

Investigation report

**Barking, Havering and Redbridge  
University Hospitals NHS Trust**

Queen's Hospital  
King George Hospital

October 2011

## About this report

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services. The Commission has the power to conduct an investigation into the provision of NHS care under s48(1)(2)(a) of the Health and Social Care Act 2008. It does so where there is evidence of a significant problem that affects a whole care economy.

This report is on the findings of an investigation carried out by CQC at Barking, Havering and Redbridge University Hospitals NHS Trust. It focuses mainly on the quality and safety of care provided at King George Hospital and Queen's Hospital.

This report should be read in conjunction with the review of compliance reports published by CQC in June 2010, October 2010, March 2011 and April 2011 and available on our website. These provide further details of the trust's performance in meeting the essential standards of quality and safety detailed in section 20 of the Health and Social Care Act 2008.

This report was first published in October 2011 without evidence on Outcome 6: 'Cooperating with other providers' and Outcome 7: 'Safeguarding people from abuse'. This was to ensure that we could publish the report as quickly as possible, so that the trust and its NHS partners could take prompt action to improve the quality and safety of services delivered to patients. The evidence has now been added.

# Contents

Summary	4
Background to the investigation	15
Main findings	
Respecting and involving people (Outcome 1)	18
Care and welfare of people (Outcome 4)	22
Co-operating with other providers (Outcome 6)	32
Safeguarding people from abuse (Outcome 7)	34
Cleanliness and infection control (Outcome 8)	36
Management of medicines (Outcome 9)	38
Safety and suitability of premises (Outcome 10)	39
Safety, availability and suitability of equipment (Outcome 11)	42
Staffing (Outcome 13)	44
Supporting workers (Outcome 14)	49
Assessing and monitoring the quality of service provision (Outcome 16)	53
Complaints (Outcome 17)	57
Records (Outcome 21)	59
Leadership	61
Capacity	64
Appendix A: Terms of reference for the investigation	67

## Summary

Barking, Havering and Redbridge University Hospitals NHS Trust had a history of poor performance under the previous regulatory framework. It has long-standing and escalating debts (in 2005/06 this was just under £16m; by 2009/10 it was close to £117m). There have been numerous changes at executive level.

At the time of CQC registration, the trust had a high number of 'conditions' placed on it to require improvements in care. A series of unannounced inspections in 2010/11 resulted in some of these being lifted, but also resulted in warning notices being issued to the trust (in March, June and July 2011) on staffing levels and maternity care.

CQC saw some evidence of improvements being made in response to these notices, but the trust's overall capacity to respond to the extent and level of CQC's concerns is in question. Throughout this period, we continued to receive information about poor quality care from patients and the public.

## The investigation

CQC's judgement was that continuing to tackle poor performance at the trust on a case-by-case basis was not going to address deep-seated issues around the quality of care. As a result, we took the decision to launch a full investigation into the quality of care provided by the trust at Queen's Hospital and King George Hospital.

The investigation was announced on 29 June 2011. A team of CQC inspectors and external expert advisors – including experts in maternity, accident and emergency, and nursing care – began the investigation on 4 July 2011.

The investigation was designed to assess the systems and procedures the trust has in place to ensure that people are protected against the risk of inappropriate care and treatment. The team focused on three care pathways – maternity, elective vascular surgery, and emergency care, and examined the trust's governance and management systems.

Evidence gathering took place from July to September. Both main hospital sites were inspected, during which we spoke to patients about their experiences and observed care being delivered. We interviewed more than 200 hospital staff in private, and spoke to staff from 13 different stakeholders. We received further information from more than 100 people who had used the trust's service, through interviews and written submissions. MPs and local councillors submitted their views and the views of those they represent.

## Our key findings

Despite some signs of improvement in recent months, patients remain at risk of poor care in this trust, particularly in maternity services. We have identified ongoing concerns in emergency care and in radiology. Widespread improvement is needed in patients' experiences; patient flows; the management of complaints; staff recruitment; and governance.

Long-standing concerns in maternity services have progressively worsened. The most significant problems were identified at Queen's Hospital during our investigation, although elements of poor care were present across both sites. These include poor clinical care, a service operating in isolation, abusive behaviour by some staff to patients and to their colleagues, a lack of learning from maternal deaths and incidents, and a lack of leadership from senior management. The attitudes of some midwives continue to cause concern among patients and staff.

Accident and emergency services at Queen's Hospital have struggled to meet the four-hour target for admission. A tipping point was reached last winter when the quality of services began to collapse. There have been some improvements in 2011 which the trust needs to consolidate to reduce the risk of poor care happening again.

Concerns were identified in other clinical delivery areas, including in the day case surgical unit and interventional radiology, with delays having an impact on treatment and care. An external review of interventional radiology in June 2011 gave the service an amber rating. Evidence from staff gathered during our investigation supported these concerns.

We have a number of present concerns about the safety and suitability of premises at Queen's Hospital, supported by accounts given by staff and patients during our investigation. It can be difficult to navigate and signage is poor; some wards and clinical departments do not have natural light, and there are line of sight problems in the emergency department and general wards. There is a lack of waiting space in the urgent care centre and poor facilities in the theatre recovery unit for patients who are cared for in that facility for up to 23 hours.

The design of the emergency department at Queen's Hospital also contributed to problems with equipment which staff raised during our investigation; some equipment cannot easily be shared between different areas. Disposable equipment in some clinical areas tended to run out.

There has been a gradual reduction in the number of permanent staff employed though staffing establishments have risen, with staff acknowledging that senior managers have had to focus on the trust's debt. Many vacancies have been filled by agency, locum or bank staff with an impact on the quality of care. Data from June and July showed significant vacancy rates in some staff groups. Staff told us that the trust has recently taken positive action to recruit more permanent staff, particularly midwives and nursing staff in the emergency department. Concerns remain regarding the number of medical vacancies.

Trust governance systems are reported as weak and corporate governance is underdeveloped. Governance systems have recently changed, but lines of communication in the new structure are unclear and there is a risk of duplication or issues being missed. The trust was reliant on external reviews to identify issues, and while it held extensive performance information, this was not used to drive change. There was a lack of learning from incidents, with investigations identifying recurring themes.

The trust's response to complaints has been very poor for a number of years, with a high number of complaints received each year and frequent breaches in timing and quality of response. The level of distress caused by poor complaint handling was, in some cases, reported to be as bad as the poor care experienced in the first place. The trust is seeking to put this right, but this was raised by stakeholders (particularly MPs and local councillors) as one of their biggest causes of concern apart from quality of care.

There is past and current evidence of poor leadership from some managers and a culture among some staff of poor attitude and a lack of care for patients, especially in maternity. There is recent evidence that this is beginning to change due to the efforts of the new chief executive, the director of nursing and medical director.

We identified a lack of cohesion across the trust. Divisions do not work together effectively to improve the quality of patient experience. This is particularly stark in the flow of patients out of the emergency department.

Capacity is a current and future challenge, particularly at Queen's Hospital. Efficiency gains that were supposed to happen have not come about. There was a universal view that too many women now attend Queen's for maternity care and that it cannot cope.

The problems highlighted around accident and emergency last winter were in part due to capacity, in part to poor care flows, and also due to interim management arrangements that prevented permanent staff from contributing views that could have improved care. Ownership of problems has since returned to permanent staff and some improvements in quality (for example, a rapid assessment and treatment service for major cases) have been seen. The durability of these will be tested over the winter months.

During our investigation, we did receive information from patients who were happy with the quality of care they experienced. This was acknowledged by stakeholder groups (although the latter did raise ongoing concerns about quality, particularly in maternity services).

Almost without exception, members of staff were positive about the impact the new chief executive is having at the trust. They have embraced the chief executive's inclusive style and believe, for the first time in many years, that there is a real opportunity for positive change.

## **What needs to be done?**

CQC has set out a range of recommendations the trust must fulfil. CQC will monitor implementation, but the trust needs the support of organisations in the local health economy, including NHS London and commissioners. The significant changes that are needed, in particular on capacity, are likely to challenge both clinical flows and trust finances.

Many leaders and managers in the trust have been overwhelmed with day-to-day difficulties and need support to turn the trust around. CQC believes this support must take the form of working with the chief executive and other leaders and staff at the trust, rather than seeking to impose change.

The area of greatest concern remains maternity services. Improvements must be made in a short time frame to ensure the immediate safety of women using services, while medium and long-term answers must be found to capacity problems.

The trust must prepare for the challenges the winter will pose to emergency care. Patient flows through the organisation need to improve. The organisation must function as a whole and services must not operate in isolation.

## **Detailed findings**

### **Respecting and involving people**

The trust has had poor results from national patient surveys, particularly about dignity and respect. The trust has systems in place to capture the views of patients, but it is not clear that these have been used effectively to improve the quality of services. New electronic systems collect patients' experiences at Queen's Hospital; initial results support the national surveys that identified variations in the quality of patients' experience.

There is evidence that some women were not treated with dignity or respect in maternity services at Queen's Hospital. Both staff and patients raised concerns over the attitude of some midwives. The trust receives a high number of complaints about the quality of patients' experience in maternity services, especially with regard to poor staff attitude.

Patients also experienced a lack of dignity and respect in the emergency department during the winter of 2010/11. For example, patients were waiting for many hours to be treated or admitted to hospital. Concerns were identified in the day case surgery unit, where patients often stayed for up to 23 hours in facilities that compromises their dignity and respect.

### **Care and welfare of people**

There is evidence that there is some improvement to the quality of care in emergency services. However, historically the emergency department at Queen's Hospital has had difficulty in meeting the four-hour target to admit patients and despite improvement in the last four months there are still challenges to overcome to ensure the flow of patients is effective.

