nor did the trust use a best practice tool such as "Sepsis Six", which is a series of life-saving interventions. In addition, we noticed that the observational charts used to respond to a patient's deteriorating condition did not prompt staff to consider sepsis.

There was an electronic incident reporting system in place. Incidents were monitored and investigated by ward managers and/or matrons. We saw an example of a root cause analysis following a serious incident in March 2013 and an action plan developed as a result, including reminding staff about the falls protocol. Staff on the ward where the incident occurred were able to describe the procedure should someone fall during the night, matching the action plan. We were told that learning from incidents was shared with staff during weekly ward meetings. However, on some wards, staff told us that these meetings did not routinely take place.

Hospital infections and hygiene

The trust infection control rates for *Clostridium difficile* (*C. difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were within the expected range. There were signs and information leaflets for patients and visitors on how to prevent infections and when to avoid coming to hospital.

According to the NHS Staff Survey (2012), only 52% of staff said that hand-washing materials were available. We saw that hand gel was accessible at the end of each bed and by the entrance to each ward or bay area. As a result of the staff survey, hand-washing sinks had also been

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placed by the entrance of each ward. The most recent Friends and Family test for some surgical wards had raised concerns about doctors not washing their hands. We were told that monthly hand hygiene audits were undertaken and staff were encouraged to challenge their colleagues. Most people had observed doctors using the hand gel to clean their hands between seeing patients.

At the time of our inspection the ward areas were clean. We observed domestic staff cleaning the wards and people told us that they had no concerns about the cleanliness of the hospital. We looked at equipment, including commodes, and saw that these were visibly clean and had a sticker applied with the date they were cleaned by staff.

The theatres at Queen's Hospital were clean. Infection control checklists were completed monthly and hand hygiene audits were completed weekly. We were told that all infection control audits were sent to the trust's infection control team.

Staffing

Some patients felt their ward was short staffed. For example, two patients on two wards felt there was not enough cover at night as it took staff a long time to respond to their call bell. On most wards the number of staff decreased at night, but on the neurosurgery ward they remained the same. We were told that staffing levels were determined by the number of beds on the ward. Most staff told us that, if there was a full complement of staff on each shift, they could manage to provide all the care that patients required. However, all staff said that the number of staff scheduled to work each shift was the minimum required and if there were unexpected absences then it was challenging. On the general surgical wards nurses told us that they usually cared for between eight and 10 patients each, but sometimes more. Staffing levels were not adjusted to accommodate fluctuations in patients' condition.

Are surgery services effective?

National guidance

The trust used the nationally recognised enhanced recovery programme for urology, colorectal and orthopaedic patients. The aim of the programme was to speed up a patient's recovery following surgery. In May 2013 the department carried out an audit of 200 patients on the programme. The sample was evenly split between Queen's and King George Hospital. 80% of patients were involved as much as they would like to be in their care, pain management was better, patients were mobilising earlier and the average length of stay had reduced. The average length of stay for surgical patients was 4.5 days, with a target of 4.45 days. This was lower than the trust's overall average of 7.05 days.

According to the June 2013 performance dashboard, 96.7% of surgical patients were risk assessed for venous thromboembolism (VTE). This was above the target of 90%. In addition, there had been no reported grade 3 or 4 pressure ulcers. There were skin care information bundles in place for when staff identified patients who may be a risk of developing pressure ulcers and input was sought from the Tissue Viability team.

Surgical assessment unit

The department audited the effectiveness of the SAU and the 'hot clinic'. The February 2013 audit findings were that the SAU was being under-utilised, but patients were providing positive feedback on their experiences, with 94% of 84 people describing it as "good" or "excellent". The March 2013 audit of the 'hot clinic' found that 39 admissions were avoided with over 67% of patients being discharged home or seen as an outpatient.

The trust participated in a variety of clinical audits. The audit for bowel cancer found that only 50% of patients were seen by a clinical nurse specialist. As a result the trust had recruited more bowel cancer nurses so that there were two nurse specialists at both hospital sites. Specialties reviewed particular cases at their clinical governance meetings and participated in research.

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Performance

Staff were not aware of how their or the department's performance compared to others. Surgeons were unable to describe how they knew that they provided a quality service to their patients. A surgeon was unable to describe how his morbidity and mortality data compared with that of his colleagues or how his unit compared to other units nationally. Senior management confirmed that this data was being collected but not formally published by the trust.

Monitoring staffing levels

The staff electronic rota system on the day of our inspection did not show where shifts had been covered by bank or agency staff. We asked to see the rotas on wards for the preceding month. We followed this up and found that bank and agency nurses had worked that day and this had been recorded in a book which was kept only on the ward. Therefore, senior management could not easily monitor staffing levels or how often shifts had been short staffed. A senior manager for the service told us there was an over-reliance on locum and agency staff.

Are surgery services caring?

Patients and relatives were complimentary about the staff. Everyone we spoke with felt the staff were caring. People described staff as "wonderful", "very kind", "superb" and "very caring". Some patients felt that staff were stretched, but told us that their needs were being met. We observed staff treated patients with dignity and respect and that overall care was good.

Survey results

The provider used the Friends and Family survey to gather people's experiences. According to the July 2013 survey overall, the trust performed worse than expected for how caring staff were. However, during our inspection of the surgical services, most people felt that staff were very caring.

The survey results showed that some surgical wards at Queen's Hospital were among the worst performing in the trust. We visited these wards during our inspection. The July 2013 survey indicated that patients were dissatisfied with the discharge process; that they had not been involved or given sufficient information. We spoke with

23 patients and where they were due to be discharged, they told us staff had explained the process and they knew what to expect.

We were told that, following the results of the Friends and Family survey, nursing staff and doctors were encouraged to spend more time with patients to discuss any of their fears or concerns. Patients were positive about staff communication. One patient told us that all their questions had been answered.

Dignity and respect

People were treated with dignity and respect. We observed staff closing curtains when providing care and talking to people about their care discreetly. Wards were divided into single-sex bays and there were designated male and female toilet facilities. Interpreter services were available and staff were required to attend mandatory training on caring for people with dementia. People who were confused or who had been diagnosed with dementia were discreetly identified on the boards in the ward area so that staff were aware.

Comfort rounds were conducted on each ward to ensure that patients were comfortable and not in pain. Staff told us that these included checking that the person was appropriately clothed and covered. In some records we reviewed, the comfort round charts had not been completed.

Nutrition

When patients were first admitted, their risk of malnutrition was assessed. Staff also monitored a patient's fluid intake. There were staff on each ward responsible for serving drinks and food. We observed that patients had drinks within easy reach. The July 2013 Friends and Family survey had indicated that patients were not satisfied with the quality of food. We were told that the trust had reinstated hot meals in the evening time, which had been received well by patients and staff. Red trays were provided to patients who needed support with eating and drinking so that staff could prioritise assisting during meal times. During our inspection we received positive comments about the food. One patient said the food was "cooked as well as I could do myself".

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Are surgery services responsive to people's needs?

Surgical assessment unit

Based on an audit of surgical readmissions in January 2013, and negative feedback from patients about waiting times for a surgical review in A&E at Queen's Hospital, the trust opened the SAU and also began a doctor-led 'hot clinic'. The aim of these two initiatives was to reduce the pressure on A&E, reduce the number of hospital admissions and reduce people's length of stay. While the length of stay for surgical patients was higher than its target, there had been a gradual reduction between January and April 2013.

Surgical consultants and their teams worked across both Queen's and King George Hospitals so people received good continuity of care. There was a separate operating list for gynae emergencies so that the general surgeons and gynaecologists were not competing for space and time on the same list.

Cancelled operations

Queen's Hospital was not always able to meet the needs of people using the service. We looked at the day case theatre list for 17 October 2013 and saw that all seven people had had their procedure cancelled previously, and six of those were cancelled two or three times. The majority of these cases were cancelled one to two weeks before their planned admission date so that more urgent cancer cases could be booked on to the list.

Discharge planning

At Queen's Hospital patients having day case surgery were being nursed in and discharged from the theatre recovery area due to bed shortages. This was an unsuitable environment as there were no working toilet facilities, patients were being served food while others recovered from their operation and there was a lack of privacy. It was also unclear who was responsible for these patients as the nurses focused their care on the patients coming out of theatre.

We were told that patients were not discharged home until they were well enough and, where necessary, arrangements had been made with other relevant services. There was a dedicated discharge team to assist with this process, but

nursing staff were able to describe the procedure should a referral need to be made to social services. There were delays in discharging patients. Staff told us these delays were caused by waiting for care packages to be confirmed by social services, bed shortages in the community and discharge summaries not being completed by doctors 24 hours in advance. Senior nurses told us that they had attended training to enable nurse-led discharges, but this had not been implemented by the trust.

Feedback

The trust gathered information on people's experiences to improve the service. The most recent Friends and Family survey results were on display in the ward areas with details of the action taken. However, in April 2013 only 67% of complaints from surgical patients had been responded to in line with the trust's policy. The Clinical Director for Surgery acknowledged that the complaint's procedure was poor as there was no consultant lead.

Are surgery services well-led?

Leadership

Staff we spoke to at Queen's Hospital felt that the surgical department was well-led. Staff told us they were proud to work for the department as they thought they delivered good care and had improved over the last year in response to negative feedback. Staff were aware of the trust's whistle-blowing policy and said they would feel comfortable using it. However the problems with transferring patients from recovery back to the wards along with the delays in discharging patients still needed to be addressed.

The matrons and medical staff worked across both sites, but were based at Queen's Hospital most days. Theatre teams met for an hour once a week and this time was protected. We looked at the meeting minutes and saw that clinical governance and training were discussed. Weekly meetings took place between matrons and ward managers. They told us they had meetings with the Director of Nursing. However, other nursing staff told us they would not be able to identify the trust's executive team. One ward manager told us they thought it would be improve staff engagement if the executive team were more visible on the wards.

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Monitoring quality

Clinical governance meetings took place monthly. Specialities also held their own governance meetings. We looked at the minutes for some of these and saw that they discussed deaths, the patient surveys and complaints. However, a senior manager for the service told us the department needed to make better use of the data available.

Ward managers told us they felt well supported by management and confirmed that they met weekly with their matron and colleagues. At these meetings they discussed incidents, complaints and quality of care audits. We were told that the trust's executive team disseminated information via newsletters and emails and that staff were able to contact the Chief Executive directly. Some staff told us they did not have time to read these and relied on their ward manager to pass on key messages.

A variety of audits were carried out to monitor the quality of care provided and to inform the department's performance dashboard. Weekly quality audits took place on each ward and involved looking at records, incidents, complaints and talking to people. However, these audits had not identified the issues we found when reviewing the documentation. Therefore, we were not assured that the provider's monitoring systems were accurate or effective.

Intensive/critical care

Information about the service

The trust has a total of 40 beds in intensive care. These are split across the two sites of Queen's Hospital and King George Hospital. At Queen's Hospital there are 12 intensive care unit (ITU) beds delivering care to patients, except children, with serious life-threatening illness; and eight high dependency unit (HDU) beds, for patients who are too ill to be cared for on a general ward. In addition, there are 12 neurological critical care beds (six ITU and six HDU beds). A Critical Care Outreach Team assists in the management of critically ill patients on wards across the trust during the day. At night, medical cover is provided by the on-call team.

We talked to patients and staff, including nurses, consultants and senior managers. We visited all of the critical care wards, observed care and treatment and looked at records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The patients and relatives we spoke to in the intensive care unit (ITU) felt that they had been well cared for and involved in making decisions about their treatment. The service was well-led by a team who had identified the risks and challenges the service faced and were monitoring them. However, there was a lack of patient flow in and out of the service due to delayed discharges and high bed occupancy in other parts of the hospital. This affected the service's ability to provide responsive and effective care to all patients. Once admitted to an intensive care ward, patients received safe and effective care from caring, qualified staff.

Are intensive/critical care services safe?

Hygiene

At the time of our inspection, the ITU ward area and equipment were visibly clean. There was adequate hand-washing facilities with hand gel dispensers at the end of each bed and by each ward entrance. We saw staff cleaning their hands between attending to patients. The ITU was spacious, with enough room around each bed for equipment and for staff to provide care safely. Resuscitation trollies were available on each ward and these were checked daily by staff. Staff told us that there was enough equipment available for each bed area.

We looked at documentation on the intensive care wards and found patients' needs had been assessed and that observations were recorded in a timely manner. Where a patient had been identified as being at risk of developing a pressure ulcer, they had been put on a skin care pathway which ensured that they were monitored regularly.

Staffing/skill mix

There was appropriate consultant cover on the critical care wards at Queen's Hospital. Each ward had an assigned consultant during the day so that, if a patient's medical condition changed, staff could respond rapidly. However, one consultant told us that there were not enough junior doctors and the department had to rely on locums. We were told that recruitment for these posts was ongoing.

Staff working on the unit had the necessary skills and experience and were all trained in intensive care with competency checked before they worked alone. There was a preceptorship programme of clinical supervision experience, mentoring and training, designed to support newly qualified nursing staff for the first six to 12 months of their roles. At the time of our inspection, there were no shortages of nursing or care staff. Patients on ITUs received one-to-one nursing care, while on high dependency units (HDUs) there was one nurse for two patients.

Intensive/critical care

Critical Care Outreach Team

During the day the department provided a Critical Care Outreach Team – a specialist nursing team tasked with responding to deteriorating patients situated elsewhere in the hospital. Staff on the wards told us that the team were usually quick to respond. All wards used the early warning score observational chart which triggered a call to the team.. At the time of our inspection the team was only available during the day, but we were told that the trust was in the process of recruiting to the team with the aim of providing cover 24 hours a day, seven days per week by April 2014.

A consultant had recently been assigned to the team at Queen's to review patients referred to the service. Staff told us this had "made a big difference to care at Queen's". If a patient's condition deteriorated during the night, wards were instructed to call the on-site manager who would call for medical support. We received mixed views from staff on the response from the hospital-at-night team. We were told the trust was in the process of recruiting to the Critical Care Outreach Team with the aim of providing cover 24 hours a day, seven days a week by April 2014.

Safeguarding

There were systems in place to protect people from the risk of abuse and safeguarding training was mandatory for all staff. Staff were able to describe the process should they have a safeguarding concern and some were able to provide examples of where they had made a referral to social services. Staff also showed an awareness of the Mental Capacity Act 2005.

Are intensive/critical care services effective?

National guidance

People received care in line with national guidelines. There was a set criteria for patients who should be admitted to the unit and the Critical Care Outreach Team were responsible for reviewing each patient referred to the unit to determine if it was appropriate or not.