There were concerns regarding poor quality care in maternity services especially at Queen's Hospital. For example, some women in labour did not receive epidural pain relief as quickly as they should; one woman recently having to wait nearly two and a half hours. There were concerns in other clinical delivery areas, including the day case surgical unit and interventional radiology; for example, delays in reporting radiological examinations that impact on treatment and patient care in the trust. There were concerns over discharge arrangements; for example delays in providing discharge medication in a timely fashion.

Although most of the information received from patients and relatives outlined poor experiences for patients, we did receive evidence where patients and their relatives had received good quality care.

### **Cooperating with other providers**

There was a history of difficult working relationships between the trust and its NHS external partners, including commissioners, and with care home and nursing home providers relating to admission and discharge practices. There were also concerns regarding the accessibility of some specialist community rehabilitation services, particularly neuro-rehabilitation services, which resulted in poor experiences for some patients.

Stakeholders acknowledged the positive impact of the new chief executive, but also felt that they needed to see sustained improvements.

### **Safeguarding people from abuse**

There were a number of vacancies at a senior level in relation to safeguarding arrangements. Some staff said they had received training in children's safeguarding but not adult safeguarding, particularly staff in the emergency department. However, they were able to articulate to us how they would recognise safeguarding concerns and what they would do in those circumstances.

Although the trust has been historically poor when working with safeguarding boards, there has been a recent improvement in communications.

### **Cleanliness and infection control**

There is a well-resourced infection prevention team that carries out audits, reports to the trust's board and provides education for staff. There were some concerns about the number of patients developing *Clostridium difficile* infections at the trust but fewer concerns about MRSA infections. Wards and departments that we visited were generally clean and we saw staff maintaining their hand hygiene.

We had some concerns about the storage of intravenous fluids on wards, and the cleanliness of public toilets in the emergency department at Queen's Hospital. The infection prevention team worked effectively to resolve another issue we raised ensuring patients were screened for MRSA before being admitted to hospital.

### **Management of medicines**

We had concerns about the recording of administering medicines to patients, and the timely provision of medication when patients are discharged from hospital. We also had concerns about access to adequate pain relief for women in labour and on some general wards. There is some evidence of audit and feedback, though the pharmacy newsletter sharing this information has only recently been published. There is evidence of changes to practice as a result of audit, and of a culture that supports the reporting of medication errors in the emergency department and corresponding learning by staff.

### **Safety and suitability of premises**

There are a number of concerns at Queen's Hospital with regard to premises. The hospital is circular in design, and it can be difficult to navigate the ground and first floor as wards and departments are set out in an outer and inner circle configuration. Signage is often poor especially on the ground and first floors. Some wards and clinical departments on the ground and first floor do not have access to natural light and this provides a poor environment for patients and staff. There are line of sight problems in the emergency department and on general wards, where due to the nature of the design some patients cannot be observed easily. There is a lack of appropriate waiting space in the urgent care centre, and poor facilities for patients who have to stay for up to 23 hours in the theatre recovery unit.

No such problems were identified at King George Hospital.

### **Safety, availability and suitability of equipment**

Access to equipment was generally satisfactory, at King George Hospital. At Queen's Hospital we had concerns over the availability of medical devices such as monitors and pumps. Staff in the emergency department raised particular concerns over access to medical devices and other equipment, though this is in part due to the nature of the design of the department where equipment cannot be easily shared between different sections, for example 'majors' and 'minors' (areas of an emergency department that treat patients that have differing severities of illness or trauma). Managers said that concerns about access to equipment had always been voiced by staff at Queen's Hospital since it opened in 2006, and suggested that this was partly due to the complexity of patients' conditions. Not all staff voiced concerns; those in the intensive care unit told us that access to medical devices was good.

### **Staffing and supporting workers**

There has been high usage of temporary and locum staff, and staff acknowledged that the focus of the senior managers has been the financial debt of the organisation. Many of the vacancies have been filled on a daily or short-term basis by agency, locum or bank staff. This is reported to have had an impact on the quality of care. The trust has recently employed a number of nurses and midwives in areas such as emergency care and maternity, but we still have concerns about the numbers of medical staff, therapists and other support staff.

The trust has not carried out skill mix reviews nor needs analysis in any systematic fashion or acted on those reviews that have been undertaken. There are examples where the trust did not utilise staff appropriately according to their clinical skills; for example, midwives who have been trained to undertake the first postnatal mother and baby checks not utilising these skills. There are also examples where the trust may not have been getting the best value for money in terms of *Agenda for Change* grading with some groups of staff. There is a need to make better use of unqualified support staff, and to ensure that more support staff are used in a variety of clinical specialities.

The trust has been dealing with high numbers of poorly performing staff, the numbers of which have been increasing year on year and are higher than comparable trusts. The trust has processes in place to support managers. However, many staff articulated that they believe there is a lack of support for managers to deal with these performance concerns, and a perception of poorly performing staff not being dealt with effectively.

The trust is a university hospital and has formal links with educational establishments. There are well-developed systems for education and training in place, and staff have access to these with some exceptions. Where there are vacancies in staff groups permanent staff have difficulty accessing mandatory and professional development. We had concerns about adequate supervision of midwives and training grade medical staff. Appraisal is one area that staff did not raise concerns about, and this is reflected in the national staff survey.

### **Assessing and monitoring the quality of service provision**

The trust's governance systems are reported as weak and do not provide assurance that would allow the board to fully manage the task of leading the organisation. Evidence regarding the governance reporting structures do not include all the committees operated by the trust, and lines of accountability are unclear. There was a risk of duplication and limited evidence of communication between groups. There was an underdeveloped corporate governance system in place. The trust was reliant on external reviews and inspections to identify issues rather than through its own internal monitoring systems and the trust has been slow to implement changes and drive improvement.

The trust held extensive performance information, which was not being used effectively to drive change. There was a risk that the trust's board was overloaded with information due to the number of committees and external reviews. There was a lack of learning from incidents, with investigations into serious untoward events identifying similar contributory factors to those found in previous incidents.

### **Complaints**

The trust's response to complaints has been very poor. The trust received a high number of complaints each year, compared to trusts of its size, and has a high number of complaints currently with the Parliamentary and Health Service Ombudsman. The trust frequently breached its own guidance on the timeliness of responses and its responses were often simply a record of the treatment an individual received with no response to the actual complaints raised. The trust

has recognised this and is making changes to its complaints process to ensure ownership at a local level.

### **Records**

The quality of records that we looked at were generally in line with established standards, but we did see some patient records and assessments that had not been completed fully. There were difficulties regarding the retrieval of patient records, resulting in multiple temporary records for the same person being created and risks of records being mixed up. There are a number of different electronic patient information systems, which do not necessarily link to each other or the hospitals' main patient administration system.

Maternity services have their own records system and clear links were not made with other hospital records. There were problems with maternity records being lost and misplaced and poor completion of maternal assessments.

### **Leadership**

There have been a number of changes at executive level at the trust in recent years. The trust has focused on reducing its financial deficit, and at the same time the quality of care has suffered. There is evidence of poor leadership from some managers and a culture among some staff of poor attitude and a lack of care for patients, especially in maternity services. There is also evidence among the staff that this culture is beginning to change and that the new chief executive, the director of nursing and the medical director are seen to be working well together. Staff believe that the chief executive is listening to them and are encouraged that their voices are being heard.

### **Capacity**

There are challenges for the trust in terms of capacity at Queen's Hospital. There has been a gradual transfer of services from King George Hospital to Queen's Hospital, but the efficiency gains that were supposed to occur at Queen's Hospital have not come about.

The majority of maternity services are now provided at Queen's Hospital. Staff, stakeholders, patients, and evidence from external reviews all indicate that too many women now attend Queen's Hospital for their maternity care, and that the trust cannot cope with the level of activity.

The trust has had difficulty in ensuring that patients are admitted from the emergency department in less than four hours, particularly at Queen's Hospital since it opened in 2006. There has been a traditional approach to how patients are managed and move through the department, and a lack of staff and poor inter-divisional working that has further restricted the flow of patients. For example, once a decision to admit a patient has been made, some clinical specialities require a junior member of the medical team to reassess the patient in the emergency department, rather than the patient simply being transferred to that speciality.

The emergency department reached its tipping point last winter when the quality of service began to collapse. This was partly due to the fact that emergency

services were not part of the medicine division, and due to interim management arrangements that had been put in place at that time. Staff told us that changes had been made to the systems and processes in the emergency department on a daily basis with no regard to or inclusion of staff in the department. One staff told us that if *'you didn't agree with the interims you were moved aside'*.

When the current chief executive started at the trust, the interim management arrangements were changed and the emergency department brought back into the medicine division. Ownership of problems returned to the staff in the department. Since then there have been improvements in the quality of the emergency service, for example the department has introduced a rapid assessment and treatment service for patients brought in to the 'majors' stream, which ensures that patients are treated more quickly.

## **Recommendations for the trust**

As a result of this investigation, we have 79 separate recommendations that the trust must fulfil. They are set out at the end of each relevant chapter in this report. There are two strategic recommendations set out below.

Because of the concerns identified in maternity services, the recommendations that the trust must fulfil in that service are also set out below.

The trust will need to develop an action plan that ensures it will implement substantive change and improve the quality of patient experience across the organisation. The Care Quality Commission will monitor the implementation of this action plan via its local compliance team.

The trust has a number of urgent problems to solve and to do so effectively will require the support of organisations in the local health economy to achieve this, including its commissioners and NHS London. The correct support is required to allow staff to retain ownership of the problems that exist in the trust, and develop the solutions that are required to deliver high quality services.

However, many of the leaders and managers who are required to lead the cultural and organisational change programmes have been so overwhelmed by the day-to-day operational difficulties that they have not been able to work strategically. Therefore, the support required will be to 'work with' the staff to turn the trust around, and not 'do to' the staff to turn the trust around.

The trust has a large and challenging agenda ahead of it. It needs to ensure that it has in place managers and leaders who can lead and support the cultural change that is required.

The area of greatest concern remains maternity services; poor service culture remains in pockets, staff shortages, an isolation from the rest of the organisation and weak governance systems. Improvements need to be achieved in a short time frame to ensure the immediate safety of women using its services, while developing long-term solutions.

The trust needs to ensure that it can cope with the upcoming winter pressures in its emergency departments and ensure the flow of patients through the whole organisation is efficient. To do this staff must ensure that they think creatively about how services can be delivered, and not just through traditional models of health care delivery. The organisation must function as a whole entity and not as appears in isolated competitive divisions and departments. The trust needs to consider how it uses all its current capacity to allow high quality patient services to be delivered across all trust sites.

The trust needs to ensure that it has monitoring systems to avoid further tipping points in other clinical services. For example, there are concerns in radiology; these need to be dealt with promptly and the quality of service improved to ensure that the risk of serious untoward incidents occurring is reduced. The trust needs to ensure that the experience of patients in areas such as day case surgery is improved.

In addition, there is a need to lead the staff of the organisation on a journey of cultural change. The cultural change programme is required so that those staff who undoubtedly endeavour to provide a high quality service are not let down by their colleagues, and that patients can feel confident that problems are dealt with. The change programme should include robust, fair and transparent processes to deal with cases where individuals have dealt with patients and their colleagues inappropriately.

The trust needs to assure itself that those services that were not included in the pathways for this investigation are also safe and that the quality of patient care and experience can be assured. Again this can be achieved with appropriate external support.

### **Strategic recommendations**

- The trust in conjunction with NHS London should seek appropriate external expertise to support a programme of organisational change and service improvement.
- The trust in conjunction with its commissioners and other partners should identify and implement plans to secure a long term solution to reduce over capacity at Queen's Hospital.

### **Recommendations for the trust for maternity services**

#### **The trust must:**

- In conjunction with its commissioners and other partners, identify and implement immediate solutions to deliver safe maternity services at the trust, especially at Queen's Hospital, while developing plans to secure a long-term solution.

- Ensure that it configures its maternity services wards and departments appropriately to improve the quality of antenatal and postnatal care at Queen's Hospital.
- Ensure that there are suitable numbers of midwives to provide one-to-one care for all women during established labour.
- Ensure that learning from incidents in maternity services takes place to reduce the risk to women of unsafe care.
- Take appropriate steps to ensure that all women can receive adequate pain relief when they need it.
- Further improve the maternity triage process with the introduction of regular monitoring and learning to ensure that services improve for all mothers.
- Take appropriate action to ensure that babies are not transferred to the neonatal care unit unnecessarily.
- Ensure it uses all staff and systems effectively to improve the discharge process.
- Undertake a skill mix review in its maternity services, for example *Birth Rate Plus*.
- Continue with its recruitment plans in maternity services to ensure that it has suitable numbers of qualified staff across all service delivery departments.
- Review the clarity of its reporting processes with regard to cardiotocography (CTG) training in maternity services.
- Increase the level of training on the interpretation of CTGs, so that all staff have undertaken this.
- Increase the number of supervisors of midwives as a matter of priority, to improve the quality of supervision and reduce the burden on those currently in post.
- Improve the quality of record keeping and records management in maternity services.
- Assure itself that it has the right managers and leaders in maternity services to deliver high quality safe services for women.

# Background to the investigation

## The trust

Barking, Havering and Redbridge University Hospitals NHS Trust (the trust) serves a population of around 700,000 in outer north east London. It operates across two main sites at Queen's Hospital in Romford, which opened in 2006, and King George Hospital at Ilford, which opened in 1993.

The trust provides services to people across three local authority areas, Havering, Redbridge, and Barking and Dagenham, and general and emergency services to the population of west Essex with some specialist services to all of Essex, for example neurosurgery. The three local authority areas have different demographic backgrounds. Havering has a population of around 232,000 with low levels of deprivation, Redbridge has around 264,000 people with average levels of deprivation, and Barking and Dagenham has around 172,000 people with high levels of deprivation.

Queen's Hospital at Romford sits within Havering local authority and so is the main hospital for that population, while King George Hospital is located at Ilford and mainly serves the population within the areas of Redbridge, and Barking and Dagenham.

There are two other locations registered to the trust, Barking Community Hospital and Victoria Hospital.

## Previous performance

The trust has performed poorly for a number of years with regard to NHS regulation. Under the previous regulatory framework (the Annual Health Check), the trust was rated 'weak' on both quality of care and use of resources in the year 2008/09.

The trust has had long-standing financial debt and concerns over the quality of care. In 2005/06 its cumulative debt was just under £16m; by 2009/10 this had risen to just under £117m.

There have been numerous changes at executive level in recent years, and a new chief executive started in February 2011. There is an interim chair, and a substantive post is currently being advertised. The director of nursing has been in post for 18 months. A new medical director started in May 2011; prior to this (since November 2009), the post was covered by non-permanent appointments.

## **CQC regulatory action to date**

CQC registered the trust in April 2010 under the new regulatory system under the Health and Social Care Act 2008. We placed eight conditions on its registration, one of the highest numbers for NHS trusts in England.

During 2010/11 we carried out a number of inspections to review whether the trust had made sufficient improvements against these conditions. We noted some improvements and lifted seven of the conditions. One remains in place, with regard to having sufficient numbers of staff in maternity services.

It was during this ongoing monitoring of the trust's compliance with the essential standards of quality and safety, that we identified further concerns, particularly in the trust's maternity and emergency services, and specifically at Queen's Hospital. There had been five maternal deaths in the 18 months before we began the investigation, two of which were in 2011, and we received numerous concerns from patients, members of the public and other stakeholders.

Acting on this information, we issued warning notices to the trust in March 2011 in respect of staffing levels and concerns about maternity care. We issued a further warning notice in June 2011 in respect of emergency care.

We issued a further warning notice in July 2011 concerning staffing levels in the trust's general wards.

We conducted further compliance inspections in September 2011, to review what progress the trust had taken regarding the final condition we had placed on its registration in 2010.

After the warning notices were issued, the trust began to improve some areas where concerns had been raised; for example it employed more permanent staff. However, despite the warning notices, we continued to identify concerns at the trust, and we continued to receive information and reports of poor quality care from patients and the public. In light of this, we took the decision to carry out a formal investigation of the trust.

## **How we carried out this investigation**

We began the investigation on 4 July 2011. The inspection team consisted of CQC staff and external expert advisors.

The terms of reference are reproduced in Appendix A.

Our aim was to assess the systems and procedures that the trust has in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment.

To do this we looked at three particular pathways of care: maternity care, elective care and emergency care. We also examined the trust's governance and management systems.

We reviewed data supplied by the trust. We visited both main hospital sites. During the site visits we talked with patients, and observed care being delivered; and carried out over 200 private interviews with members of staff. We also interviewed staff from 13 different stakeholders.

We held a number of private interviews with patients and members of the public at locations across Ilford, Romford and Barking as well as receiving written submissions. In total, we received information from more than 100 people who had experience of the trust's services.

## **Main findings of the investigation**

### **Respecting and involving people (Outcome 1)**

The trust has poor results from national patient surveys and, while it has systems and processes in place to capture patient experiences, it is not clear from the data supplied by the trust that the evidence is being used to effectively improve the quality of care and to allow patients to know what has changed. Patients and relatives told us that on many occasions that they didn't feel they were involved in decisions about their care, and this is supported by survey information.

From a review of information supplied by the trust, we saw evidence that it has a number of committees or groups that examine patient experience and include patient representatives. While these groups appear to discuss a large range of areas that affect patient experience, it is unclear, from the information provided, how these groups actually affect changes in outcomes for people who use services. Similarly, in response to the poor national survey results, the trust has devised a number of actions to address areas such as information provision. Many of these actions involve reviewing and enhancing existing practices but, from the information provided, it is not clear what effect these have had on outcomes for people who use services.

The trust has a patient experience strategy in place for the years 2010-2013 which includes 10 aims (areas). These include improving communication, fundamentals of care, patient and public involvement, and end of life care. However, the trust performed poorly in both national patient surveys conducted during 2010, scoring in the worst 20% of organisations in England for 40 (out of 77) questions in the 2010 inpatient survey and 18 (out of 19) questions in the 2010 maternity survey. We were told that previously staff were not aware of these patient surveys, nor were they being made aware that the trust was performing so poorly. Although progress has been made, this lack of communication was also expressed to us by staff. The main areas of problems highlighted by these survey results were:

1. Communication with patients and information provision
2. Involvement of patients and carers in decisions about care
3. Patient choice
4. Respect and dignity
5. Confidence and trust in staff.

The director of nursing at the trust has introduced a visible leadership programme to begin to address some of the concerns raised in surveys and complaints. Audits have been undertaken that demonstrate some improvements in discharge planning, privacy and dignity, and pain management; with audits taking place as part of a rolling programme. However, as this is a recent introduction, insufficient data was available to allow for confidence in the effectiveness of the outcomes. One member of staff told us:

*'Visible Leadership happens on a Thursday afternoon 2 to 4pm, every two weeks. It focuses on patient experience. (They) discuss what staff want to talk about and (she) feels they are good meetings.'*

In addition to locally arranged visible leadership meetings, trust-wide visible leadership events take place weekly.