The trust submitted data on the outcomes for intensive care patients to the Intensive Care National Audit & Research Centre (ICNARC) and monitored its performance compared to others nationally. We looked at the data and saw that the number of deaths for intensive care at Queen's Hospital was within the expected range. We were told that the neurological ITU was now able to care

for people with multi-organ failure whereas previously patients would have been transferred to the general ITU. For example, staff could provide haemofiltration therapy for patients with acute renal failure.

The unit was well designed and well equipped. Bispectral index (BIS) brain monitors were used on the neurological critical care unit to accurately determine the level of sedation required by each patient.

Handover

Comprehensive handovers took place twice daily between shifts and were attended by consultants, junior doctors and nurses. Consultants also conducted daily ward rounds. However, we were told that, on the Neurological Critical Care Ward, the neurosurgeons and anaesthetists did not do their ward rounds together and nursing staff felt it would be more effective if they did.

Are intensive/critical care services caring?

Dignity and respect

People were treated with dignity and respect. There was enough space between each bed to provide patients and visitors to the ward with some degree of privacy. Staff acknowledged that the ward could be noisy due to the equipment, but said that most people were understanding of this. One patient told us they had received "exceptional treatment".

Involving patients in decisions about their care

People told us they understood the care that they or their relative was receiving and had been involved in making decisions about their care. People were satisfied with the level of information they had been given. One patient told us they had been asked to provide written consent to their care and treatment and that any risks associated with the procedure or anaesthetic had been explained in detail. Another patient told us they were given pain relief soon after requesting it.

Each intensive care ward was covered by a consultant during the day. Nursing staff on the ITU wards looked after one patient each and two patients on the HDU wards. Therefore, there was sufficient staff to respond to peoples' questions and to meet their emotional as well as their medical needs. We observed positive interactions between staff and people using the service.

Intensive/critical care

Are intensive/critical care services responsive to people's needs?

Managing capacity

The service was not always able to meet demand due to high-level bed occupancy on the wards and delayed discharges throughout the trust. Between April 2012 and April 2013 the bed occupancy rate in the critical care wards at Queen's Hospital was 99%. In the same time period about 35% of patients experienced a delayed discharge from the ITU and 64 people were transferred from the ITU to other hospitals for non-clinical reasons. This was having an impact on those who needed to access the service. Medical staff described the situation as "frustrating". In order to mitigate the risks associated with transferring acutely unwell patients, a consultant would transfer the patient and provide a face-to-face handover to the receiving service. However, this was only where the patient was transferred during the day and some people were being transferred after 10pm. The fact that patients were being transferred to wards late at night where staffing levels were reduced had been identified as a risk and was on the risk register.

Discharge

We were told that there were no delays in discharging people from the neurological ITU as there were eight higher dependency beds on the neurosurgical ward. However, delays in discharging patients from the general critical care wards due to bed shortage on the wards meant that some patients who needed to be admitted to the ITU had to be nursed elsewhere in the hospital.

Therefore, we could not be assured that all patients were safe and receiving appropriate treatment. At the time of our inspection, one patient was being nursed in theatre recovery as there were no ITU beds available. At the same time, there were five patients who were ready to be discharged from ITU, but there were no beds available in the hospital.

Feedback

People were encouraged to give feedback about their experience and the Friends and Family survey results were on display. Staff told us that feedback from people was discussed at ward meetings.

Are intensive/critical care services well-led?

Management

Intensive care was a consultant-led service and staff told us they felt part of a supportive team. The senior managers and clinicians had a good understanding of the department's performance. They had identified the risks within their service and were able to demonstrate how they were attempting to mitigate these. For example, by recruiting to increase the Critical Care Outreach Team and ensuring that consultants led transfers of patients to other units during the day. Where risks had been identified, these had been placed on the risk register.

Staff told us they had regular team meetings to discuss issues such as incidents and complaints. All staff we spoke with enjoyed working for the critical care service.

Maternity and family planning

Information about the service

Queen's Hospital has one of the largest maternity services in England and delivers over 8,000 babies a year. A midwife-led birth centre for women with low-risk pregnancies opened in January 2013 and increased capacity at Queen's which allowed closure of the delivery unit at the King George Hospital. The labour ward has 17 delivery rooms, 16 antenatal beds and 22 postnatal beds. Another postnatal ward has 24 beds. There are two dedicated operating theatres and a high dependency unit (HDU) for mothers with severe complications from delivery. Another postnatal ward has 25 beds. A neonatal intensive care unit (NICU) for babies works closely with the delivery unit. For our report on the NICU, please see the section on children's services.

We visited the antenatal clinic, labour and postnatal wards and the birthing centre. We talked to 13 women and three relatives. We also spoke to 24 staff, including midwives, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at care records. We looked at comments and compliments from parents, and heard from people who contacted us to tell us about their experiences. We also reviewed performance information about the trust.

Summary of findings

Most of the patients that we spoke to were pleased with the antenatal and maternity care they received, and said that they had found midwives to be sensitive and supportive and had received clear information from doctors. The staff we talked to were positive about working at the hospital.

Most areas in the maternity unit were clean, but not all medicines had been locked away and we found some out-of-date items which indicated poor stock control.

All safety incidents were followed up, discussed widely and lessons learned were disseminated to staff. Although some staff were unaware of the link between changes in practice as a result of learning from incidents.

Although staffing levels were good, some staff told us they felt under pressure and consideration needs to be given to how support roles can be used more effectively. The consultant cover was lower than in some similar services and given the number of deliveries cover should be in line with national guidance. We understand that recruitment for more consultants is underway. There were opportunities for formal and informal training for staff at all levels, and all midwives completed four days of mandatory training in the year.

Doctors and midwives used performance information to assess the service against national guidelines. Midwives used comments and complaints to improve women's experiences of care.

Maternity and family planning

Are maternity and family planning services safe?

Most of the women were happy with their care at the time of birth and felt the service was safe. One woman said “the care was brilliant – the doctors and midwives listened, understood and offered advice.”

Managing risks

Mothers were risk assessed during their pregnancies at antenatal appointments (with care plans developed to take account of identified risks) and again at the onset of labour.

The maternity service monitored the quality and safety of care using the maternity dashboard (a performance reporting system using a number of quality and safety indicators). The dashboard was reviewed monthly and concerns escalated as appropriate. We were told that the threshold for some of the indicators needed to be reviewed as they were too low and triggered a review which was not always necessary. Not all staff were aware of this valuable tool.

All safety incidents were followed up, discussed widely and lessons learned were disseminated to staff. An example of a recent change was the training programme for all staff on using and interpreting cardiotocography (CTG) which monitors the heartbeat of the baby and the mother’s contractions to identify potential foetal distress. We found that some staff were unaware that some changes in practice had been the result of learning from a serious incident.

A named midwife was responsible for carrying out a programme of audits on topics such as maternity record keeping, documentation of consent and compliance with pre-birth assessment of safeguarding. Clinical and surgical audits were undertaken and staff carried out random spot checks. Where poor practice was found the trust took action to investigate why it had happened and took action to address it, for example by including a topic such as record keeping in mandatory training. On each shift there was a midwife allocated on the roster to provide support either in the Birth Area or the Labour ward in times of high activity.

Safeguarding vulnerable women and babies

We spoke to staff and saw records that demonstrated staff had a good awareness of safeguarding vulnerable women and children. All new midwives had safeguarding training.

A named safeguarding lead for maternity shared an office with social workers from two of the three hospital boroughs who were responsible for people who were homeless, trafficked or had learning disabilities. There were clear and confidential processes for referral.

There had been a recent review of physical security in the hospital to prevent the risk of a baby or child being abducted. An action plan was being implemented.

Environment

Most areas in the maternity unit were visibly clean. However, toilets on the postnatal ward were not clean towards the end of the second day of our inspection. Hand hygiene gel was available and used throughout the service. In the antenatal clinic there was no sluice room so staff had to test urine in toilets which posed a possible health risk.

Equipment and medicines

The stock control system did not seem robust. We noted some poor practices in relation to the storage of medicines had been identified during random audits in May and September. On our visit, we found some out-of-date drugs, blood culture bottles and disposable equipment, and noted that not all medicines were stored in locked cupboards which was against trust policy. In some cases, items such as x-ray detectable swabs were stored alongside ordinary swabs. Daily checks on milk fridges, resuscitation equipment and infant resuscitaires had not always been recorded. None of these incidents resulted in harm and the trust took swift action to correct the concerns when we raised them. Resuscitation equipment and drugs for babies and adults were available on the wards.

Staffing levels

Although the delivery unit was very busy, staff and women thought there were sufficient staff to meet women’s needs. The midwife-to-birth ratio of 1:29 enabled the trust to give one-to-one support for women in the labour ward. Staff turnover of about 16%, was higher than the trust’s 11% target, but turnover had decreased over the past year. Some staff raised concerns about the management of the antenatal and postnatal wards and the expectation that staff will move to support each area. Support roles could be used more effectively to reduce some of the pressure on midwives.

Maternity and family planning

Sickness absence among midwives was 3.9% in September 2013, in line with the trust average and lower than the same month in 2012. Action was being taken centrally by the trust to manage long-term sickness absence. Newly qualified midwives said they were well supported by more experienced colleagues.

The 20 obstetric and gynaecology consultants provided 98 hours of cover on the labour ward rather than the 168 hours a week recommended by the Royal College of Obstetricians and Gynaecologists. Consultants were on call during nights and at weekends and the trust intended to recruit more consultants to increase this cover. Two resident anaesthetists enabled both theatres to be used at the same time if necessary.

Ward capacity

The occupancy rate across the maternity unit was high at 82 percent. Ward capacity was sufficient but new patient pathways were being developed to free up postnatal beds more quickly. Staff showed us an action plan for facilitating more timely discharges from the postnatal wards, to be in place by early November 2013. Some staff raised concerns about the management of the antenatal and postnatal wards and the expectation that staff will move to support each area. Support roles could be used more effectively to reduce some of the pressure on midwives.

In the High Dependency Unit (HDU), staff reported that they were working under considerable pressure, which was increased during times of sick leave when it was difficult to get replacement staff. Some staff felt that the unit had been underfunded in the past. However, the trust has confirmed it is appropriately funded. Staff pressure resulted from the need to manage a recent increase in the number of caesarean sections* (although overall, there has been a downward trend in caesarean section rate) as well as caring for pregnant women who had been identified as being high risk. More women on this unit were at the higher dependency end of the spectrum.

Are maternity and family planning services effective?

Triage

Most women were also happy with the triage system on arrival in the labour ward. The trust was meeting its targets for seeing women within 30 minutes of arrival 90% of the time, but some mothers said they had not been seen as quickly as they would have liked.

Staff handovers

We observed a staff handover when staff on the labour ward were changing shifts. This was well attended and well organised and included representation from night and day shift staff. The Director of Midwifery also attended. The handover ensured that all staff had up-to-date information about mothers on the ward to ensure continuity of care.

Benchmarking and national guidelines

Women received care according to best practice clinical guidelines. Women who needed planned caesarean sections were treated according to national guidelines and were first assessed for potential surgical risks. The World Health Organization's (WHO) checklist was undergoing a relaunch checks. The two theatres were needed for caesareans and other surgical interventions required during and after delivery so there was often significant pressure on theatre time. Obstetricians told us that main theatres could be used as a back-up in an emergency. The trust's caesarean rate was low at 25% compared to a London average of 29% but we were told there were some errors with the data so this may not be an accurate reflection. Emergency caesarean sections sometimes impacted on mothers awaiting for routine caesarean sections and plans were in place to appoint a surgical care practitioner to co-ordinate elective surgery more effectively.

Doctors we spoke to were very conscious of national and international clinical guidelines and standards such as those produced by NICE and British Association of Perinatal Medicine (BAPM).

Maternity and family planning

Audits

Clinical audits were undertaken to ensure that the unit was performing in line with national guidelines. The trust's targets for performing grade 1 caesarean sections within 30 minutes and grade 2 caesarean sections within an hour were not being met. We were told that staff followed up the reasons for delay in each case but a few staff we spoke with were unaware of this process. The analysis for September showed causes of the eight delayed cases to be due to data entry errors, patient factors (such as delay in consenting) and one capacity issue where both theatres were occupied. Obstetricians were satisfied that the safety of women and babies had not been compromised. There is no national benchmark for the timing of grade 2 caesarean sections.

Supervision of midwives

Midwives had access to a supervisor of midwives for advice and support and most (84%) received timely annual supervision. An audit of midwives' views on supervision between November 2012 and January 2013 showed 99% of midwives sampled found supervision valuable and supportive. Midwives told us they attended four days mandatory training a year and were also able to access professional development opportunities.

There were regular short teaching sessions for staff on the maternity ward as another means of spreading information. An example was a short session on preventing venous thromboembolism (blood clots).

Appraisals/training

Appraisals had also been completed for over 80% of staff and there was a strong focus on supervision for midwives. There were opportunities to develop skills and a plan to rotate midwives and MCAs around different areas of maternity services would further develop skills.

Pain management/consent

Women we spoke with thought their pain had been managed well. There was evidence that formal consent was sought for surgical intervention and women gave verbal consent to other procedures.

Are maternity & family planning services caring?

Support for women

Women in the antenatal clinic said they felt cared for and were given useful information and time and support to discuss their care. The maternity unit offered classes in the last trimester of pregnancy.

Many women and their families spoke very highly of staff around the time of their baby's birth. The Maternity Patient Experience Survey showed that women felt involved in developing their birth plans, their partners were made to feel welcome, and they had sufficient information to enable them to make choices about their care and treatment during labour. They rated pain relief highly and families told us that staff were sensitive to their needs and emotions. A patient champion visited wards periodically to find out how women using maternity felt about their care.

Many women in the postnatal ward mentioned that staff had bolstered their confidence in caring for their babies. One mother mentioned that her caesarean section had taken place several hours later than she had expected, "but that everything else had gone very well – the postnatal support was brilliant". Patient feedback from the Maternity Patient Experience Survey showed that 95% of women felt they had had good support on feeding their baby and 91% felt involved in decisions about their care. There was a score of 91% on the positive recommendations indicator.

Patients' privacy

On the wards families could draw curtains around the bed for privacy. We saw staff speaking respectfully and kindly to women and their families. There was specialist support available for bereaved families.

Maternity and family planning

Are maternity and family planning services responsive?

Antenatal care

Women thought the antenatal service was responsive to their needs. However, some expectant mothers were given appointments before staff arrived which increased their waiting time unnecessarily. There were no arrangements for notifying people of appointment delays. We noted that there was potentially an issue about confidentiality because women could be overheard when speaking to the receptionist. The clinic booking system was shortly to be reviewed.

Midwives had developed specialist areas of expertise in response to the needs of the local population. These included obesity, diabetes, mental health, substance misuse and safeguarding.

Birth centre

The birth centre (opened in January 2013) had large rooms with plenty of space. Two rooms were equipped with a birthing pool, bean bags and mood lighting that women could use if they wanted. Staff had reviewed the birth centre guidelines to broaden the admission criteria and were encouraging more mothers to use this service.

Midwives had developed specialist areas of expertise in response to the needs of the local population. These included obesity, diabetes, mental health, substance misuse and safeguarding.

Patients' feedback and complaints

Women's experiences of care were gathered through patient surveys, complaints and comments. We saw examples of patient comments being discussed with staff to consider ways of improving the service. Where actions were identified, a named member of staff was asked to follow up and this was recorded in the minutes of the meeting. We were told that complaints had fallen in the past year. One person commented that clinicians did not seem to "own" complaints in their areas.

We saw that an ice machine had been delivered to the labour ward in response to requests from women. Changes to more timely discharge from postnatal wards were, in part, a response to women's complaints about waiting for medicines to take away, or for discharge letters.

In response to complaints about the attitudes of some staff, mandatory customer care training had been introduced in maternity and a partnership had been set up with an external organisation to deliver training in respectful maternity care.

We were told that a maternity services liaison committee met twice monthly and actively collected feedback from women and families. This fed into the trust governance structure.

Are maternity and family planning services well-led?

Managing quality and performance

We saw evidence that the service responded to and learned lessons from serious incidents. For example, in response to two serious, largely preventable patient safety incidents, known as Never Events, surgical protocols had been reviewed to avoid a similar incident in future. However, despite much work being done, we noted that these incidents had still not been fully closed and some senior members of staff were unaware that changes in practice were as a result of these incidents. A revised perioperative plan and revisions to the audit were still required. In addition, staff we spoke to were unclear if x-ray detectable swabs were now being routinely used. The September 2013 swab count audit noted that the 'sign off' phase of the WHO checklist, which requires staff to confirm swab counts, was not always completed.

There was a clear maternity risk management strategy. The Director of Nursing was the named executive responsible for Maternity at the trust Board. A number of sub-groups fed into the Maternity Quality and Safety Committee, which reported through the Women's Board to the trust Quality and Safety Committee and to the trust Board. Feedback from senior staff was passed down by email and through staff meetings, a Risk newsletter, The Link e-magazine and a Maternity Message of the Week. Some staff felt there was too much reliance on emails and were not always aware of any changes.

Staff monitored the quality and safety of care across the maternity service through their programme of audits and spot checks as well as the maternity dashboard. Many changes been introduced relatively recently and time was needed to realise the benefits.

Maternity and family planning

Management arrangements

The maternity service had recently recruited new staff at all levels. The Delivery Unit Matron and the clinical lead for maternity were both fairly new in post. There was a clear structure for management and communications but there had been many recent changes and the new systems needed time to bed down. The Director of Midwifery had a clear strategy for moving forward and was a visible leader. Staff and managers considered the service was continuing steadily on its journey of improvement.

Staff felt their job roles were clear, they were supported by their managers and could escalate concerns. Regular staff meetings had helped them to understand where improvements were needed. Staff felt that maternity services were developing a stronger learning culture than in the past and morale had improved.

Team working

We noted that some maternity care assistants felt they were not well integrated into teams. They felt they had no one to speak up for them and nowhere to refer their concerns.

The last audit by the Local Supervisory Authority identified barriers to team working among the supervisors of midwives. The service responded by holding team-building exercises and setting ground rules for meetings to support positive discussion and raise morale. A plan for staff to work in different areas of the maternity service on a two-year rotation had been developed to encourage staff to see the service as a whole and not just focus on their individual area. Working and improve women's experiences.

Staff reported that communications had improved but there was an over reliance on emails to share information.

Children's care

Information about the service

Queen's Hospital children's services comprise two distinct units, led by a matron.

The neonatal intensive care unit (NICU) has 24 cots and provides special and high dependency and intensive care services.

There is a general paediatric service for children and young people aged up to 19. There is a 14-bed day assessment and treatment unit and a five-bed, short-stay paediatric assessment unit for seeing some patients/children coming in through the A&E service. The inpatient ward, which caters for young people with a wide range of conditions, has 25 beds including six single rooms. There is also a dedicated children and young people's outpatient clinic.

We talked with staff including doctors and nurses, and parents or relatives. We observed care and treatment and looked at care records. We reviewed performance information about the trust.

Summary of findings

Parents told us they were happy with the services provided for new-born babies and that staff listened to their concerns and answered their questions. The standard of hygiene was high, and all babies were routinely swabbed to identify any colonisation of bacteria and preventative treatment was given if needed. Parents of children and young people using the paediatric services said that staff were caring and kind, and responded well to people's needs. Parents considered that their children had received safe and effective treatment.

Staff engaged positively with children of different ages. The facilities on the ward were good and included indoor and outdoor play areas, a sensory room and a tuition service.

Performance information, and comments and complaints were used to improve the service.

The services were complemented by a special care baby unit and second general paediatric ward, both based at King George hospital.

Are children's care services safe?

Neonatal intensive care unit (NICU)

The NICU provided a high level of specialist care to babies according to the British Association of Perinatal Medicine guidelines. Most babies were admitted from the delivery unit at Queens.

Admissions

The decision to admit a baby to the neonatal unit was the responsibility of the neonatologist who examined and assessed the baby. There were regular and close links with obstetricians to discuss potential admissions and cot occupancy and there was always one emergency cot available in the NICU. Doctors assured us that, if capacity in NICU, either cots or staffing levels, became an issue, then new-born babies needing intensive care would be transferred to another hospital after being stabilised at Queen's. No babies would be accepted from other hospitals at such a time. We were told this had happened in August 2013. Staff said this had happened occasionally. All unexpected admissions to NICU of babies born at full term were followed up under the risk management process. The trust maintained close oversight of all admissions to NICU. An analysis of the reasons for unplanned admissions in September 2013 showed that most admissions were related to jaundice and sepsis. It revealed that the data collection on admissions needed improvement and we were told that closer monitoring was now taking place.

All documentation of emergency cases was required to be completed at the same time to maintain an accurate audit trail.

Medical staff told us that they were able to seek advice from more specialist baby units at other hospitals when needed.

We noted that an incident in Spring 2013, when up to 12 babies [in the hospital] had colonisations of bacteria, had been managed effectively and none became ill.

Staffing

NICU staff were either neonatal doctors or nurses trained in neonatal nursing. There was a national shortage of such nurses and the trust had sent some of its own staff on training to help remedy this. Agency nurses were sometimes used and there were clear induction checklists

Children's care

for such staff to ensure safety. All nursing staff below band 7 rotated between the NICU and the SCBU. The doctors covered both sites.

Environment

The standard of hygiene was high. All babies were routinely swabbed to identify any colonisation of bacteria and preventative treatment was given if needed. Staff had drawn up a NICU infection and control action plan and monitored compliance with procedures.

Paediatrics

Most children admitted to the paediatric ward had come through A&E, some as GP referrals. We looked at records of four children admitted from A&E. These contained documentation in line with trust policy, including observations taken in A&E and a care plan for ward staff. Where there were safeguarding concerns, appropriate referrals had been made on standard forms. We saw that children's risks were assessed on admission and care planned accordingly.

We saw that incidents were reported and monitored and all nurses we spoke with understood the process for incident reporting and could explain how they learned from incidents. For example, following one child's cardiac arrest, an age-specific Paediatric Early Warning System had been introduced with appropriate staff training.

The parents on the paediatric ward were very complimentary about the service they received and were generally confident in the expertise of the staff. Some parents mentioned that they had had to be quite persistent with their concerns about their child in A&E, prior to being seen and admitted. Parents thought their children were well looked after by the nurses.

Staffing

One parent mentioned that it felt confusing to see different doctors on the ward on different days and consultants were not always present at the evening handover and if there was a different consultant on the next day they may make a different decision. Nursing staff recognised that this could be a problem. It arose because paediatric doctors rotated daily between the children's wards, outpatients and A&E.

The nurse to child ratio was 1:5, day and night, unless an individual child needed one-to-one care. There was also a healthcare assistant on the ward. An electronic staff

rostering system was in place to support planning of staff numbers and skill mix. Parents felt there were sufficient nurses and other staff to meet the needs of children.

The trust had a full complement of paediatricians. Registered nurses on the paediatric ward had paediatric qualifications so they had the necessary skills to care for young patients. Staff from the trust's bank of paediatric nurses, and occasionally nurses from agencies, were used to replace vacancies on shifts. Most had worked at the hospital before so were familiar with ward processes. There was a mechanism for permanent staff to report unsatisfactory agency or bank staff.

Consultant paediatricians were on call at night and on weekends to provide additional medical cover when required. Junior doctors said consultants were accessible and supportive. The doctor on duty in the ward at night contributed to the morning handover when new staff came on shift. A registrar was present at the weekend. There was a paediatric doctor responsible for the short stay paediatric assessment unit from 9am to 5pm, and on call outside these hours.

Safeguarding children

All nurses on the ward had mandatory safeguarding training to level 3. A named nurse and consultant were responsible for safeguarding children and young adults. There were weekly multidisciplinary meetings about children of concern. Two of the three local authorities served by the trust had social workers based at the hospital.

There had been a recent review of physical security in the hospital to prevent the risk of a baby or child being abducted, and an action plan was being implemented.

Patient safety and environment

All areas in the children's unit were visibly clean. Hand hygiene gel was available and used by staff, parents and visitors on the ward.

There were toys and activities suitable for different age groups. Toys were clean and in good condition. There was a children's play co-ordinator on the ward.

The paediatric outpatient area was quite crowded and not all areas had natural day light. There was information about late-running clinics and the waiting time was long for some families. On the day of our visit, one clinic was an hour late, another half an hour late. There was no confidentiality for people speaking to staff on reception.

Children's care

People mentioned that it was hard to find the children's outpatient area in such a big hospital. They would have welcomed more play space for children when waiting times were long but appreciated the availability of a room where they could heat their baby's food.

Are children's care services effective?

Neonatal intensive care unit (NICU)

There were systems in place to ensure that the neonatal unit was prepared for routine as well as unexpected admissions. The neonatal emergency bag containing all equipment necessary for resuscitation and stabilisation and the transport incubator were checked at the start of each shift and always ready.

All babies were seen by a consultant every day, including weekends. Audits had shown that there was a low mortality rate by comparison with other units. The unit also discharged babies more quickly than others. There were clear arrangements for babies on the neonatal unit to transfer to another hospital if they had an exceptionally high need.

There were protocols for staff responsibilities including transport arrangements for babies, sharing information and learning lessons from admissions, and these processes were audited annually by the lead consultant paediatrician. The findings and recommendations of this audit were notified to the Quality and Safety meeting.

A consultant told us that admissions to NICU in relation to the number of births had reduced over recent years from 10% to 7% and survival rates were improving. A six-month audit of babies with hypoxic ischemic encephalopathy (a condition where the baby has not had enough oxygen in its blood) showed the unit had a low mortality rate.

Paediatrics

The parents and children we talked to in the paediatric areas said they were well looked after and had prompt and effective pain relief when they came onto the ward.

The hospital aimed to discharge young people back home as soon as possible. Sometimes family care was supported by the children's community service. Children were discharged with medical notes sent out to GPs or others and staff said there were rarely delays in discharge. There was a home discharge team based on the ward.

Resuscitation equipment and drugs for babies and children were available on the ward. Staff said that equipment was good. A continuous positive airway pressure machine had been brought into use in February for babies needing help with breathing, and nurses had been trained on its use.

Are children's care services caring?

Neonatal intensive care unit (NICU)

Parents said that their babies' care and treatment was clearly explained and staff supported them well in an anxious time. One mother said the staff were "extremely good. I can't fault them".

Communication

Parents said they trusted the expertise of staff and the explanations of the care and treatment given. Parents also praised staff for their support, including in bereavement.

Paediatrics

Parents told us that the nursing staff were kind and caring. The ward environment was attractive and suitable for young people. Our observations showed nursing staff working well with children and treating them with respect.

Parents said they were well informed by doctors and able to discuss their concerns. Parents also said they felt supported by nursing staff. One parent said "staff have been great. Everything has been done just right".

Are children's care services responsive to people's needs?

Neonatal intensive care unit (NICU)

Accommodation

There was a double room near the NICU where parents could stay overnight before their baby was discharged and be given help by staff on caring for their baby.

Capacity

The cot occupancy in the NICU was monitored daily and throughout the shift. There was always an emergency cot available to the delivery unit in NICU. A baby might be transferred from the delivery suite, obstetric theatre, maternity wards including the HDU and sometimes from other neonatal units. There were clear protocols in place to manage these transfers. Babies with very complex needs, including babies requiring surgery, would be transferred

Children's care

to a hospital with a level 3 NICU within the hospital network using the neonatal transport service. (The NICU at Queen's was level 2).

Staff told us that fewer babies need to be transferred to tertiary centres since the unit had bought equipment for inhaled nitrous oxide therapy (iNO) for breathing and lung function problems.

There was a medium-term plan to bring the special care baby unit at King George Hospital onto the Queen's site to integrate the service better and avoid transporting babies between sites. This had the support of nursing staff and doctors.

Paediatrics Accommodation

Parents were pleased that pull-out beds were available for them to stay with their children on the ward, making parents and children feel more comfortable and secure about being in hospital. They considered there were a good range of activities and toys to keep children occupied.

We saw evidence of compliments from parents. In the children's outpatient department, for example, a laminated set of comments describing children's positive experiences of giving blood was a useful tool to allay fears and promoting the skills of staff taking blood.

There was open access to the ward for parents of children with cancer and sickle cell anaemia.

Are children's care services well-led?

Neonatal intensive care unit (NICU)

NICU was well-led. A new matron had recently taken up post and had established himself quickly in his role.

There were regular audits of all aspects of the NICU and investigation of incidents. Doctors considered that significant improvements had been made in communications with parents of babies in special care. Parents and families mentioned that the system was "well organised".

Paediatrics

The matron was visible to her staff and nurses and the healthcare assistant considered they worked together as a team and with medical staff. Two staff said the ward was very well run. The matron told us that, when she first joined, there were a lot of management changes and the nursing leadership structure had been unclear. The structure now seemed fairly stable.

Staff told us they had regular supervision and appraisal and that there were regular training opportunities.