In January 2011, the trust introduced electronic patient surveys that can be accessed by patients on wards through hand-held touch-screen devices. There are also a number of kiosks around the hospital in public areas, including the accident and emergency and outpatient departments, that patients, relatives or visitors can access to provide feedback. Currently this system is only in place at Queen's Hospital, though we were told that there are plans to introduce it at King George Hospital. For inpatients that have been discharged, there is also a link to the surveys via the homepage on the trust's website. Results from the first six months since this system was introduced show that the medical division scores below the trust average across the 11 question areas; while the surgical division scores equal to or above the trust average in all 11 question areas.

The outcomes from more than 600 people who have used the public kiosk at Queen's Hospital in the emergency department were reported. The results were mixed: nearly 50% of patients waited over an hour to speak with a nurse or doctor and, while 52% of patients answered positively about being involved in decisions about their care, 40% did not. In addition to this, 35% of patients felt they were not treated with dignity and respect, and nearly 50% felt that not enough was done to control their pain.

The trust has also introduced an hourly vital signs check, so that basic observations such as blood pressure and pulse can be checked as required and staff check the condition of their patients. When talking with staff, while they were aware of this initiative, some emergency department nursing staff at Queen's Hospital told us that in practice they do not do these checks as they do not have enough time.

During our site visits in July and August 2011, we observed and spoke to patients across a variety of general wards, the medical admissions unit, intensive and high dependency units and the emergency department. We saw and patients told us that staff took the privacy of patients seriously. We observed the majority of curtained bays or bed spaces were displaying 'do not enter' signs and when staff wanted to enter these spaces, they would check with the patient first. We observed staff speaking to patients with respect.

However, the experience of patients in the emergency department during the winter of 2010/11 was not good. Of the information we received from patients, 15 were in relation to poor care in the emergency department; only two identified good patient experiences in the emergency department. The main complaint has been in relation to a lack of basic nursing care and privacy and dignity being maintained, and many instances of patients being kept in the emergency department for several hours, where they and/or their relatives were

not provided with information and were not aware of what was happening to them.

Staff attitude towards some women in maternity services has been poor. We received information from over 30 people who had experienced what they considered to be poor quality care. The theme of these concerns range from women routinely being ignored and their description of their labour being dismissed by staff; being left alone for long periods of time while in labour; being spoken to rudely by staff; and not receiving adequate pain relief. One woman was denied assistance with her hygiene needs despite asking for help on numerous occasions. Another woman told us that she was told that she needed to hurry up and give birth as the midwife's shift finished at 7am. Another woman told us that she had presented to the maternity triage at Queen's Hospital after her waters had broken; she suspected that there was meconium in her waters; she was in a lot of pain and required pain relief. On telling the midwife this, the midwife ignored the woman concerned, turned to her colleague and said '*and she thinks it hurts now*'.

This attitude was not only directed at women in labour; information was provided to CQC regarding the experience of the husband of a woman on the antenatal ward at Queen's Hospital. The woman's husband was concerned over his wife's condition but stated that staff ignored his pleas for help with tragic consequences for his wife and their unborn baby.

At Queen's Hospital, when women are discharged following the birth of their child but prior to leaving the hospital, they are sent to a discharge lounge. We were told that women are given postnatal advice such as breast feeding, and baby checks are carried out. Women told us that they felt there was little privacy in the discharge lounge and that they were often kept waiting there a long time. During the site visit we heard one woman ask how long they would be there, to which the midwife responded that she didn't know.

It is not only people who use services who have articulated problems with the attitude of staff; around 25 staff that we interviewed from maternity services indicated that they had witnessed examples of poor attitude and rude behaviour between midwives and medical staff and women in their care. In data supplied by the trust, the attitude of midwifery staff was also one of the most common causes of complaints. Staff described to us a culture of abuse that has been a consistent problem for many years but has not been dealt with effectively by senior managers. For example, one staff member stated that a colleague:

*'Shouted and argued with me on the ward, in front of staff, visitors and patients because I had refused to do a job she was allocated to do. When I approached supervisory members of staff regarding this, their attitude was flippant and they said they were already aware of previous issues regarding this member of staff.'*

There was some evidence that the recently recruited staff from overseas were having a positive effect on staff attitude, but midwifery services is still receiving complaints about the attitude of some staff.

During the winter of 2010/11, the antenatal ward at Queen's Hospital was moved some considerable distance from the labour ward and postnatal ward. This has resulted in a number of women giving birth in the antenatal ward, or being transferred while in labour to the labour ward, which requires that they are transported through public corridors while in labour and in distress. Clinical staff told us that there was a lack of consultation with them regarding this move, which they did not agree with. We were told that the trust is now considering relocating the antenatal ward again to try to reduce these situations from occurring.

We were told by staff and observed that for some patients undergoing day case procedures, there are often not enough beds, and some patients end up staying in the theatre recovery area for up to 23 hours. We observed that toilet facilities are inappropriate and the area does not have any natural light. The female toilet does not have a hand rail and is not suitable for people that use wheelchairs. The toilet is located in the area of the recovery unit where people who have just had surgery are cared for. Women using the toilet have to walk through this area, so compromising their privacy and the privacy of those patients from theatre. The male toilet facilities are located on a corridor between the theatre rooms and the recovery unit and similarly are not suitable for people that use wheelchairs. If a patient wishes to have a shower, then women need to go to the gynaecology ward on the same floor as the theatre recovery, but men need to go upstairs to another ward, which does not support the dignity and privacy needs of patients.

## **Recommendations for the trust**

### **The trust must:**

- Ensure that it acts on the outcomes of its own and national patient surveys and demonstrate that improvements to the quality of the patient experience across the trust are made.
- Enhance its existing systems for involving patients in the development of services to ensure that the patient's voice is an integral part of every division, ward and department engagement strategy.
- Make sure that proactive and mandatory training and education regarding dignity, respect and tolerance is delivered to all staff.

## Care and welfare of people (Outcome 4)

CQC received nearly 90 submissions from patients and relatives outlining examples of poor care. The majority were from patients who had experienced care at Queen's Hospital, though some were from King George Hospital. We did receive some positive feedback from patients who had experienced care at both of the hospitals, and MPs and local councillors also noted that, while they received many complaints about the quality of care from their constituents, they also acknowledged that many people do receive good care at the trust. The terms of reference for this investigation identified three pathways to follow to explore the quality of care. The remainder of this section examines the quality of care given to people within those pathways, as well as other issues that were identified.

### Maternity

Trust data raised some concerns over quality indicators. There are a high number of caesarean sections being performed at the trust (though this is not unique when compared with other trusts in London). The trust's target for less than 22.5% of births by caesarean section was not being met from January to June 2011, and was red rated for four of these months. This was also an issue in 2010 and was highlighted in several internal meetings.

In addition to the high number of caesarean sections being performed, they are not all being carried out in a timely manner, especially grade two sections (urgently requiring caesarean section within 30 minutes due to concern for the mother or baby's wellbeing). The trust's maternity performance report for the week commencing 4 July 2011 contained an audit of 17 sets of records for women who had had caesarean sections. The results indicated that 75% of women classified as grade one (urgently requiring caesarean section within 30 minutes due to immediate threat to the mother or baby's life) had their caesarean section within the recommended time. Only 18% of women classified as grade two and 50% of women classified as grade three (requiring caesarean section within 75 minutes) had their caesarean section within the recommended time. The following week's report (11 July 2011) containing an audit of 18 sets of notes showed that four out of five grade one sections were performed within 30 minutes (the fifth case was only delayed by a further three minutes); however only 20% of grade two sections were carried out within the recommended time. Two out of three grade three sections were delayed; one woman waited almost three hours, and the second waited for almost four.

One-to-one care of women in established labour was found to be a key area of risk by an external review in early 2011. According to the trust's data, one-to-one care was not consistently given at Queen's Hospital between February and June 2011, and its target for over 95% of women to receive this was not met. However improvement is being made: 95% of women received one-to-one care in June, compared with 89% in February 2011.

Recent audits of patient records have found variability in the time taken for women to receive pain relief. Generally it has been found that pethidine is given within the trust's target of 15 minutes. However, this is not the case for the administration of an epidural. The most recent audit provided by the trust (July 2011) showed that six out of 13 women did not receive an epidural within the trust's target of 30 minutes. One woman waited almost two and a half hours. Patients' records from two weeks in June were also audited by the trust. In the first week, only one out of 13 women did not receive the epidural within 30 minutes, but in the second week four out of eight did not receive it in the required time. The main reason for this was the anaesthetist being busy in theatre.

One woman who contacted CQC told us that she had waited many hours for an epidural and felt that she was simply ignored by staff until her husband raised his concerns. She told us that, when an anaesthetist did arrive, an epidural was sited, which the woman believes was incorrect as she gained no pain relief from the epidural and had leg spasms. We were told that:

*'I begged hospital staff for four hours for the epidural to be correctly sited; I was ignored; my husband kept looking for the anaesthetist. He finally found him having a joke with a nurse. When the anaesthetist entered the delivery room he was with a female consultant, he was laughing and joking with her. I told him to please stop laughing as I found nothing funny; he then corrected my epidural. I had endured around 10 hours of excruciating labour.'*

During the course of the investigation, we received many personal accounts from women detailing poor experience about their care in maternity services, the majority at Queen's Hospital, which are not appropriate to publish. These examples include women being ignored by midwifery staff, being sent home from triage inappropriately, and traumatic experiences while giving birth, including a lack of analgesia.

Another indicator of quality is the time taken to transfer a mother and her baby from the labour ward after delivery of the baby. An internal audit in March 2011 showed a minimum interval of 1h30m and maximum of 19h35m at Queen's Hospital. The reasons for the delays included no postnatal beds, staff caring for other patients, and delays in suturing. Long waiting times for transfer have been discussed in several internal meetings. Some improvement was seen in April 2011 which, as noted in a trust internal meeting, coincided with the introduction of a new staffing template and supernumerary bed coordinators. However, the trust's average waiting times are still approximately double the national average (four to five hours at the trust and two hours nationally).

At Queen's Hospital, historically there have been numerous problems with the trust's triage systems. Understaffing and long waits for review, inadequate telephone advice and lack of privacy have been cited at internal meetings, and triage has also often featured in complaints received by the trust.

One woman's experience was not good; despite timing her contractions at two minutes apart, the midwife in triage informed the woman that she was not in labour and would have to go home.

*'I was shocked that the midwife was not one bit sympathetic towards me and the agony I was in, instead she was patronising.'* The woman then made her way to the car park at Queen's Hospital with her husband but noticed that people were staring at her. *'Once we got to the ticket machine two nurses ran over to us with a wheel chair and asked where I was going and why. My husband explained to her what the situation was and she turned around and said I could not leave the hospital as I was bleeding...and (needed) to sit in the wheel chair. I looked down and saw lots of blood on my trousers.'*

The woman was taken to the emergency department and subsequently to the labour ward, where she gave birth to her baby.

In April 2011, a new system was introduced. The service is now midwife-led and available all day. Staff indicated to us that they believed that this had improved access to maternity services for women. Recent data has indicated that the waiting time target for 98% of women to be assessed within 15 minutes is not consistently being met. Data from the week commencing 4 July 2011 showed that on average only 78% of women were seen within the target time. A recent serious untoward incident (SUI) report noted a two-hour wait in triage for one woman.

There have also been concerns reported internally and by staff over the admission of babies with a low body temperature to the neonatal care unit (NNCU). In early 2010 it was reported that babies with a low body temperature were being admitted to NNCU from the labour ward and in particular from the operating theatres. The issue was resolved after some months by increased training; however it was mentioned again at an internal maternity risk management meeting in May 2011.

## **Emergency care**

Concerns over the quality of care in the emergency department, especially at Queen's Hospital, were raised. Concerns raised by patients and relatives were in relation to waiting times and the quality of care provided, especially during the winter of 2010/11. People told us that they had extremely long waits in the emergency department and often experienced poor care. One person told us that they had been asking staff for assistance for their relative with mouth care for four and a half hours, only to be told that the staff were busy.

Queen's Hospital has had difficulty achieving the four-hour maximum wait to admit patients since its opening in 2006. Concerns were raised with regard to the poor flow of patients and long waiting times in an external review in 2008. In bed management reports in 2009, these difficulties still existed, the report noted that:

*'Since opening, in 2007, Queen's Hospital has had difficulty reaching the NHS four-hour waiting time standard for emergency cases. It has significant financial and staffing problems and is currently being supported in a turn around plan by the Department of Health'. In particular there were problems noted over weekend working: 'This weekend situation should score as at least 'extreme-major' if not 'extreme-catastrophic' in terms of the potential impact on reputation and adverse publicity. It is also not a one off event and would score at least as 'possible' if not 'likely' to occur again.'*

These concerns continued to be identified in minutes from the emergency department meeting in September 2010, noting that:

*'Patients as a rule should be ideally seen in chronological order and what sort of case it is, however now any patient who is deemed to pass the four-hour wait is left to concentrate on not breaching the next one. Overall the department sometimes looks like a medical ward with nurses and docs tied up with incredible pressure on bed managers.'*

Although waiting times have improved in recent months, there are still examples of waiting times being excessively long, and not always for clinical reasons. One patient whose records we reviewed at the beginning of August 2011 did not receive a diagnosis until they had been in the emergency department for six hours. This was during the night (when trust data indicates that the number of patients attending the emergency department is lower). We checked the records and spoke to staff and could not find any reason for the delay.

There are concerns regarding the care for pregnant women who present or who are taken by ambulance to King George Hospital. There is a perception among some staff that ambulance protocols do not include not taking high risk pregnant women to King George Hospital. However, protocols changed in November 2010 to ensure that ambulance staff take all high risk pregnant women to Queen's Hospital. We were also told that if a woman is in the mid to late stages of pregnancy, the emergency department would send her straight up to maternity services with no assessment or treatment in the emergency department. We were given a number of examples of women who were brought to the maternity department without any initial assessment, including one woman who was brought to the maternity unit with swine flu, which took maternity staff over three hours to stabilise her condition before transferring her to the intensive care unit.

Some improvements have been noted in the emergency department at Queen's Hospital. The department has introduced a rapid assessment team (RAT) initiative within the 'majors' stream where a team, led by a senior clinician, quickly assesses all 'majors' patients soon after their admission to the department. This initiative, along with improved flow through the medical admissions unit, has resulted in some improvements. Staff at King George Hospital stated that they are also considering introducing this approach once workforce issues have been addressed. The resuscitation areas in both

hospitals were seen as examples of good practice where patients appear to be cared for in a sequential, standardised and seamless manner. Staff emphasised that they have observed improvements in the emergency department over the last six months, for example improvements as to how trauma patients are managed.

We visited the emergency department at Queen's Hospital on a number of occasions, and on one such visit we undertook a spot check on compliance with one trust policy related to the insertion of intravenous cannulae. Unfortunately, none of the patients in the 'majors' stream had all of the mandatory documentation completed, nor were any of the cannulae signed and dated by the attending clinician as per policy. One of the senior staff said she wasn't surprised as there weren't any consequences for those staff who failed to comply with trust policies and procedures. Another member of staff stated that this may also be a reflection of the current middle grade medical workforce that is neither permanent, nor compliant with trust policies. This is a concern and a clinical risk, as it would be very difficult to retrospectively address procedural problems with staff related to technique or other compliance issues if they do not sign the cannulae and complete the necessary documentation.

## **Radiology**

We reviewed radiology services as part of the elective care pathway, and identified a number of concerns. Patients admitted for an angiography (a test examining a patient's cardiovascular system) need to stay in hospital overnight after their procedure. These patients are often admitted directly through the short stay surgical unit. This unit does not have overnight beds and these patients often require overnight beds. This can result in patients staying for up to 23 hours in the theatre recovery area. The staff on the short stay surgical unit have to contact the vascular wards to try and find a bed for the patient after their procedure. If the vascular wards are full, the patient stays overnight in the theatre recovery area; this happens several times a week. Even though the admissions are planned, there are still not always beds available.

We were told that staff on the wards are required to prepare patients for radiological procedures but this does not always happen. For example, on the morning of our visit a patient who should have been nil by mouth had just been given their breakfast. When radiology staff asked the ward nurse why this had happened no reasons could be given; we were told this happened regularly and goes unreported. Clearer pathways are being developed, along with a programme of staff re-education, but despite protocols being in place, they are not being followed in practice.

Minutes of the August 2010 vascular consultant meetings raises issues regarding interventional radiology service. It was stated that the service does not meet the level of care as set out in regional guidance. Further concerns were raised in an external review in January 2011 regarding staffing levels and capacity of the service, and a further external review in June 2011 gave the

service an amber rating regarding the availability of interventional radiology services being available on site at all times.

We were told that the radiological department is not fully compliant with a National Patient Safety Agency (NPSA) alert issued in 2007 concerning the need to ensure that radiology imaging results are communicated and acted on. The trust was alerted to the fact that they were non-compliant with this in 2010 following a reminder from the NPSA and they discovered that this had not been addressed. We were told that the risk posed by non-compliance with the alert from 2007 is on the trust's risk register, and the trust hopes to be able to procure an electronic information system to address the alert fully in 2013/14. In the interim, the trust has introduced a protocol for flagging incidental findings, in particular cancer.

There are difficulties in reporting some radiological tests, for example chest x-rays. Overall the trust has one of the longest reporting times for all radiological tests in the London area, but there are some exceptions, including some of the quickest reporting times for certain radiological tests performed on patients from the emergency department. We were told that there have been significant levels of non-reporting, for example with chest x-rays. We were told:

*'Some chest x-rays go unreported and these could have a positive result. This has been documented as having happened several times where someone has had a chest mass and it has worsened before being picked up by a later scan. This has resulted in poorer outcomes for patients.'*

Data from July 2011 indicates that, during the period from January 2010 to December 2010, only 44% of the backlog of chest x-rays were reported on. During January 2011 to July 2011, this had risen to 80% of the backlog of chest x-rays being reported on.

We received information that in September 2011 a 'never event' occurred (events that are so serious that they should never occur) during which a wrong site procedure took place in interventional radiology. The trust has raised this as a serious untoward incident and has already undertaken an internal review.

## **Discharge**

There were concerns raised about the discharge process within the trust, with a reported lack of consistency in applying discharge processes or recording decisions regarding the discharge of patients. There have been a number of personnel changes within the bed management and discharge teams, which has led to confusion over leadership and management of the teams. There have been a number of patients whose discharge had been delayed, in one case by 78 days as they were awaiting a bed in a community hospital. This was predominantly at Queen's Hospital.

We were told that one of the delays in discharge is due to lack of 'to take away' medication (TTA) at Queen's Hospital. Patients should be sent home with all of

their TTA medication. The pharmacy will dispense within one hour for urgent TTAs and four hours for a non-urgent TTA, and that doctors are requested to write the TTA 24 hours before discharge. The ward pharmacists identify patients due for discharge and request that TTAs are written by a doctor. However, doctors do not always write TTAs 24 hours before discharge. This causes significant delays and the departure lounge often has a number of patients who have been discharged, but are waiting for their prescriptions. For example, on 19 July 2011, five of the seven people in the discharge lounge had not had their TTAs requested until after they arrived in the discharge lounge. Patients sometimes leave without their medicines and either have to go back to hospital or send someone on their behalf, on occasions the medicines are simply not collected at all. Staff informed us that they have reported this issue, but they are not aware of anything that has been done to improve the situation.