Senior managers within the paediatric service had a clear vision for developing aspects of the children's service. There were plans to rotate paediatric nurses through A&E to help liaison between that service and the ward. A meeting to discuss this was to be held shortly after our visit.

Staff said that the hospital was slow at managing poor staff performance. Quicker processes would be better for all staff because nurses who were not performing well became supernumerary.

End of life care

Information about the service

Queen's Hospital has a palliative care team based next to two cancer wards. The team provides end of life care directly to patients throughout the trust, where appropriate, as well as supporting and training staff on the wards. They are available Monday to Friday from 9am to 5pm.

We spoke with patients and members of staff, including staff nurses, the lead nurse for end of life care, the co-ordinator and consultants for end of life care, a social worker, bereavement service officers, and ward sisters. We observed care and treatment and looked at four patient records. We received comments from our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service.

Records regarding end of life care were completed in a timely fashion. However discharges were not as fast as required and the level of care could fluctuate depending on which member of staff was looking after a patient as a consequence of variable take-up of training between ward areas.

Are end of life care services safe?

Documentation

Patients received a safe end of life care service. The records of four patients who had received palliative care or end of life care demonstrated that they had received appropriate care for their condition. Pain relief, nutrition and hydration were provided according to their needs. Their wishes for their end of life care were clearly documented, including if they wanted to be resuscitated. Mental capacity assessments were in place where required and patients or their next of kin had signed these plans as accurate.

Staffing

The palliative care team included specialists who understood their role and were passionate about ensuring patients received good end of life care. The team was fully staffed, although they wanted further staff seconded to the service which had not been fully successful. The service had one consultant lead. The trust had an end of life co-ordinator who trained staff on the wards in end of life care.

Are end of life care services effective?

Range of support

Patients received effective support from a multidisciplinary palliative care team. The palliative care team generally responded swiftly to referrals to ensure that patients received an effective service. The team included a consultant, a lead nurse, clinical nurse specialists and a social worker. An end of life care co-ordinator provided support to all patients and staff across the trust. A multi-faith and bereavement service was also available. Links with community services and hospices had been made to ensure families had support out of hours. All staff in the palliative team were trained to provide specialist care and expertise in palliative and end of life care.

Multidisciplinary working

Ward staff were aware of end of life care pathways although different wards told us they would request support from the palliative team for different aspects of a patient's end of life care. Some staff were reluctant to involve the palliative care team whereas others would ask the palliative team to provide all end of life care. All staff we spoke with felt well supported by the palliative care team.

National guidelines

The end of life care team followed government guidelines. Recently the Department of Health asked all acute hospital trusts to undertake an immediate clinical review of patients on end of life care pathways. This was in response to the national independent review More Care, Less Pathway: A Review of the Liverpool Care Pathway published in July 2013. The trust had undertaken this review and had an interim policy on end of life care which replaced the Liverpool Care Pathway they had used.

End of life care

Training

The palliative care team supported ward staff to ensure continuity with end of life care when there was no direct palliative clinical support. All clinical staff had mandatory training in basic end of life care every two years and more comprehensive training was also available to staff.

However, some staff who were not working on the oncology wards felt training was not flexible enough and take-up of training ranged between ward areas. This meant that care could fluctuate depending on which staff was looking after a patient.

Staff informed us that the trust had introduced the Gold Standard Framework (GSF) on two wards in the trust for end of life care. The National Gold Standards Framework Centre is the national training and co-ordinating centre for all GSF programmes, enabling ward staff to provide a gold standard of care for people nearing the end of their life.

Are end of life care services caring?

National/local surveys

Although the trust was in the bottom 20% in the National Bereavement Survey in 2011 in three of six quality indicators, the trust met their Commissioning for Quality and Innovation (CQUIN) targets for end of life care in 2012/13 and were on course meet higher standards in 2013/14. The trust had carried out its own bereavement survey in the last year and had had positive results.

Patient and relatives experience

Patients had positive views about the end of life care service. Patients commented that they felt well cared for and their privacy and dignity was maintained. When we observed consultations, staff were sensitive to the patient's prognosis. Outpatient consultations with the end of life consultant lasted an hour to ensure the patient was able to discuss all the issues they wanted and patients were able to make choices regarding their end of life needs. The oncology wards at Queen's had relative rooms so families could have privacy, although this was not always available in other wards. The palliative care team tried to ensure all patients on end of life care pathways were in side rooms and we observed that this had been arranged, although one patient told us they had only been moved from a bed in a treatment room after complaining.

Families of patients receiving end of life care had dedicated parking and their visiting hours were not restricted. The bereavement service had private and comfortable relative rooms. The mortuaries had viewing areas that were dignified and viewing could be arranged before a post mortem was started. A multi-faith service was available.

Information

The bereavement service had a number of leaflets to support relatives of patients that had passed away. These leaflets included contacts of support organisations and networks such as counsellors as well as a step-by-step guide in what a family needs to do when a relative has died.

Are end of life care services responsive to people's needs?

Referrals

We saw examples of referrals to the palliative team late on Fridays and Mondays. Due to the service being Monday to Friday, this led to delays with palliative team input as no referrals could be completed over the weekend and there was a backlog of referrals on a Monday. We were told this was due to consultants not completing the necessary paperwork in a timely manner.

If the palliative team were not on site during their opening hours, a telephone advice service was available to patients, families and ward staff.

Discharge

Patients were discharged safely with the right care and support. We listened to some palliative care patient consultations with the end of life consultant, end of life care nurse and ward nurses. The patient's palliative care needs were discussed in-depth, including end of life care. This included making sure support services were in place so that the patient could return home safely, psychological and religious support and a review of the patient's pain relief needs.

Although patients were fast-tracked to get immediate funding to facilitate the right home care package or nursing home depending on their wishes, this was not always done as efficiently as it could be. One patient who was referred for fast-track care as they wanted to spend their last days at home was still at Queen's Hospital six

End of life care

days later when they passed away. Staff reported that fast-track discharges were delayed due to the length of time it took to complete the referral form. This resulted in delays with arranging social care in the community due to limited providers being available through the local authorities and referrals to the palliative team being rejected for not having enough information to show that fast-track discharge was required. To resolve this problem, one ward had recruited a discharge nurse to speed up the discharge process but this role covered one ward only.

Are end of life care services well-led?

Leadership

All staff were positive about their work and wanted to provide a high quality service. While many aspects of the service are good action needs to be taken by senior staff to address the outstanding issues related to referrals and fast track discharges.

Outpatients

Information about the service

Outpatient Services at Queen's Hospital are separated into seven separate areas. The clinics run from Monday to Friday 9am to 5pm. The trust offers outpatient appointments for all its specialties where assessment, treatment, monitoring and follow-up are required. During our inspections there were separate outpatient clinics for neurology, trauma, cardiology, chest, geriatric, pain, general medicine, epilepsy, hepatology, orthodontics, dermatology, vascular, ear, nose and throat (ENT), ophthalmology, stroke, chiropody, orthopaedic, urology, endocrinology, rheumatology, sexual health, maxillofacial, anaesthetics, breast, general surgery, paediatrics, obstetrics and anti-coagulation.

We talked with patients and members of staff, including the outpatient managers, matron, booking and clerking staff, healthcare assistants, doctors and consultants. We observed care and treatment. We received comments from our listening event, from people who contacted us to tell their experiences, and we reviewed performance information about the trust.

Summary of findings

The outpatient service did not always provide safe and effective care. Patients received treatment and follow-up appointments, although these were not always held in appropriate private locations. Patients were able to ask questions to help understand their treatment and monitoring plans but sometimes this could be rushed. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed, although some patients felt they were not kept informed. Some clinics were not managed efficiently and areas of the service needed to improve. On average, between 10-12% of patients did not attend their appointment and there were a high number of cancelled and delayed clinics.

Are outpatients services safe?

Staffing

Patients had consultation, diagnostic tests and assessment and consultations with appropriately qualified staff and advice was sought from other healthcare professionals where necessary. However, sometimes patients did not see the correct clinician to deal with their treatment, in some cases this was because of mismanagement of cancellations when the consultant either did not arrive or needed to take last-minute leave.

Environment

Some of the outpatient services were provided in a clean, safe and accessible environment. However, the sexual health clinic had been moved from a purpose-built location to increase the capacity of paediatric A&E but the location was now being used as an IT suite. The current location was unsuitable as the area was not big enough to accommodate patients and staff. Patients had to wait in a corridor which was narrow and used by other staff to transfer medical records on trolleys. We were told the trolleys often bumped into patients and staff and we were informed of an incident where a child had been hit by a medical record trolley. Although staff said that some incidents were reported, records showed this had not always occurred. Staff, including the General Manager, and a consultant had expressed their concerns about the move but told us nothing had been done. The clinic also used a former storage cupboard as a treatment room. No review of the decision to move the sexual health clinic was recorded.

Infection control

Hygiene gels were not always clearly available at Queen's Hospital due to poor signage or poor location of the sanitisers. In the sexual health clinic, temporary wash basins were in place for staff which had to be sterilised three times a day. However, this meant that consultations were sometimes interrupted. We observed some staff treating people while not following infection control guidance of being bare below the elbows.

Accessibility

All clinics were either on the ground floor or could be accessed by lift, making access safe and easier for patients with mobility difficulties. There were wheelchairs in the outpatient areas for use if needed.

Outpatients

Safeguarding

Staff understood safeguarding processes and what to do if they needed to raise an alert. Staff told us they had received training on safeguarding children and vulnerable adults and knew how to access policies and procedures. The trust had a safeguarding team if staff required support.

Are outpatients services effective?

Quality and monitoring

The trust had recently started auditing their appointment times to ensure efficiency and obtain feedback from patients. We were told that, in the first month, patient feedback had been positive and meetings were being held in the outpatients department that involved a patient representative. The sexual health clinic had collected information about the number of patients who should have come back for follow-up appointments but this had not been analysed yet.

Team working

Some staff told us that frontline staff worked as a team and staff were moved between both Queen's and King George if there was a shortage of staff.

Are outpatients services caring?

Staff attitude

We were told staff were reassuring and explained their current treatment as well as next steps including risks and benefits. When we observed patient consultations, staff were friendly, explained the next stages of their treatment and gave patients contact details if they needed further support after discharge.

If a patient did not see their usual doctor, they told us that they felt the doctor was informed about their condition and background. We were told about one occasion when a patient arrived for an appointment that had been cancelled. However, the original consultant who ran the clinic agreed to see the patient.

Information was available in all outpatient clinics informing patients of any delays and most patients told us they felt informed about their appointments at both sites. One outpatient's receptionist had received an internal 'PRIDE' award (the trust vision – Passion, Responsibility, Innovation, Drive and Empowerment) due to their positive attitude with patients.

Some patients told us they were helped to their clinic by volunteers. Although there were information desks in public areas, in some outpatient clinics, patients were required to sign in using an electronic system, with no visible support or information about how to do this. Clerks were also available but there were queues at these desks.

Are outpatients services responsive to people's needs?

Appointment times

Although patients were allocated sufficient time with staff when they attended clinics, in some cases this time was reduced due to clinics being delayed or overbooked. A text reminder was in place for all outpatient clinics but staff and patients told us they had been experiencing difficulties with the system. The trust is taking action to address the problems. One patient explained that they were unable to get through to the call centre despite phoning on multiple occasions.

Staff in the outpatient area felt that call centre staff had not been adequately trained due to the amount of errors that were occurring: an average of 40% of appointments not being booked correctly and causing more delays. Call centre staff had recently been undertaking work at the weekends to help with the introduction of a new IT system.

Some patients told us that appointments were sometimes delayed and staff told us delays could go up to 90 minutes for scheduled appointments. Staff said these delays were due to a number of factors, including: consultants being scheduled to conduct ward rounds or other duties at the same time as scheduled clinics; patients and staff having to wait for parking spaces; staff travelling from other trust sites without enough time allocated; patients not receiving appointment letters or receiving multiple appointment letters; and lost medical notes.

It was estimated that around 10% of medical notes were missing for each clinic, equating to around 200 a week. This was due to staff not tracking notes correctly. It was also reported that doctors completed administration work during clinics and this was also causing delays. At a focus group with nurses, they told us that this was due to a lack of specialist doctors. We were told of one patient who had attended a walk-in clinic after being directly referred and had waited over 8 hours for an appointment. Those patients who were either directly referred to an emergency

Outpatients

clinic by their GP or had their follow-up booked directly with the consultant were less affected by these issues. An audit by the trust in May 2013, the Chief Operating Officer and complaints data confirmed these issues were being experienced and an action plan was in place to address them, but we did not find evidence of any improvements during our visit.

Privacy and dignity

The general outpatients' areas had private consultation rooms. However, although the sexual health clinic had private consultation rooms, other patients were waiting outside and the walls were thin enough to hear private consultations. The sexual health clinic was not gender divided. The storage area that was being used as a treatment room was not initially signed correctly and this led to an incident of a patient being locked in temporarily. When security staff unlocked the door, they did not knock and found the patient naked. Following this incident, clear signage for the room was put in place.

Vulnerable patients and patients requiring support

Staff were aware of how to support vulnerable patients, although we were told no patient had needed a chaperone as they always attended with a carer. All outpatient areas had a telephone system that enabled staff to speak to patients in up to 60 languages without an interpreter. The trust also had an interpreter service if patients needed it. However, one patient with leukaemia was attending a clinic and, despite their compromised immune system, was not separated from other patients.

Are outpatients services well-led?

Leadership

Most of the senior staff, matrons and general managers felt supported by their colleagues and their line management. Staff were briefed by senior staff in the trust and trust-wide messages and updates were cascaded by email and by managers or clinical leads in team meetings.

Monitoring quality

The outpatient department had an item on the risk register since 2008 regarding waiting times being longer than 18 weeks for new patients. This was reviewed in 2012 and the manager who was responsible for the area was unable to tell us what was being done to reduce the risk.

Staff told us they escalated issues and complaints to their line management and via a daily issues logbook but, other than one example regarding dictaphones, we were told nothing had been done or staff had not had any feedback. Some staff told us they tried to contact managers when there was an issue but had been unable to get hold of them. One senior member of staff told us they were unable to be as visible as they had been previously due to a lack of staff.

Good practice and areas for improvement

Introduction

The inspection has identified many areas that require improvement notably in the domains of effectiveness and responsiveness and a few that were inadequate in the safety domain. However, one area that is a key strength is in the domain of caring.

Areas of good practice

Our inspection team highlighted the following areas of good practice:



- The e-Handover system in the medical services which allowed doctors to manage their workload more effectively.
- The virtual ward, in medical services, which was established in 2009. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- Patients were positive about the care they received from staff, many of whom were positive about working for the trust.
- The inspection team was impressed with the care provided to patients who have had a stroke.

Areas for improvement

Action the trust MUST take to improve



- Waiting times in the A&E department must be reduced
- Increased number of permanent senior medical staff in the A&E department
- The care provided in the medical and surgical care services
- The management of sepsis
- Discharge planning and ensuring patients are cared on the appropriate wards and clinical areas
- Management of the appointment times in some of the outpatient clinics
- Environment in the sexual health clinic
- Documentation relating to patient care.
- Sharing information to monitor performance and quality of care

This section is primarily information for the provider.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010: Care and welfare of patients</p> <p>People who use the service were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by ensuring the welfare and safety of the service user.</p> <p>Improvements are needed in respect of:</p> <ul style="list-style-type: none">• The care they receive in the A&E department and medical services• Discharge planning and ensuring patients are cared on the appropriate wards/clinical areas• Management of the appointment times in some of the outpatient clinics <p>Regulation 9 (1)(b)(i) Regulation 9 (1)(b)(ii) and Regulation 9 (1)(b) (iii)</p>
Treatment of disease, disorder or injury	<p>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010: Safety and suitability of premises</p> <p>People who use the service were not protected against the risks associated with unsafe or unsuitable premises.</p> <p>Improvements are needed in relation to the environment in the sexual health clinic.</p> <p>Regulation 15 (1)(a)</p>

This section is primarily information for the provider.

Compliance actions

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010

Staffing

- There were not enough qualified, skilled and experienced staff to meet the needs of patients.
- There are insufficient permanent medical staff employed in the A&E department.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010

Records

Improvements are needed in respect of nursing documenting all appropriate documentation relating to patient care.

Regulation 20 (1)(a)

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010

Assessing and monitoring the quality of service provision

The provider did not have effective systems in place to monitor the quality of the services provided.

Regulation 10 (1)(a) 2 (b)(i)

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HEALTH & WELLBEING BOARD

Subject Heading:

Assistive Technology – ASC and CCG partnership

Board Lead:

Joy Hollister

Report Author and contact details:

**John Green
 Tel: 01708 433018
 John.green@havering.gov.uk**

The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- Priority 1: Early help for vulnerable people
- Priority 2: Improved identification and support for people with dementia
- Priority 3: Earlier detection of cancer
- Priority 4: Tackling obesity
- Priority 5: Better integrated care for the ‘frail elderly’ population
- Priority 6: Better integrated care for vulnerable children
- Priority 7: Reducing avoidable hospital admissions
- Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Over the past 2 years there has been a significant increase in the use of assistive technologies (AT) by adult social care (ASC) clients in Havering. At the core of every package of AT is a basic telecare alarm and pendant which links the individual to a monitoring service. It is the increased use of this basic package that is delivering the benefits outlined within this report. The benefits indicated so far are significant and are cross sector and have prompted the development of a joint initiative between Health and ASC to extend its use and which the joint team felt should be raised with the HWB board.

RECOMMENDATIONS

The Health and Wellbeing Board is recommended to:

- i. Note the benefits of AT
- ii. Note that Havering Adult Social Care and Havering CCG are working together in partnership to increase the use of AT and maximise benefits realisation.

REPORT DETAIL

The use of AT

Since 2011 significant work has been undertaken that has resulted in greater use of AT by adult social care clients, underpinned by improved operational efficiency in assessing, referring, providing, installing and monitoring equipment.

The provision of FACS eligible AT now stands at nearly 1,500 individuals, predominantly pendants, with a further 2,500 or more FACS eligible clients under consideration to have AT as part of their care package.

Current funding

AT is currently funded through S256 funding and this will be continued throughout 2013/14 and is committed for part of 2014/15. There is a commitment within the AT board, however, to consider future mainstreamed joint commissioning between health and ASC based on a strong understanding of the benefits provided by AT.

Benefits Analysis

To identify the benefits delivered by AT, two cohorts have been monitored over an extended period of time to provide robust, longitudinal analysis of a number of key measures. This monitoring will continue on a quarterly basis to further improve the robustness of the analysis reported. The cohorts are:

- Cohort A - ASC clients who receive AT and homecare (70 at outset)
- Cohort B - ASC clients who only receive homecare (407 at outset)

The cohorts are not selective other than in respect of either being in receipt of homecare or homecare and AT services. The outcome of this is that the two cohorts are not equal in size but the level of needs should be broadly similar.

The three key benefits measures are:

- Benefits Measure 1: General impact on hospital admissions as indicated in ASC systems¹
- Benefits Measure 2: Reductions in admissions due to falls from health data²
- Benefits Measure 3: Impact on admission to residential/nursing care from ASC data

These benefits measures extend beyond the organisational boundaries of the Council and show that the use of AT is having a positive impact across the measured benefit areas:

¹ Benefits measure 1 uses data from the ASC AIS system where a "section 2" notice is issue by Health to ASC indicating that an ASC client has been admitted to hospital.

² Data has been supplied from Health systems by CCG analysts from the BHR CSU team on the number of Havering residents aged over 65 who over a specified period have been admitted to hospital and the reason for admission has been recorded as a fall.

- **Benefits measure 1 - General impact on hospital admissions (ASC data)**

Cohort A, (AT and homecare) is less likely to be admitted to hospital than cohort B (homecare only) after a period of 18 months by a margin of 25.02% (see figure 1 appendix 1). This indicates that the application of AT will have a beneficial impact on reducing hospital admissions. To validate this there should be an actual impact on hospital admissions. Benefits measure 2 (below) uses health data to quantify this impact.

- **Benefits measure 2 - Reductions in admissions due to falls (Health data)**

Having used ASC data to evidence the apparent decline in hospital admissions health data relating to admissions due to falls has been analysed. This indicates that there is a correlation between the increased number of pendants in the community and a reduction in hospital admissions due to falls of 44% in 2013 compared to 2011 – which would convert to an estimated annual saving of £2.24M³ – or if attributing 50% of this to AT then £ 1.12M (see figure 2 in appendix 1).

- **Benefits measure 3 - Impact on admission to residential/nursing care**

Cohort A (AT and homecare) are less likely to be admitted into residential or nursing care by a margin of 5.9% than cohort B (homecare only) see figure 3 in appendix 1.

Cohort A also demonstrates that of those who are admitted there is significant delay in the elapsed time from when they start to receive services until admitted of at least 3 months but this is likely to be significantly longer.

A delay of 3 months in the start of a typical residential care package costing £25,000 indicates a gross benefit of £6,250. However, the average cost of domiciliary care prior to admittance to residential care is £12,500 or £3,125 per quarter. The net saving is therefore £3,125 per person (£6,250 less £3,125). If these numbers are factored up, with approximate numbers entering residential care of 300 per year, the projected minimum annual saving would be £937,500.

This analysis is based on the best possible information but recognises that greater numbers in cohorts would provide greater assurance of impact. It is therefore within on-going plans to keep monitoring benefits and expand numbers where possible.

Quality of life

In January 2013 a survey was conducted for recipients of AT and their carers.

- 194 surveys were sent to AT service users with a response rate of 35.57% (69 service users)
- 80 surveys were sent to carers of AT service users with a response rate of 36.25% (29 carers)

The survey asked a series of questions focussed on general feelings of wellbeing and safety, levels of help and support and incidents of admission to hospital (see appendix 2).

³ Abayomi-Lee, F. (2012). Havering Falls Prevention and Bone Health Strategy Implementation Report. Havering: Public Health.

Generally the responses were extremely positive from both carers and users. Observations include:

- In regard to questions around feelings of well-being, 80% - 90% of users and carers agreed that people generally 'feel better' with the AT in place
- Between 50% and 60% of respondents agreed that AT prevents escalation to hospital or residential care
- There is a general similarity of response between users and carers

In light of the more tangible benefits outlined in this report, the survey has been included to indicate the sense of well-being imparted by the AT and the support service behind it. It provides some explanation, by explicit answers and by the implied 'feel good', why some of the benefits identified are being delivered.

IMPLICATIONS AND RISKS

There are no implications or risks arising from the Board noting this report at this time.

BACKGROUND PAPERS

None.

Appendix 1 - AT Benefits Measures.

Benefits measure 1 - General impact on hospital admissions (ASC data)

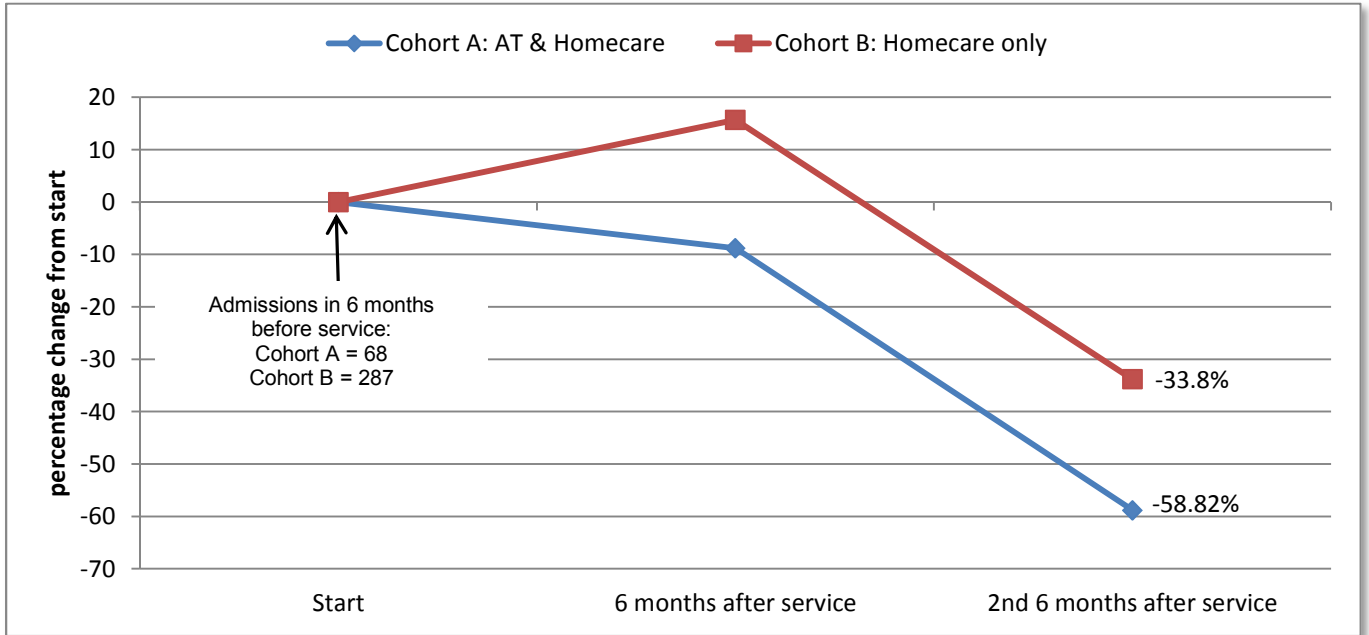


Figure 1: Percentage of cohorts admitted to hospital

Benefits Measure 2: Reductions in admissions due to falls

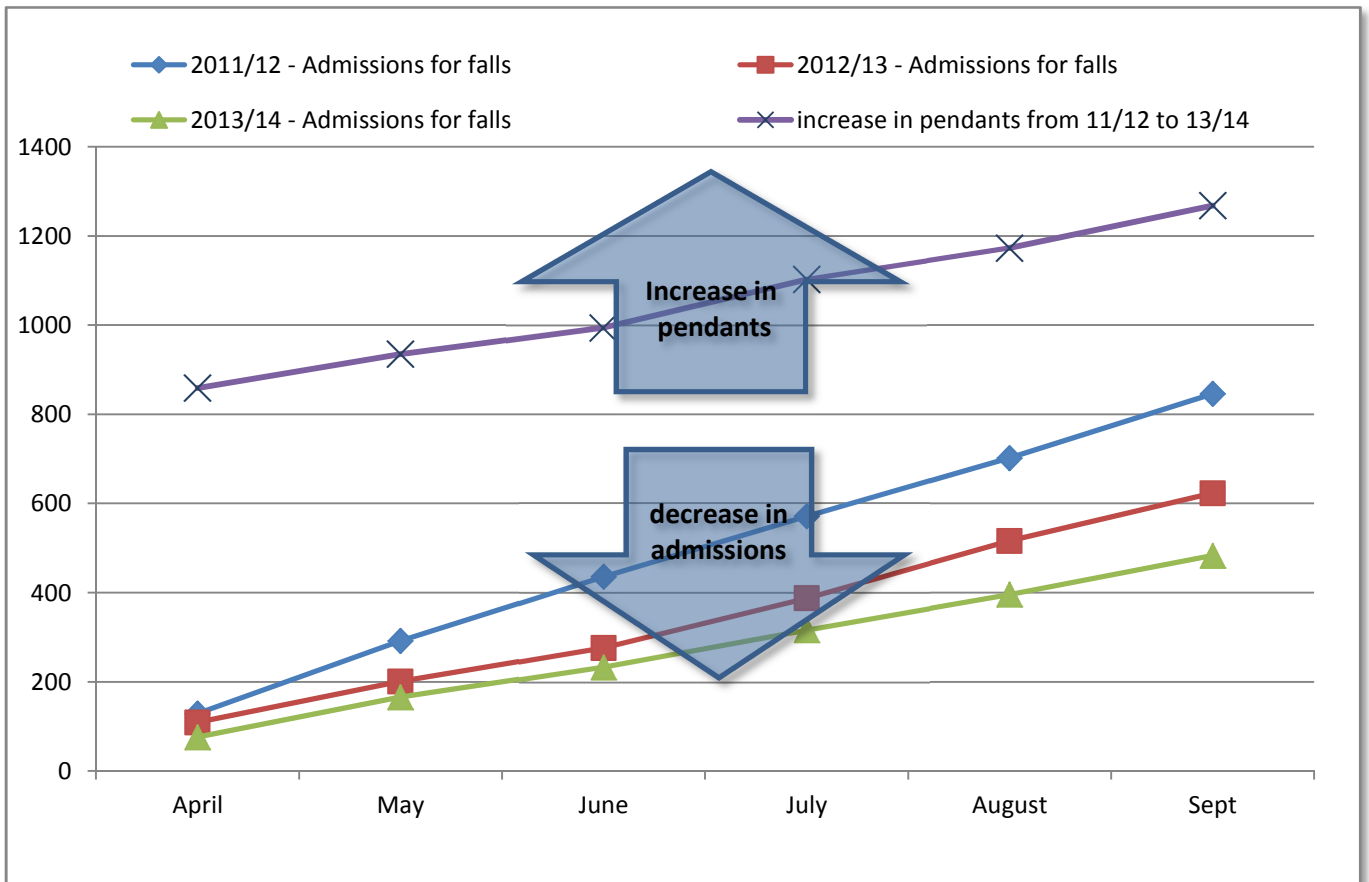


Figure 2: Correlation between hospital admissions due to falls and increased number of pendants in the community