There are two electronic bed management and discharge systems in place, and neither is apparently fully utilised. The two systems are not linked. One of the systems provides a record of the pathway that a patient is on and assists in discharge planning. It provides information on a patient's stay in the hospital, what clinical care they are receiving, and when referrals have been made to various staff as part of the discharge process. It can then provide a theoretical figure for the number of people likely to be discharged on any given day, but this can vary dramatically to the number actually discharged. For example, on one of the days that we were at the trust, the system indicated that there were 72 proposed discharges; when we followed this up the following day, there had only been 29 discharges. The system was introduced two years ago, but staff were not initially trained how to use it. A new drive has begun to get staff to use it since the new chief executive has been in post.

The second system is a live web-based system that should track a patient through their hospital stay and provide a 'live' picture of the number of beds in the trust. However this is not used by many wards, and those that do, do so not to maintain a 'live' bed state for the trust, but because it links into the hospital's patient administration system (PAS) so that information can be added to the PAS system indirectly.

There is a community discharge team that works within the trust and supports patients being discharged from the hospital. They have links with the hospital discharge team, though no one we interviewed from the hospital discharge team told us about them. The community discharge team take referrals from staff via another electronic system, but told us that around 50% of the referrals did not meet the criteria for referral to the community discharge team. We were told that nothing has been done to reduce this level of inappropriate referrals or to provide hospital ward staff with training to assist with the discharge process. We were also informed that the local authorities differ slightly in the community services that they provide, which impacts on the ability for patients to be discharged, with a lack of neurological rehabilitation the biggest concern for the majority of staff we spoke to.

## **Surgery**

Vascular services were transferred to Queen's Hospital in March 2011. We did not receive any major concerns from patients or relatives regarding vascular surgery, though we did receive a number of complaints about care in other surgical specialities.

However, while following the elective surgical pathway, some concerns were identified regarding the quality of care that patients experience in the day surgery unit and how this is planned.

Patients coming for routine gynaecological surgery are consented at a pre-admission appointment or in the outpatient department. In contrast, we were told that most general surgery patients are not consented beforehand. The patients arrive on the unit at 07.00 and are consented by the consultant that morning. We were told that this has resulted in some patients refusing their consent or asking for more time to think about the procedure.

For example, there were two patients on the day we visited who were not sure they wanted to go ahead with the procedure after the consultant explained it and wanted time to think. We also reviewed a set of patient's notes; the consent form did not cover the risks associated with general anaesthetic, and in this instant the patient was asthmatic and there was no evidence of a discussion of the risks this may pose to the patient. For patients who take anticoagulation medication (drugs that slow down the blood clotting process), they are told to stop taking this medication prior to surgery. However blood tests to check how quickly the patient's blood clots are not done until their arrival on the unit. Although the results take less than two hours, patients have to wait for the results before being able to have surgery. Sometimes their operation is cancelled or staff have to reorganise the operating list to accommodate the wait for these blood test results.

Further issues with day case surgery were also identified. We were told that there are occasions when patients requiring gynaecological procedures are added to the emergency surgery list at the end of the day, for surgery the following morning. These patients are often requiring surgery due to a miscarriage of their pregnancy. The patients are added to the day surgery list at 18.00 the day before, but day surgery staff do not know about the numbers of patients until 07.00 the following day when they see the days operating lists. At this point, the unit is already full with planned admissions, so a number of the patients requiring a gynaecological procedure are required to wait in the units lounge until a bed becomes available. Many of these patients complain about waiting in a crowded waiting room for long periods of time, and staff told us that they are subject to verbal abuse by patients *'on an almost daily basis'*.

## **Other experiences**

Although we followed three specific pathways, we were informed of a variety of other experiences by patients and/or their relatives. It is important to note that a

number of these were positive. Those people that commented on their experiences in oncology were positive about their experiences of care, for example:

*'Since the beginning of March my wife has been under the excellent care of Dr XXX and has just completed six intravenous chemotherapy treatments and four intrathecal treatments. Her care by Dr XXX and Dr XXX has been beyond anything we could have imagined and the...trust should be thankful that they have such competent, professional and caring specialists on their staff.'*

Also people provided us with examples of good quality care in cardiology.

However, the majority of information we received from patients was to outline experiences of poor quality. We recognise that the respondents were a self-selected group and that it is common for people to respond to feedback requests with concerns more often than compliments.

While the majority were in relation to maternity care and emergency care, other examples were in orthopaedics, medicine and surgery. For example, the relative of one patient told us that, despite their relative having a broken hip, nursing staff on two occasions attended alone to place their relative on a bed pan, one of the nurses rolling their eyes and walking off when the relative told them that their relative has a broken hip. Another relative told us that their husband was not assisted for over a week to have a shower, despite her husband wanting to have one. We were told that it took persistent requests for staff to take her husband to have a shower.

## **Recommendations for the trust**

### **The trust must:**

#### **Emergency department**

- Develop its strategy and work for improving flow of emergency/urgent patients. This strategy needs to have the engagement of all clinicians and managers as a key component.
- Develop a culture where everyone feels empowered to challenge episodes of variable or poor practice, including regular monitoring of practice and feedback and learning opportunities for staff.
- Ensure that all staff, both permanent and temporary, follow hospital policy and procedures.

#### **Radiology**

- Develop its planning and bed management processes to ensure all patients are cared for in appropriate facilities.

- Put in place clear protocols for the management of interventional radiology patients with audit and improvement cycles to ensure standards are attained and maintained.
- Ensure that it fully implements the 2007 NPSA alert regarding radiology imaging results being communicated and acted on as a matter of urgency.

### **Discharge**

- Develop its discharge and bed management teams and processes to ensure that they are interlinked and that patient flow is managed effectively from the point of entry to the point of discharge.
- Ensure that clear guidance outlining the expectations of all staff is produced and enforced so that the prescribing and dispensing of ‘to take away’ medication is managed effectively and patient discharges are not delayed. The trust needs to ensure that it monitors adherence with policy, guidance and audit and takes any appropriate action to support staff to deliver a high quality service.
- Review and rationalise the discharge and bed management information systems to ensure that the most effective and accurate system is fully utilised.

### **Surgery**

- Develop its day case surgery service to ensure that appropriate patient flow is maintained including effective pre operative assessment.
- Improve standards of care for obstetric patients who undergo minor surgical procedures.

## Co-operating with other providers (Outcome 6)

Both the trust and NHS partners, including commissioners, reported that historically there have been difficult relationships between them. Staff at the trust and stakeholders also described a variation in the quality of relationships with other providers, for example, care home and nursing home providers.

Senior staff at the trust stated that there have been strained relations with commissioners and indicated that they believed there was some evidence of anomalies across the region with regard to commissioning decisions. The trust has recently agreed a common assurance framework with their commissioners and this was confirmed by stakeholders.

Evidence provided by both the trust and stakeholders raised some concerns regarding effective working relations with providers of social care services in the area. For example, staff at the trust told us that many patients from care homes did not need to be admitted to hospital, and this issue has been raised a number of times with community providers, but that providers were not working with the hospital to reduce numbers of admissions. However, stakeholders indicated that patients are often discharged to care and nursing homes at inappropriate times of day, for example, late evening and with a lack of communication from the trust.

However, there was evidence of integrated teams working across the trust to support the discharge of patients. Some staff are employed by the local community trust but work within Barking, Havering and Redbridge University Hospitals NHS Trust to facilitate discharge either to social care or to community hospital beds.

Another area of concern raised by staff was the accessibility of some specialist community rehabilitation services, particularly neuro-rehabilitation services. Staff indicated that a lack of neuro-rehabilitation had resulted in a small number of patients experiencing long delays in their discharge.

External stakeholders described a culture at the organisation that is defensive, denying that problems existed and not open in discussions with them. The stakeholders we spoke to told us specifically that during the winter period of 2010/11, they raised concerns with the trust regarding access to its emergency care, but were told that there were no problems in the department. However, evidence from the trust indicates that there was contact with stakeholders and through the media regarding the difficulties being experienced in the emergency department. Stakeholders did acknowledge the positive impression that the new chief executive was making, but also felt that they needed to see sustained improvements as so much had been promised before but not delivered by previous boards of the trust.

## **Recommendations for the trust**

### **The trust must:**

- Continue to engage, and develop effective working relations, with external providers and partners.
- Work with partners to ensure adequate provision of specialist rehabilitation services.
- Work with social care partners to develop robust working practices to ensure appropriate admission and discharge practices.

## Safeguarding people from abuse (Outcome 7)

The trust's safeguarding arrangements have recently been assessed as part of the joint regulatory assessment of children's safeguarding and services for looked after children as part of the Ofsted/CQC inspection of Havering Local Authority. Additional information can be found in those recently published reports.

The trust had committees for safeguarding adults and safeguarding children, which discuss a range of issues regarding its safeguarding arrangements, including education for staff. Minutes from the committee meetings indicate that a range of issues are discussed, for example the February 2011 minutes include a report and discussion on trend analysis from safeguarding referrals. There were also discussions and reviews regarding the prevention of pressure sores, which had previously been raised as a concern with the trust.

The trust had a number of vacancies at a senior level in relation to safeguarding arrangements, although it had begun to recruit to these vacancies. The lead for adult protection had been in post for only five months, while the post of named nurse for child protection had been vacant since May 2011 and was being covered by the named midwife for child protection. There was a named doctor for child protection who is an associate specialist. We were told that the trust is in the process of appointing a consultant who will take over this role.

Stakeholders indicated that the trust had been historically poor when working with safeguarding boards, although they did note that they had seen recent improvement in communications with the trust, as well as a more appropriate level of representation on safeguarding adults boards, with people who are empowered to make decisions. The trust indicated that they were using pan district safeguarding policies and procedures; this was confirmed by stakeholders.

Data supplied by the trust showed some variation in the number of staff who had completed safeguarding training. Training was split into a number of different levels but more applicable staff had completed level one training than levels two and three. For example, in the surgical division 82% of applicable staff had attended level one training, while only 33% had attended level two training.

The staff we interviewed told us that they received training in children's safeguarding, but a proportion of staff told us that they did not receive training in safeguarding adults. This was particularly so in the emergency department. However, staff were able to articulate to us how they would recognise safeguarding concerns and what they would do in those circumstances.

During our observations at the hospital, we looked at the records of a child who had attended the emergency department. Possible safeguarding concerns with the child had been raised in the emergency department. The child had been admitted and transferred to the children's ward. We spoke with staff in both

clinical areas and looked at what action they had taken and documented. At all times during the process, staff appeared to have taken the correct decision and had reported their concerns appropriately.

## **Recommendations for the trust**

### **The trust must:**

- Complete the recruitment of senior staff into safeguarding roles.
- Ensure that all staff are able to access and receive the appropriate level of safeguarding adults and safeguarding children training.
- Continue to develop its joint working practice with external partners.

## Cleanliness and infection control (Outcome 8)

The trust has been subject to three separate inspections under a previous regulatory regime regarding the prevention of healthcare acquired infections. These took place during 2009 and 2010. Improvements were identified in five different areas in the 2009 report including requiring a programme of audit, ensuring the environment is kept clean and that effective arrangements are in place for the decontamination of instruments and other equipment. A follow-up visit in February 2010 identified that some areas of concern from the previous visit had not been rectified. A final visit in March 2010 identified that all concerns had been rectified.

The trust has in place a board level lead for infection prevention and control. There is a well established infection prevention team in place. There is an infection control committee. There was evidence that infection prevention audits are in place, for example commode cleaning audits in ward areas and in the emergency department and hand hygiene audits. There is reporting to the board regarding infection prevention and control and the infection prevention and control staff are currently developing a link into the main reporting dashboard. Training is provided to staff and a programme of winter preparation is in place.

The number of patients with hospital acquired MRSA infections is generally lower compared to the number of patients with *Clostridium difficile* infections. There was a sudden peak of hospital acquired MRSA infections in December 2010 with three confirmed cases, but this has been stable since. The number of *Clostridium difficile* infections peaked between September and October 2010, but fell sharply by the end of October 2010. Following a slight increase, the number of *Clostridium difficile* infections appears to have stabilised, but the trust is still higher than average when compared to other trusts.

During the site visit we observed a wide range of clinical areas and spoke with staff about the cleanliness of clinical areas. In general, clinical areas were clean and staff indicated that they were able to access domestic staff when required. We saw alcohol disinfectant gels at the end of beds and in the entrance to wards. We also observed signs around the hospitals advising visitors of the need for good hand hygiene. We did identify some examples of poor practice with boxes of equipment and intravenous fluids stored on storage room floors. We also identified a potential problem where patients who have attended the emergency department with orthopaedic conditions and need to return for procedures in the day surgical unit are not screened for MRSA. We raised this with the infection prevention team and they reacted promptly, putting in place a process to ensure that these patients are screened appropriately.

Some concerns were raised by patients over cleanliness, especially the public toilets in the emergency department at Queen's Hospital. Staff raised concerns over audit of infection prevention in maternity, with some staff indicating that no audit takes place and others indicating that staff in maternity use their own audit tools that are separate from the rest of the trust.

Another issue identified is that many of the female medical staff, especially in the emergency department, wear small handbags when treating patients. This was also identified by a woman who told us that a midwife had worn her handbag all the time while delivering her baby, and may increase the risk of cross infection.

## **Recommendations for the trust**

### **The trust must:**

- Ensure that all equipment and disposable products are stored appropriately.
- Ensure that all public toilets are kept clean especially in areas of high usage.
- Ensure that maternity audit processes are integrated with the rest of the trust.
- Ensure that staff are not posing an increased risk to patients from cross infection. The trust should take any necessary steps to ensure that staff can store personal property as necessary.

## Management of medicines (Outcome 9)

Concerns were identified with the management of medicines. These concerns were largely in relation to 'to take away' (TTA) drugs as outlined previously in this report. Other concerns were identified in relation to pain relief for women in labour, also outlined earlier in this report.

Patients raised concerns with us over the availability of pain relief on general wards, but the majority of patient concern was with regard to the availability of TTA drugs.

Staff told us that the pharmacy department undertake audits of medication prescribing and administration; for example an audit of antibiotic usage and an audit against the NPSA alert on insulin has been completed. The results of audits and projects are presented via the safer medication practice group and clinical governance group. We were also told of some of the changes to practice that have occurred, including changes to paediatric drug charts and the oral syringe policy.

During our site visits to both Queen's Hospital and King George Hospital we observed examples of medication errors. In the medical admissions unit at Queen's Hospital three out of four charts we looked at had errors, including evidence that drugs had not been signed for, or administered at the wrong times. We also noted that oxygen was not being prescribed for patients; we raised this with staff who confirmed this was the case.

We spoke with staff about reporting drug errors and, while staff were aware of the process to do this, not all staff told us that they receive feedback following the reporting of medication errors, though we did see evidence of the analysis of drug errors reported in the newly developed newsletter from the pharmacy department.

Staff in the emergency department told us of an open culture with regard to medication errors where staff were provided with additional support to learn from errors, rather than a blame culture existing.

## Recommendations for the trust

### The trust must:

- Reinforce its policy on medication prescribing, dispensing and administration, ensuring that all staff are aware of their roles and responsibilities.
- Ensure that the results of learning from medication errors are widely publicised across all services in the organisation.

## Safety and suitability of premises (Outcome 10)

There are a variety of issues concerning the premises specifically at Queen's Hospital. The hospital was opened in 2006 following the closure of two local hospitals. There is a confusing layout, especially on the ground and first floors. The hospital is of a circular design with inner and outer rings. This makes it more difficult for people to get their bearings. In comparison, we did not find the same concerns regarding the safety and suitability of premises at King George Hospital.

Sign posts on the ground and first floors at Queen's Hospital are confusing and often point in opposite directions. There are numerous additional locally made signs stuck to the main hospital signs to help visitors and patients find the area they are looking for, but these are in various shapes and forms which can be hard to read and add to the confusing nature of the main signs. The number of ward moves hasn't helped this, as additional temporary signs are added when wards move location. While walking around the hospital, we observed numerous times people asking for directions as they couldn't work out how to leave the building, and in some cases the staff they asked were also unable to direct them. We did note the presence of an information desk that is large and easy to access in the atrium, and leaflets to provide further guidance.

The paediatric waiting area at Queen's Hospital offers no line of sight to observe children in the waiting area. We were told this has caused problems in the past when sick children could not be readily observed. The trust is aware of this and told us that they are beginning to plan alterations to improve this.

Poor line of sight is also a problem for staff with patients who are on trolleys waiting for x-rays in the emergency department at Queen's Hospital. Currently patients wait in the corridor next to the x-ray department, but this is outside the main part of the emergency department and there is no one to observe these patients apart from administration staff. While on the site visit at Queen's Hospital we observed an elderly lady who spent 25 minutes alone outside the x-ray room. She had been assessed as requiring observations and these were not undertaken. The trust told us they were aware of these problems and are planning to employ a nursing assistant to observe these patients. In addition, we were told that the x-ray room in the emergency department was never designed as such (we were told it had originally been planned as a discharge lounge), and so there is limited space to get trolleys in and out of the room. For patients who could walk, there are no changing rooms, so staff have to leave the x-ray room to allow patients to get undressed before their x-ray.

Also in the emergency department, patients who attend the urgent care centre have little space to wait, and on the majority of days on which we attended Queen's Hospital, patients and visitors were seen sitting on the floor and on the window ledge. Staff also told us that there are not enough toilets for the public in the emergency department, and that blind spots in the middle of the majors section of the emergency department means that not all patients can be observed by staff in that section.

There are a number of wards and departments at Queen's Hospital that have no windows and therefore no access to natural light; both staff and patients complained about this and the impact it has on them.

While the general wards on higher floors had access to natural light, the circular design of the wards meant that lines of sight could be poor. Staff told us it was difficult to observe the patients all the time especially at night when fewer staff were present.

As outlined in the section on the care and welfare of people who use services, for patients who stay for up to 23 hours in the surgical theatre recovery space, toilet facilities are inappropriate and the areas does not have any natural light. The female toilet does not have a hand rail and is not suitable for people who use wheelchairs. The toilet is located in the area of the recovery unit where people who have just had surgery are cared for. Women using the toilet have to walk through this area, so compromising their privacy and the privacy of the patients from theatre.

The male toilets are located on a corridor between the theatre rooms and the recovery unit. All of the rooms on this corridor were found to be unlocked, so could be directly accessed by men using the toilet facilities. The security of the premises is therefore at risk.

The shower facilities were difficult to access for people having just undergone surgical procedures. The women had to go to another ward on the same floor and the men had to use the facilities on another floor. Staff told us that most of the men are discharged without a shower due to the location of the showers.

## **Recommendations for the trust**

### **The trust must:**

- Review the directional signage at Queen's Hospital. The trust should ensure that it seeks the input of patients, relatives, visitors and staff, to ensure that any new signage meets the needs of its populations.
- Review the emergency department paediatric facilities at Queen's Hospital in line with the standards outlined in *Services for children in Emergency Department's* document and then develop an appropriate strategy involving both the emergency and paediatric departments.
- Finalise and implement plans to improve x-ray facilities and ensure that patients waiting for x-rays in the emergency department are appropriately cared for.
- Ensure that appropriate waiting facilities are available for patients and relatives in the urgent care centre.