Benefits Measure 3: Impact on admission to residential/nursing care

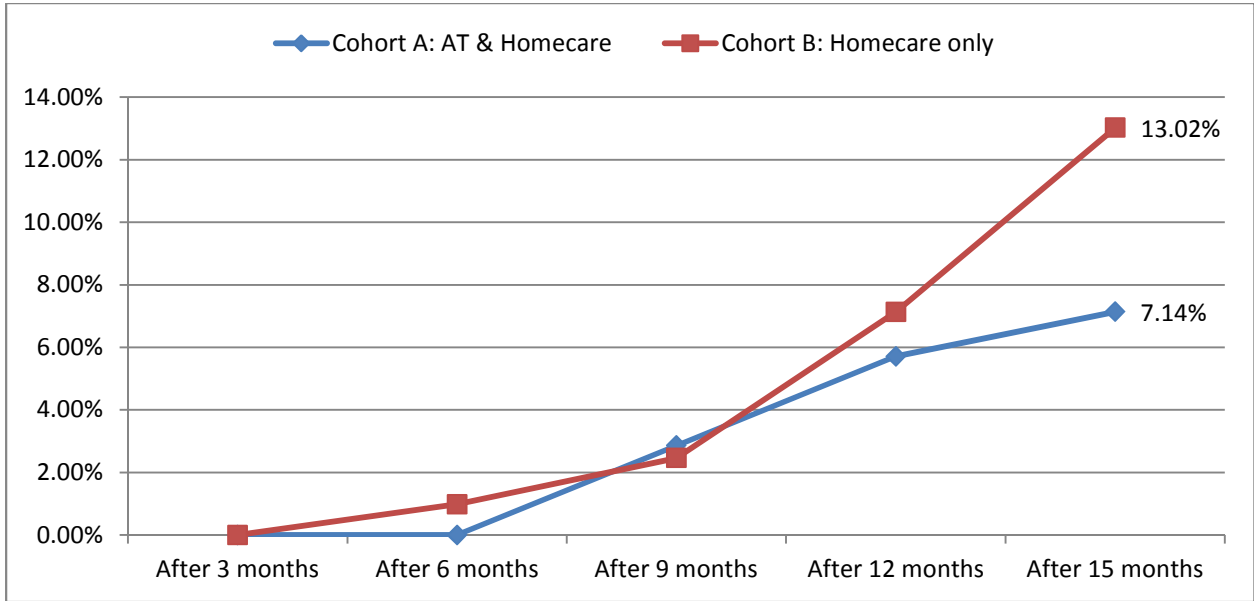


Figure 3: Impact of AT on admission to residential/nursing care

Appendix 2 – AT Users & Carers Survey

Key:		Strongly agreed or agreed		Strongly disagreed or disagreed	
<input type="checkbox"/>	Service user response				
<input type="checkbox"/>	Carer response				
No.	Question	Service Users	Carers	Service Users	Carers
1.	I am more secure knowing that someone would respond in an emergency	97%		1.59%	
	The person feels more secure because they know that someone will respond in an emergency		96%		
2.	I feel safer in my own home	95%		1.56%	
	The person being cared for feels safer in their own home		93%		
3.	I am being helped to remain independent in my own home	89%			
	The person being cared for is being helped to remain independent in their own home		93%		
4.	I feel more confident being on my own	84%		3.17%	
	The person being cared for is more confident to be on their own		82%		3.57%
5.	It has prevented me having to go to hospital (or reduced the risk of it happening)	65 %		3.17%	
	The person being cared for has been prevented from having to go to hospital (or the risk of it happening has been reduced)		62%		3.45%
6.	The amount of help I need from others has reduced	61%		14.06%	
	The person being cared for needs less help from others		52%		10.35%
7.	HTC's response prevented me from calling emergency services	52%		10.81%	
	HTC's response prevented the calling of emergency services (Ambulance, Police or Fire Brigade)		55%		10.00%
8.	I am more able to manage my medication on my own	52%		9.68%	
	I feel that the person I care for is more able to manage their medication on their own		42%		16.67%
9.	HTC's response prevented a stay in hospital	45%		4.55%	
	Havering Telecare Centre's response prevented a stay in hospital		40%		5.00%
Only asked of carers:					
10.	I feel that the person I care for is less likely to need to move to a residential home		59%		7.4%

To be noted:

- The percentages not adding up to 100 are accounted for by responses of 'neither agree nor disagree' or 'don't know'.
- Analysis of response between those with pendants only or enhanced AT showed no significant difference.

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HEALTH & WELLBEING BOARD

Subject Heading:

**Havering Special Educational Needs
and Disability Project Update**

Board Lead:

Joy Hollister

Report Author and contact details:

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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- Priority 1: Early help for vulnerable people
- Priority 2: Improved identification and support for people with dementia
- Priority 3: Earlier detection of cancer
- Priority 4: Tackling obesity
- Priority 5: Better integrated care for the 'frail elderly' population
- Priority 6: Better integrated care for vulnerable children
- Priority 7: Reducing avoidable hospital admissions
- Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

Background

The Special Educational Needs and Disabilities (SEND) section of the Children and Families Bill (the Bill) has arisen out of the Green Paper Support and Aspiration which was published in March 2011. The intention of the legislation is to create a more family friendly SEND process which draws together the support a child requires across education, health and care (EHC). Statements of Special Educational Needs, which are mainly education documents, will be replaced by a single plan called an Education, Health and Care plan. The legislation is currently going through parliament and will become law early next year. The draft

regulations and Code of Practice (COP) have now been published and have a September 2014 implementation date. Work is currently being undertaken to ensure Havering is well placed to implement the changes. A number of Local Authorities across the country have received funding as pathfinders for the new approach. Havering is working with Bexley and Bromley who are London Pathfinder Champions.

This report:

- outlines the key measures
- updates the board on progress within Havering
- alerts the board to implications and issues

SEND Project Governance

A SEND Project Team with representatives from across education, children's, adults, parents and health services has been set up. It has met three times and reported to the senior management team. A project plan has been produced and working groups set up to cover all of the major changes. There is a Parents Forum and an advocacy group are working at gathering the views of children and young people.

RECOMMENDATIONS

That the Health and Well Being Board notes the Report and commends the work of the team supporting this major piece of integrated working.

REPORT DETAIL

1. The Changes

1.1 There are 4 major areas of change and development:

- The Local Offer
- Education Health and Care Plans from 0-25
- Joint Commissioning
- Personal Budgets

2. The Local Offer

2.1 It is a requirement of the new legislation that the Local Authority will publish its local offer of services for children with SEND on its website. The Local Offer must show parents how services can be accessed and include health, education, social care, schools and the voluntary sector. Parents must be able to comment on services.

- 2.2 Work on the local offer is well underway. Over 50 parents with children across the age range have been consulted about how the offer should look and how they would wish to access it. Parents were unanimous in wanting the site to be divided in age ranges and to be very clear about thresholds and criteria. Three working groups looked at services at early years, school age and post 16. Templates have been created on which to gather the information and about 20 services have completed them so far. A web developer has created a model to see how the site could work. It is anticipated that mainstream schools and early years' providers will have links from the website to the SEND section of their own sites. A working group has been convened to see how this website can be incorporated into other sites managed by the Council.
- 2.3 **Issues:** Whilst it is relatively straightforward to list the services provided it is proving difficult to show how therapy and other health services are accessed. The provision of therapy services does not appear to be sufficient for the needs of children with SEND in the borough and the Local Offer may raise parental expectations of the level of service they can receive. A group has been formed to consider the joint commissioning of health, social care and education services. This group will consider how joint commissioning could improve the amount of service available within the budget envelope. The group will also examine the role that public health could play in early intervention services for children with disabilities.
- 2.4 In order for parents to use the Local Offer to determine how they will spend a personal budget it is necessary to identify a unit cost for services for which the data is not currently available. Work is well underway to ensure that accurate data is held and shared.

3. Education Health and Care Plans 0-25

- 3.1 Clause 25 of the Children and Families Bill requires Local Authorities to ensure the integration of education, health and social care for children and young people with SEND up to the age of 25. The draft Code of Practice says that there must be a single assessment procedure (involving parents and children) on which health, social care and education agree so that families do not have to repeat their story a number of times. This must result in an outcomes based single Education, Health and Care (EHC) plan document which draws together the support and resources required across education, health and social care as well as leisure and voluntary sector activities as appropriate.
- 3.2 A working group has been set up across education, health and social care and work has begun to rationalise the large number of panels and groups which currently meet to discuss children with SEND. An informal multi agency system is in place to discuss and provide for the youngest children with complex needs. Initially this panel system will be used as a pilot on which to base a new system.

- 3.3 **Issues:** There are currently no integrated formal systems with health for keeping data, sharing budgets, and commissioning services. Whilst professionals on the ground work well together it will be challenging to develop formal systems across a number of different agencies and budgets. Pathfinders have successfully developed joint resource panels which bring together the budget holders across education, health and care to allocate appropriate funds to the child's plan. It is anticipated that the same system will be used with support from the joint commissioning group outlined below.
- 3.4 Parents will require considerable support to enable them to be at the centre of this planning and key workers are recommended. There is currently no additional funding for key workers and so the support will need to be provided by a number of professionals as part of their role. In order to support parents effectively the SEND project Management team will consider at its next meeting which roles within the current workforce could be developed and trained to assume this role.
- 3.5 Creating the culture change necessary to identify outcomes for children rather than assess needs will prove challenging and require a multi agency workforce development programme. Pathfinder Champions have developed a support programme for London Boroughs and together with other boroughs in East London it is proposed that a workforce development programme will take place in the spring beginning with a cultural change session and followed up within the borough.
- 3.6 Plans stretch from 0-25 and as such children under 2 and over 16 may gain an additional statutory right to services. In order to ensure that these additional rights do not result in escalation of the spending on SEND the working group will need to ensure that the threshold for accessing support to deliver outcomes is maintained. To this end the Local Offer will contain universal services which can support children with disabilities as well as costly specialist services.
4. **Joint Commissioning**
- 4.1 Clause 26 says there must be joint commissioning arrangements between education, health and social care in order to ensure that sufficient resources are provided to assess children and then provide for their needs. There must also be a formal mechanism for resolving complaints and difficulties between the agencies.
- 4.2 A working group has been set up with representatives from the local authority, CCG and business partners. The initial plan is to review what is currently commissioned and identify the budgets used to provide the services with a view to reviewing a number of services to see how they could be jointly commissioned in the future.
- 4.3 **Issues:** There is a lack of agreed data on numbers and expenditure across services for disabled children and this is necessary so that the whole picture is clear before changes are made to the way services are commissioned. Work is underway across agencies to ensure that this information is available.

- 4.4 There are currently insufficient therapy services available to provide timely intervention for disabled children. During the debate in Parliament on the Bill the Government has accepted an amendment from their own party which will compel health to provide what the disabled child needs to achieve the outcomes in the plan. There do not appear to be sufficient therapy services commissioned to comply with this which could lead to disputes with parents early on in the implementation of the new legislation. The joint commissioning working group will examine urgently how therapy services are currently commissioned and look to improving the efficiency in this area.
- 4.5 Health visitors are a key resource in the identification of disabled children and they are not currently commissioned by the CCG. The existing generic health visitors may need to receive additional training until such time as the service can be reviewed in 2015 to provide specific support.

6. Personal Budgets

- 6.1 As part of the changes parents of children with SEND must be offered a personal budget for the services their child requires. This can range from a managed budget in which the parents understand all that is spent on their child's plan so that they can redirect spending if necessary to parents receiving direct payments for all or part of the services in the plan. A pilot project is currently underway with a number of families receiving short breaks. A working group including parents will be set up to look at how this can be rolled out across other services.
- 6.2 **Issues:** This is a flagship proposal by the Government and it seems clear that they want to see the development of a private market so that parents can purchase services which are not readily available through the Local Offer. It is not yet clear whether parents will have to be offered what the service costs to purchase or the equivalent of what is spent at the moment but given the lack of sufficient therapy provision this could prove costly for health unless sufficient service can be provided through the Local Offer. In Pathfinder areas there have been issues with the viability of block contracts as parents have chosen to purchase services themselves from private providers. It is crucial that Havering's Local Offer can demonstrate that the services provided within Havering are of high quality so that parents choose to either have their services provided in house or spend their personal budget on Havering services.

7. Implementation

- 7.1 The DfE is currently consulting on how quickly the move to education health and care plans should be made. The proposal is that from September 2014 all new assessments should come under the new system and that over 2 or 3 years all children and young people should have their statements changed to EHC plans after consultation with parents.
- 7.2 **Issues:** There is an issue about the threshold for receiving an EHC plan. Some children who currently have statements may not require EHC plans and so could lose the legal protection afforded by a statement. Work will begin

with schools in the spring to ensure that they understand the threshold for the EHC plan and how they can support children with lower levels of SEND through their pupil premium.

IMPLICATIONS AND RISKS

Financial implications and risks:

Financial modelling of the resource impact of implementing all the requirements of the Health and Social Care Bill is in progress. Work based on the recent CENSUS (January 2013) data will need to be done to model the financial impact of changes to thresholds and implication for service provision based on eligibility criteria. By publishing the Local Offer i.e. core entitlements and how services can be accessed, there is risk that uptake of services is likely to rise making it financially untenable. Services not available on the Local Offer will be accessed by parents via personal budgets and this would include provision of therapy services which may be financially prohibitive for health. An independent mediation service offered by an external provider must be offered to parents where there is a disagreement about the content of the education, health and care plan which is a cost to the local authority.

Legal implications and risks:

There are no apparent legal implications in noting the Report which sets out the substantive legislative changes currently progressing through parliament. Legal advice may be necessary in connection with the detailed plans arising out of compliance with the proposed new legislation as and when this becomes necessary.

Human Resources implications and risks:

There are a number of HR implications and risks that will need to be addressed during the formulation of some of the potential changes currently under discussion with service areas within the Council and with stakeholders. It should be noted that any change to structures, roles, working arrangements, etc, that may affect Council employees who are likely to be impacted by implementing the provisions of the SEND section of the impending Children and Families Bill, will be undertaken using relevant processes under the Council's HR policy framework, and with due regard to employment legislation.

Eve Anderson, Strategic HR Business Partner (Children, Adults & Housing and Public Health)

Equalities implications and risks:

8th January 2014

The report alerts the board to a number of changes and issues with regards to the implementation of the SEND section of the Children and Families Bill. Some of these issues will potentially have significant equality implications on children with SEND and their families. For example, the current lack of provision of therapy services to meet the needs of children with SEND in the Borough; ensuring parents, guardians and/or carers have the appropriate support to effectively contribute to the planning process and make informed decisions; those children who have statements but do not require an EHC plan potentially losing the legal protections afforded by a statement.

An initial Equality Analysis (EA) has been carried out to capture the potential and likely implications and is available in Appendix A. The EA will be updated when the Bill receives Royal Assent and there is more clarity on the legal and service changes the Council is required to implement, to ensure that the impact of those changes is fully considered.

Andreyana Ivanova, Diversity Advisor

BACKGROUND PAPERS

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LONDON BOROUGH OF HAVERING EQUALITY ANALYSIS

HAVERING SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND) PROJECT

SCOPE OF PROPOSAL

- 1. What is the scope and intended outcomes of the activity being assessed; in terms of both the Council's organisation and staffing, and services to the community?**

The Special Educational Needs and Disabilities (SEND) section of the Children and Families Bill has arisen out of the Green Paper "Support and Aspiration" which was published in March 2011. The intention of the legislation is to create a more family-friendly SEND process which draws together the support a child requires across education, health and social care (EHC). The draft legislation is currently going through parliament and will become law early in 2014. The draft regulations and Code of Practice (COP) have now been published and have a September 2014 implementation date. Work is currently being undertaken to ensure Havering is well placed to implement the changes. A number of Local Authorities across the country have received funding as pathfinders for the new approach. Havering is working with Bexley and Bromley who are London Pathfinder Champions.

Havering's SEND Project focuses on the four major areas of change and development:

The Local Offer

It is a requirement of the new legislation that the Local Authority will publish its local offer of services for children with SEND on its website. The Local Offer must show parents how services can be accessed and include health, education, social care and the voluntary sector. Parents must be able to comment on services.

Education, Health and Care Plans 0-25

The legislation requires Local Authorities to ensure the integration of education, health and social care for children and young people with SEND up to the age of 25. The draft COP says there must be a single assessment procedure (involving parents and children) on which health, social care and education agree so that families do not have to repeat their story a number of times. This must result in an outcomes-based single Education, Health and Care Plan document which draws together the support and resources required across the three areas, as well as leisure and voluntary sector activities, as appropriate.

Joint Commissioning

Under the new legislation, there must be joint commissioning arrangements between education, health and social care in order to ensure that sufficient resources are provided to assess children and then to provide for their needs. There must be a formal mechanism for resolving complaints and difficulties between the agencies.

Personal Budgets

As part of the changes, parents of children with SEND must be offered a personal budget for the services their child requires. This can range from a managed budget in which the parents understand all that is spent on their child's plan so that they can redirect spending if necessary, to parents receiving direct payments for all or part of the services in the plan.

1 (a) Organisation and Staffing

These changes will require reorganisation in some areas of the Council as well as new ways of working. In particular, much more integrated working will need to take place across education, health and social care.

If any restructure is required, a separate Equality Analysis will be carried out.

1 (b) Services to the Community

Services required by children and young people with SEND will be assessed and provided differently as a result of the new legislation. The move from Statements of SEN to the new Education, Health and Care Plans will probably be the most significant change for parents and carers but this, as well as the introduction of managed budgets and direct payments, should result in a more streamlined and effective service giving parents and carers more choice and control and ensuring better outcomes for these children and young people in the longer term.

PEOPLE AFFECTED

2. Which individuals and groups are likely to be affected by the activity?

2 (a) Staff Individuals and Groups

Staff across various teams in the Council are likely to be affected by the changes required by the new legislation, including:

- Learning & Achievement (in particular, the SEN Team);
- Adults' Social Care;
- Children's Social Care;
- Commissioning.

2 (b) Community Individuals and Groups *(including voluntary organisations)*

- Children and young people in Havering aged 0-25 with special educational needs and/or disabilities.
- Parents and carers of those children and young people.
- Schools and colleges (both special and mainstream schools).

DATA AND INFORMATION

- 3. What data/information do you have about the people with ‘protected characteristics’ or other socio-economic disadvantage among these individuals and groups? What information do you have about how they will be affected by the activity? Will you be seeking further information in order to assess the equalities impact of the activity? How is this information being used to influence decisions on the activity?**

3 (a) Staff

As over 70% of Council staff are local residents, we also recognise that some staff members might be indirectly affected as parents/carers of children and young people with SEND. The impact on those staff members and their children has been considered under the Community sections of the Equality Analysis (EA).

3 (b) Community

At the time of writing, it is not possible to provide accurate and complete data relating to children and young people aged 0-25 with SEND, nor is it possible to provide service users’ diversity profile breakdowns. The Council uses several different data systems for different age groups and types of need. This has already been identified by the project team as an important area for development. An ICT solution will be needed in order to capture and maintain service users’ data across education, health and social care covering the expanded age range of birth to 25 and diversity profile monitoring. This will enable the accurate recording of data, monitoring and reporting on service take-up and any gaps identified, and projecting future need and trends.

The following data is available in respect of children and young people aged 0 to 18:

The number of children in Havering with learning difficulties and disabilities (LDD) will increase, most significantly among primary school age children. Current projections suggest an overall increase of 7.5% across all categories of LDD by 2017. The most common categories of LDD are Moderate Learning Disability (30%), Behaviour, Emotional and Social Difficulties (19%) Speech, Language and Communication Needs (17%). The latest School Census (January 2012) identified that there were 1,966 pupils in Havering receiving some sort of Special Educational Needs (SEN) provision. The most common presentations were speech, language and communication needs (546 cases), moderate learning difficulty (458 cases) and behaviour, emotional and social difficulties (401 cases).]

Please note that the following information relates to adults with learning difficulties and/or disabilities between the ages of 18 and 64 (data is not available specifically for ages 18 to 25):

It is estimated that more than 14,000 adults in Havering have a moderate or severe disability. This will rise by around 7% in the next ten years, with more than 15,000 adults in Havering having a physical disability by 2021. The number of adults with learning disabilities is predicted to increase by roughly the same amount.

No data is available in relation to parents and carers of children and young people in Havering aged 0-25 with SEND.

CONSULTATION

4. If no data and information is available about the groups likely to be affected by the activity, how would you inform your EA? Will you be considering carrying out some consultation to inform your EA?

4 (a) Staff

Managers whose staff are likely to be affected by the project are already involved in either the main SEND Project Team and/or the various sub-groups which have been established to manage the four major strands of the project. Health colleagues from the Clinical Commissioning Group have also been involved.

Staff are already engaged in and will continue to be involved in designing and creating the new processes which will be required.

4 (b) Community

The changes brought about by the legislation will require the involvement of families in many ways, including developing new processes and providing feedback on the Local Offer.

Views from children and young people with SEND are being gathered through an organisation called Advocacy for All, which uses a team of young advisers to enable young people with a range of disabilities to have a voice. They support their peers by arranging a safe place to discuss and voice their opinions on issues that are relevant and of interest to them and any changes that are happening. Advocacy for All is running workshops at Havering's special schools and will be preparing a report of their findings.

A parents' forum has been fully engaged since the start of the project and have provided input on a number of issues, in particular the Local Offer and EHC Plans. This will continue throughout the project, with parent representatives being invited to join several of the working groups looking at specific areas of the project.

Special schools and colleges, as well as voluntary sector organisations have also been included in discussions and will continue to be involved in various subgroups of the project.

LIKELY IMPACT

5. Based on the collected data and information, what will be the likely impact of the activity on individuals and groups with protected characteristics or other socio-economic disadvantage?

5 (a) Staff

The changes will impact the ways staff work and the roles they perform. A realignment of roles and responsibilities is very likely.

The full extent of any impact will not be known until new processes and ways of working have been discussed and agreed. If any restructure is required, it will be a subject to a separate Equality Analysis and will be carried out in accordance with Council policies.

We do recognise that some staff members living locally might be indirectly affected as parents/carers of children and young people with SEND. The impact on those staff members has been considered under the Community sections of the EA.

5 (b) Community

By their very nature, the legislative changes will impact all children and young people with SEND in Havering and the intended lasting effect on this group and their families is anticipated to be wholly positive.

It is anticipated that the introduction of personal budgets will give families more choice and control, and the publication of a Local Offer will provide them with transparency and clarity as to what support might be available to them. The multi-agency approach for EHC plans and joint commissioning will result in joined-up working and more straightforward, streamlined systems. Putting families at the centre of the planning process will ensure better support and more positive outcomes for young people, preparing them for adulthood and supporting their independence.

There are potential issues which mean that some children and young people, and also a small number of parents and carers, may have difficulty in engaging in the change process and understanding the new systems due to disability or language. For example, disabilities such as visual or hearing impairment, learning difficulties or language barriers may hinder parents' and carers' ability to participate in the changes and access new systems.

Please refer to section 9(b) for further information on how we will mitigate this adverse impact.

6. What is the likely impact on arrangements for safeguarding children and/or safeguarding vulnerable adults?

6 (a) Vulnerable children and 6 (b) Vulnerable adults

All existing safeguards will remain in place and necessary checks (e.g. DBS checks and disclosures) will continue to be carried out as required.

Staff will continue to be trained so that they can respond appropriately to the needs of the expanded age range (0-25).

PREVENTING DISCRIMINATION

7. If any negative impact is identified, is there a way of eliminating or minimising it to reasonable level? If not, how can the negative impact be justified?

7 (a) Staff

If any negative impact on staff is identified, a separate Equality Analysis will be carried out. Please refer to section 1(a).

We will ensure that all staff members working with children and young people with SEND have completed relevant Equality and Diversity training and comply with the Equality in Service Provision policy at all times.

Staff members who live locally and have children with SEND are considered under section 7(b) below.

7 (b) Community

The potential barriers for children and young people to engage, understand and contribute to the change process have already been identified and addressed. Please refer to section 9(b) for further information.

There may be a small number of parents and carers with learning difficulties or other disabilities or limited English language skills who may not be able to understand the changes or navigate new systems. Please refer to section 9(b) for further information.

PROMOTING EQUALITY

8. How will the activity help the Council fulfil its legal duty to advance equality of opportunity in the way services are provided?

8 (a) Staff

Please refer to section 7(a).

8 (b) Community

Please refer to sections 7(b) and 9(b).

SPECIFIC NEEDS

9. What actions will you be taking in order to maximise positive impact and minimise negative impact from the activity?

9 (a) Staff

Positive impact will be maximised by fully involving staff in the project and encouraging them to take ownership of work streams which will directly benefit them. This will ensure that new ways of working are progressed to meet the legislative requirements whilst giving staff the opportunity to develop their existing skills sets.

A programme of staff training will be established as part of the main Project Plan as the project progresses.

9 (b) Community

Positive impact will be maximised by involving parents, young people, head teachers and other professionals to result in a system which provides the best outcomes for children and young people with SEND.

As mentioned in section 4(b) above, we work with a team of young advisers from an independent charity who support children and young people with SEND, including those whose first language is not English, and ensure their peers are informed and engaged, and their voices are heard. Advocacy for All is running workshops at Havering's special schools and will be preparing a report of their findings that will feed into the service planning and development process.

A communication plan is being developed to ensure that information is easy to understand and is accessible to all affected families, particularly those who face barriers accessing our services or information about services due to disability or language. In order to ensure that families are aware of the service changes arising from legislation and are able to make informed decisions, we will use a diverse range of communication channels and methods, including alternative formats and other languages, where appropriate.

As we develop the Local Offer website, we will ensure that it is fully accessible by involving parents, considering compatibility with Assistive Technology and other accessibility features.

MONITORING AND REVIEW

10. Once implemented, how often do you intend to monitor the actual impact of the activity?

10 (a) Staff and 10 (b) Community

The Equality Analysis will be revised when the legislation is passed to take account of any other significant changes in SEND service provision. If necessary, separate equality analyses will be prepared for different strands of the project.

Feedback will be obtained via parents' forums and through the Local Offer website, and will be monitored on a regular basis.

Specific monitoring mechanisms will be developed as the project progresses in order to provide families with a wide range of opportunities and methods to feed back any concerns, suggestions, complaints and compliments.

SIGN OFF AND PUBLICATION

- 11. When completed, the Equality Analysis needs to be signed off by the Head of Service. Once signed off, it should be forwarded to the Directorate Equality Analysis Web administrator to publish it on the council's website.**

HEAD OF SERVICE

Name: Mary Pattinson

Date: 11 November 2013

Signature:



Report to the Urgent Care Board

Authors: Bruce Morris, Divisional Director, Adult Social Care,
London Borough of Barking and Dagenham

Date: 21 November 2013

Security: Unrestricted

1. Recommendations

- That Coalition partners agree implementation of the proposed Joint Assessment and Discharge Service.
 - That partners review outcomes 6 months and 18 months after implementation, alongside service costs and resources and determine the further steps required.
 - That further communications be developed which positively identify the benefits of the service and its contribution to achieving objectives for the local health and social care economy.
 - That partners nominate senior representation for the JAD Steering Group to provide consistent leadership and oversight of the work required.
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2. Update on Implementation of the Joint Assessment and Discharge Service

- 2.1 This paper updates the Urgent Care Board on the work to develop revised proposals for the implementation of a Joint Assessment and Discharge Service across health and social care.

3. Introduction

- 3.1 Proposals for a shared Joint Assessment and Discharge Service (JAD) were discussed at the Integrated Care Coalition meeting on 14th October. While all partners signed up to the principle of a joint discharge team for patients with complex needs, London Borough of Redbridge was unable to join an integrated service covering BHRUT at this stage. They will however consider joining in the arrangements when the service is established and the model allows for later inclusion.
- 3.2 Coalition partners asked for an urgent redesign of the JAD proposal to take into account London Borough of Redbridge providing a separate hospital social work service for Redbridge residents who may need social care services at the point of discharge. This needed to ensure:

- That the Coalition preserves the original design principles with decisions about care and funding for the services in scope, are made as close to the patient as possible- including Continuing Health Care;
- Redbridge residents are not disadvantaged compared to the current arrangements;
- The operational benefits of the JAD for BHRT are preserved as far as possible;
- That the service is able to flex to accommodate L.B. Redbridge if and when they are able to join the service in the future.

4. Revised Proposals

- 4.1 Revised staffing structures and operating procedures have now been developed taking into account the reduced budget available and the need to ensure Redbridge residents were not disadvantaged. These are detailed in **Appendix 1**. Essentially, the revised proposals now involve 4 rather than 5 ward groups and these have been re-aligned to take into account current ward arrangements and activity levels.
- 4.2 The JAD Steering Group reconvened on 12th November to review the revised proposals and operational pathways. The principle of the ward MDT referring to a single service, regardless of address remains the same, and referrals for patients potentially requiring services from London Borough of Redbridge will go via the JAD which will take responsibility for referring on appropriately. This will be a purely administrative function which will ensure timely and appropriate referrals for assessment for all Redbridge residents. It was agreed the operational processes and implementation plans are feasible, although they carry increased risk in terms of performance, given the reduced resources now available. Concern was expressed about the feasibility of an implementation date of 1st April 2014 in view of the delay and significant tasks still remaining.
- 4.3 Work with managers in the teams and services involved, has continued to ensure that staff remain positively engaged in both the process and the detail. It is important that effective leadership is maintained in order to ensure clear messaging for all staff.
- 4.4 The model assumes decisions about Continuing Health Care will be made as close to the patient as possible with the JAD undertaking a quality assurance function, and the goal of delegated decision making.
- 4.5 Progress is being made on the development of a common operational IT platform that will also be able to generate reports for monitoring activity and performance. Implementation of the JAD is not dependent upon this being in place ahead of implementation.
- 4.6 Accommodation will be required for the JAD in both Queens and King George Hospital. BHR have mapped this into the overall accommodation strategy for the Trust.

5. Implementation

- 5.1 Potential projected implementation costs of £150,000 were identified at the Coalition meeting on 14th October. These costs can be assumed to be similar as

the scope of the development work remains largely the same. Details with revised contributions are outlined in **Appendix 2**.

- 5.2 The original timetable for implementation envisaged the service being operational by April 2014 and the implementation plan provides for this. However, as noted above, this is likely to be challenging and dependent upon the active engagement of all partners in the process and progress in completing key tasks.

6. Risk Management

- 6.1 There will be additional risks in being able to provide the level of service to BHR with a smaller staff team. It is proposed that a review of JAD performance is undertaken after a period of 6 months operation, with a view to considering whether agreed metrics are deliverable within the resource available.
- 6.2 The development of JAD specific indicators are a specific work stream within the project plan and will seek to capture what are shared indicators, what is already being measured and reflect individual organisations' performance priorities.
- 6.3 Whilst the delivery date is challenging, it is proposed that we maintain 1st April 2014 for implementation at this stage, and review this dependent upon the outcome of staff consultation and legal work in relation to the Section 75.
- 6.4 Key to delivery is the early appointment of the Service Manager providing leadership as well as support to project tasks. A recruitment process has been agreed with HR leads and reported to the Steering Group and this can commence immediately following agreement to proceed from Coalition partners.

7. Communication

- 7.1 Development of the concept of a Joint Assessment & Discharge Service has been widely communicated through staff communications, and Health & Well-Being Boards, Trust Boards etc. It is an integral element of wider development plans for the health and social care economy. It is vital that the revised proposals are communicated positively by all Coalition partners.
- 7.2 The concept remains ambitious, groundbreaking and unique; and the original timetable was challenging from the outset. If the proposals are agreed at this stage, an agreed communication statement will need to be issued by all Coalition partners recognising the commitment to implement the joint service.

8. Next Steps

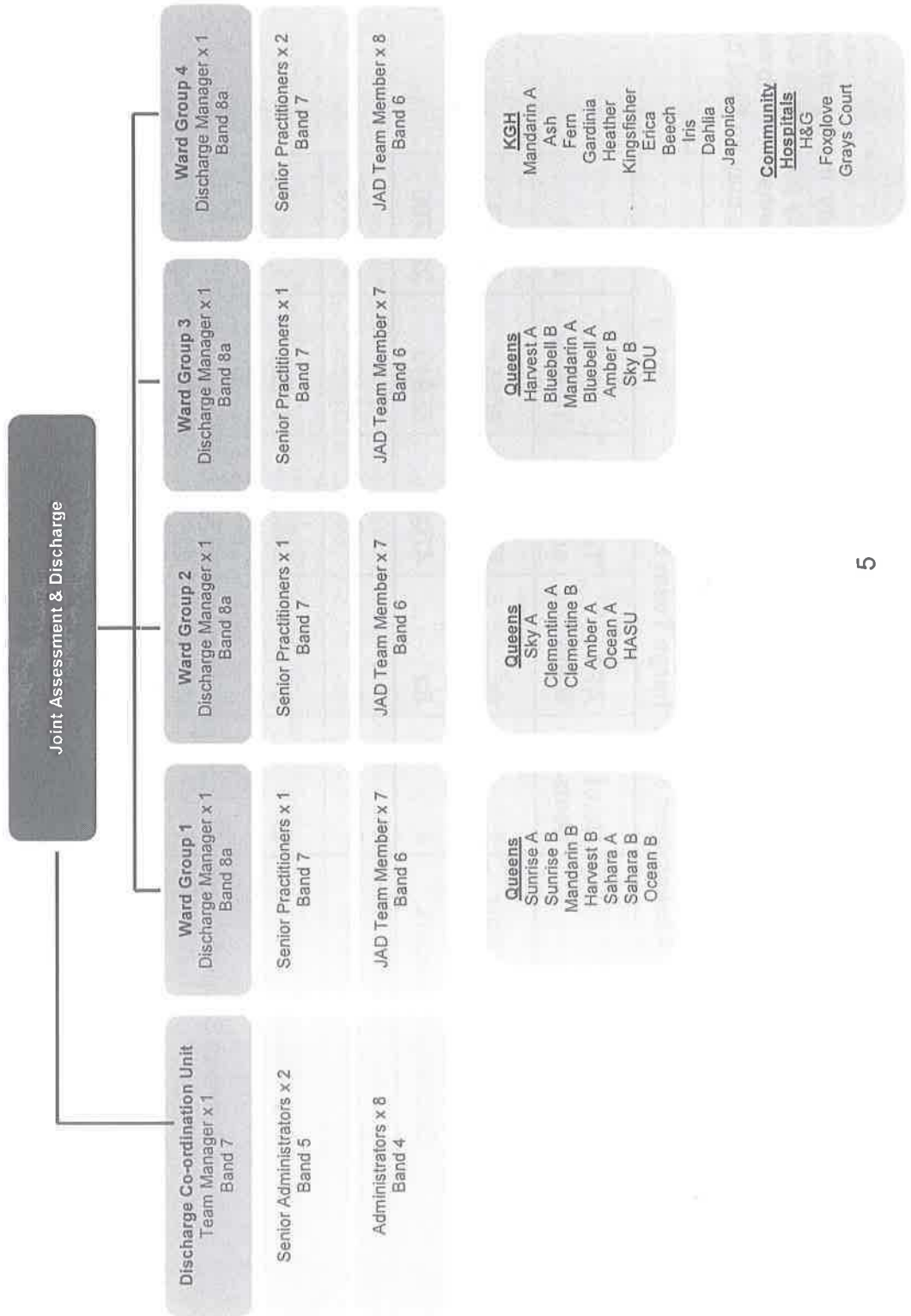
- 8.1 The Steering Group with senior representation from all partners will be reconvened and meet on a monthly basis to oversee the delivery of a detailed implementation plan. Following implementation this group will form the basis for an ongoing s.75 Executive Steering Group to oversee the service performance and management of the service. Regular updates on progress will be provided to future Urgent Care Boards.

9. Background Papers

- 9.1 Attached at **Appendix 3** is the previous paper on the proposals for the Joint Assessment and Discharge service, produced in August 2013.

APPENDIX 1

Revised Staffing Structure and Ward Groups for JAD Service



The table below gives the numbers and indicative costings for the proposed JAD service. For simplicity, the top of the Agenda for Change pay scales + 18.8% on costs, have been used for these calculations. In reality the NHS and local authority pay scales will be different and there are inconsistencies in the pay scales between the London Boroughs of Havering and Barking & Dagenham. As job descriptions are created and evaluated and posts are recruited to actual costs will change. All manager and JAD worker posts may be filled by a qualified nurse, or social worker.

Proposed Joint Assessment & Discharge Team Staffing						
Post	No.of posts	AFC Band	Top of scale	18.80%	Total	
JAD Service Manager	1	8c	67805	80552	80,552	
Discharge Managers	4	8a	47088	55940	223,760	
Senior Practitioners	5	7	40558	48183	240,915	
JAD Workers	29	6	34530	41022	1,189,638	
Business Support Manager	1	7	40558	48183	48,183	
Admin Managers	2	5	27901	33146	66,292	
Administrators	4	4	22016	26155	104,620	
Administrators	4	3	19268	22890	91,560	
TOTAL	50				2,045,520	

APPENDIX 2 JAD Implementation Costs

Issue	Comments	Costs
Legal	<ul style="list-style-type: none"> ▪ Preparation and agreement of a Section 75 Agreement ▪ between 4 provider organisations and 3 CCGs 	£30,000
IT	<ul style="list-style-type: none"> ▪ Development of IT System/s that can capture key performance data for the JAD service and provide the necessary reports for each organization. 	£25,000
Communications	<ul style="list-style-type: none"> ▪ Communication about the new JAD service to relevant teams, and organizations. This will include interface discussions and protocol agreements with Wards, Therapies, Pharmacy, Mental Health services, Integrated Case Management Teams and other relevant teams. ▪ Service User involvement via Healthwatch and development of patient information. ▪ Publicity material to share learning with professional colleagues. 	£10,000
Training	<ul style="list-style-type: none"> ▪ JAD staff will be working across 3 boroughs and will need to be made aware of the different protocols and resources within each borough. ▪ Training JAD staff on newly developed JAD operational policies and protocols. ▪ JAD team building. ▪ Development of ethos with BHRUT staff and JAD staff to discharge patients to their own homes with dignity and compassion wherever possible. This will require ongoing awareness training. 	£5,000
Recruitment	<ul style="list-style-type: none"> ▪ Recruitment of JAD Service Manager for 6 months prior to implementation date in April 2104 	£35,000
Project Management	<ul style="list-style-type: none"> ▪ Ongoing Project Management will be needed until JAD Service Manager is in place, plus a handover period. 	£25,000
Set up Costs & Contingency	<ul style="list-style-type: none"> ▪ Possible set up costs may include IT hardware, furnishings 	£12,000
Evaluation	<ul style="list-style-type: none"> ▪ An evaluation to be carried out at the 18-month review, to include a paper for publication 	£8,000
Contingency		£500
TOTAL IMPLEMENTATION COSTS		£150,500

UNRESTRICTED

Apportionment

Organisation	£ contribution
BHRUT	£21,500
LB Barking and Dagenham	£21,500
Barking and Dagenham CCG	£21,500
LB Havering	£21,500
Havering CCG	£21,500
NELFT	£21,500
Redbridge CCG	£21,500
	£150,500

*A regular monitoring report will be provided identifying spend and activity and any under spend redistributed to partner organisations.



HEALTH & WELLBEING BOARD

Subject Heading:

Update on the Implementation of the Joint Assessment and Discharge Service - Revised Proposal

Board Lead:

Barbara Nicholls
Head of Service – Adult Social Care

Report Author and contact details:

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The subject matter of this report deals with the following priorities of the Health and Wellbeing Strategy

- Priority 1: Early help for vulnerable people
- Priority 2: Improved identification and support for people with dementia
- Priority 3: Earlier detection of cancer
- Priority 4: Tackling obesity
- Priority 5: Better integrated care for the 'frail elderly' population
- Priority 6: Better integrated care for vulnerable children
- Priority 7: Reducing avoidable hospital admissions
- Priority 8: Improve the quality of services to ensure that patient experience and long-term health outcomes are the best they can be

SUMMARY

The Health and Wellbeing Board is asked to consider the revised proposals with regards to a Joint Assessment and Discharge Service (JAD).

Proposals for a shared Joint Assessment and Discharge Service (JAD) were discussed at the Integrated Care Coalition meeting, on 14th October. While all partners signed up to the principle of a joint discharge team for patients with complex needs, London Borough of Redbridge was unable to join an integrated service covering BHRUT at this stage.

The Integrated Care Coalition partners asked for an urgent redesign of the JAD proposal to take into account London Borough of Redbridge providing a separate hospital social work service for Redbridge residents who may need social care services at the point of discharge.

Revised staffing structures and operating procedures have now been developed taking into account the reduced budget available and the need to ensure Redbridge residents were not disadvantaged. These are detailed in Appendix 1 of the attached report.

RECOMMENDATIONS

- The Board is asked to consider the revised proposals contained in the attached report and to indicate whether it supports them or not and what comments, if any, it has.

REPORT DETAIL

The attached report provides the detail to the revised Joint Assessment and Discharge Service.

Given that six public authorities are involved in the proposed JAD, there is likely to be a significant amount of work needed to achieve consensus through the executive parts of each of the Authorities, failing which further progress might be jeopardised. Therefore, at this stage the intention is that Authorities give indications of their support or otherwise of the general direction of travel and provide any comments on the attached proposals to guide its future development.

IMPLICATIONS AND RISKS

Financial implications and risks:

The current budget for Havering's Hospital Team is £811,742. The combined cost of the joint team is estimated as £2,045,520, per appendix 1. The exact financial implications and risks as a result of moving to a joint service will be established as the implementation progresses, and will be detailed as part of the decision making process.

There will also be implementation costs of which Havering's share is expected to be £21,500.

Caroline May – Strategic Finance Business Partner (Children, Adults and Housing).

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Legal implications and risks:

There are no direct legal risks or implications associated with agreeing to the proposed direction of travel. However, assuming the JAD is to progress, detailed work will be necessary in order to ensure that the proposals can be lawfully implemented and meet the needs of each of the constituent authorities. A number of agreements will need to be completed.

Stephen Doye – Legal Manager

Human Resources implications and risks:

There are significant HR risks and implications that will directly affect the Council's workforce, which would emerge when change management processes are followed to bring about the new joint structure for the hospital service. The Council will need to consider, and take action to deal with, any HR risks and

Health & Wellbeing Board, 8 May 2013

implications that are likely to arise from the implementation of a joint structure involving the Council and the other partner organisations for the proposed Joint Assessment & Discharge Service as the project moves towards that stage. This will be dealt with by Adult Social Care management, with HR support, using the Council's HR policy and procedure framework, with due regard taken of relevant employment legislation obligations.

Eve Anderson – Strategic HR Business Partner (Children, Adults & Housing and Public Health)

BACKGROUND PAPERS

- Initial Joint Assessment and Discharge Service Report - attached

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