- Explore options and take action to improve access to natural light and ventilation in all clinical areas that currently do not have windows at Queen's Hospital.
- Review and take any necessary action in all inpatient areas to ensure that there are clear lines of sight so that patients can be observed at all times.
- Develop appropriate facilities to ensure the day case surgical patients are cared for in appropriate environments at Queen's Hospital.

## **Safety, availability and suitability of equipment (Outcome 11)**

Access to equipment was generally satisfactory, though there were differences across the two sites. At King George Hospital, staff did not articulate any specific concerns with access to equipment for example fluid pumps or monitoring equipment or disposable equipment. At Queen's Hospital, staff in the emergency department indicated that they often did not have enough of the correct equipment in the right locations. This is partly due to the design of the emergency department, where the different parts e.g. majors and minors are not located immediately next to one another, making utilisation of equipment more difficult. Under the contracting arrangements put in place when Queen's Hospital was built using the private finance initiative scheme, medical devices at Queen's Hospital are supplied as part of this contract.

Access to disposable equipment at Queen's Hospital could be difficult. In a number of interviews, staff reported that they would often run out of equipment before the end of the week. When we asked what they would do about this some simply said it was the responsibility of the manager, and did not recognise any responsibility that they may have to ensure that disposable equipment is available; such attitudes are unacceptable.

Staff at Queen's Hospital told us that they had problems accessing equipment such as fluid pumps and monitors. This was because, as patients were transferred between wards, equipment wasn't returned and staff spent time searching for equipment to ensure that their ward had enough.

Senior staff told us that a lack of equipment had always been a problem at Queen's Hospital, though they believe this is partly due to the acuity of patients increasing and requiring more equipment due to the complexity of their conditions.

The trust has indicated that there are systems in place to audit the availability of equipment. Although staff articulated their concerns to CQC, the trust has not received any requests from the divisions for further equipment and it stated that staff do not appear to be following the correct process for ensuring they have sufficient equipment.

Another issue raised related to access to sufficient stationery. We were told by a number of staff from different clinical areas that they often ran out of stationery and paper specifically, and their orders for additional stock would be refused.

However, not all staff indicated that there were problems accessing equipment. Staff in the intensive care unit at Queen's Hospital were happy that disposable equipment is readily available and, when monitors are faulty, the supply company is quick to attend and the problems are resolved quickly.

Some staff raised concerns over availability of therapy equipment such as wheel chairs; we were told it could take anything from two weeks to four months to get a wheel chair, especially if a larger wheel chair was required. Some concern was also raised about access to equipment from the community for patients being discharged, with differences being experienced between the different local authorities.

## **Recommendations for the trust**

### **The trust must:**

- Review the availability of medical devices in clinical areas to ensure that appropriate levels of equipment are available for the acuity of patients that it receives at Queen's Hospital. Further revalidation of the review needs to take place following any changes to service provision.
- Ensure that systems are in place in all clinical areas so that sufficient disposable equipment is available.
- Develop as part of its cultural change programme people's sense of responsibility to take positive action to ensure that clinical areas are suitably equipped to provide safe patient care.

## Staffing (Outcome 13)

From the data supplied by the trust, an accurate figure for the number of vacancies could not be established. The vacancy totals and funded establishment calculated across different staff groups and divisions from the documents provided by the trust did not match. This meant that it was not possible to conclusively determine the number of vacancies. Furthermore, CQC was told that there had been no systematic skill mix reviews or needs analysis that would assist the trust to determine an appropriate funded establishment level.

What was clear from the documents was that the trust has too few permanent staff compared to its funded establishments. This is shown by the high usage of temporary staff and the numerous recruitment drives being conducted. For example, in the emergency division over the period August 2010 to March 2011, over 50% of the division's pay bill was spent on agency and bank staff. The trust is implementing new systems to enable it to more clearly identify where vacancies exist. All posts at the trust are now individually numbered, so when they fall vacant it will be easier to identify them and thus recruit to them.

Vacancy problems also appear to be significant in the other divisions. In addition to high levels of vacancies, staff turnover and sickness rates have all at various times been high. The trust's overall sickness levels for 2010/11, although still higher than the NHS average, are now only 0.13% above; whereas they were 1.06% above in 2008/09. Although the majority of problems as a consequence of a lack of staff are focused on Queen's Hospital, we were also told that recruitment at King George Hospital is difficult. We were told that this is due to the uncertainty surrounding the hospital and its future. This does cause problems at King George Hospital where areas that are staffed to their funded establishments lose staff to other wards at the hospital.

A lack of registered nursing and midwifery staff is also highlighted by the fact that the trust has the lowest ratio of nurses to beds of all London acute trusts. The main areas of recruitment difficulty for the trust appear to have been around midwives and middle grade doctors, although problems recruiting consultants and nursing staff in general have also been noted. These difficulties have led to the trust increasingly pursuing international recruitment.

Given the impact on the quality of care due to a lack of staff, the trust's workforce strategy for the years 2010-2013 worryingly includes the statement:

*'To achieve its cost reduction plan the Trust anticipates that the headcount will need to reduce by circa 850 FTE (including temporary staff) during the period 2010 to 2015.'*

The document goes on to suggest that the reduction in staff numbers will be achievable due to the increase in community provision. However, as outlined in this report, throughput of patients continues to rise, especially at Queen's Hospital. The trust has stated that these proposals were based on the models

being proposed within the *Health for North East London* consultation and that the workforce strategy will be subject to revision once the final decision regarding the consultation is made.

Lack of staff is not just a problem in maternity services and the emergency department; a breakdown of nurse staffing levels in the surgical division provided by the trust for June 2011 showed the vacancy rate among qualified and unqualified nursing staff was running at 18%, and individually between wards varied from 1% to 34%. The same is seen with medical vacancies across the trust. Information on the current position in the emergency department in July 2011 indicated that there was a vacancy rate of 31% for consultant medical staff, and further vacancies across a range of medical positions, especially those identified as staff grade doctors.

Despite the high level of medical vacancies in the emergency department and the long standing difficulty in recruiting medical staff, when we spoke to senior staff in the emergency department, their vision for the service was restricted to a 24-hour consultant led service. Some thought had been given to utilising other staff groups, but the vision of using other staff groups to deliver care was limited. There are a small number of emergency nurse practitioners (ENP) who might work more autonomously for those patients attending with minor injuries and illnesses. However, ENPs have historically been pulled from their work to undertake traditional nursing roles when there is insufficient flow (that is patients are not being transferred to wards or discharged from the emergency unit quickly) to attend the needs of patients awaiting admission to hospital. This reduces the clinical exposure of the ENP group, who may never gain the confidence in treating a wider range of clinical presentations. We were told that when this occurred after Queen's Hospital opened in 2006, a proportion of ENPs left as they were dissatisfied with their roles. A meaningful workforce review or staffing plan cannot be undertaken until an overall emergency department strategy has been developed. Some of the perceived need for extra staff may not be required once a more structured pathway is introduced and working styles are changed.

From discussions with staff and the review of evidence, it is clear that the trust has been taking positive action recently to recruit permanent staff. Since the new chief executive has been in post, weekly rolling adverts have been stopped and more targeted recruitment plans have been put in place. Evidence seen from the three clinical specialities under review and from talking to staff indicates that the trust is beginning to take proactive action, and staff indicated that the newly recruited staff are beginning to have a positive impact at the trust. For example, the emergency department at Queen's Hospital has been able to meet the four-hour target to admit patients with greater regularity since the recruitment of more permanent staff.

Although the trust has begun to recruit staff to fill vacancies, the next step is to ensure that staff are deployed effectively and their skills used appropriately. One concern raised with us was the lack of paediatricians to carry out post natal checks and the impact this was having on discharges from the maternity units.

However we were also told that a number of midwives are trained to undertake specific post natal checks but are not utilised.

We were also told that there is variation in expectation and role between staff on the same *Agenda For Change* band. For example, there are 20 band 8b nurses working in bed and site management and five band 8b nurses working in the emergency department. While these roles may be entirely appropriate, the trust is currently unable to establish whether these roles are functioning effectively or indeed need to function at this level, as no skill mix or needs analysis has taken place.

There have been longstanding problems with staffing in obstetrics and midwifery. There has been a programme of overseas recruitment in midwifery and a large number of midwives have been recruited. We were told that, while this is beginning to have a positive impact, a knock-on effect of this is often a poorer skill mix, as many of the new staff are newly qualified midwives who need greater supervision.

Obstetric cover was identified as a problem by the trust, and was included in the risk register as recently as December 2010. In 2007, a report by the Royal College of Obstetricians and Gynaecologists recommended that there should be 24-hour obstetric cover due to the size of the unit at Queen's Hospital. The follow up review in 2008 found that this level of cover had not been implemented and, in 2011, a further external review found that, while there was 98 hours a week of cover (the trust being only one of two in the London region to achieve this level), this was still 70 hours short of the recommendations made four years earlier. Staff also indicated that the lack of middle grade doctors in obstetrics continued to have a detrimental impact on the effective delivery of obstetric services.

There are concerns over the lack of anaesthetic cover which is a long standing issue; the trust's level 2 assessment for the clinical negligence scheme for trust's (CNST) in 2009 found that the trust was non-compliant in the standard related to staffing levels of obstetric anaesthetists and their assistants. The risk of harm due to insufficient anaesthetic cover in maternity was on the unit's risk register in June 2010. Discussions about extending hours of consultant anaesthetic cover continue to take place. A recently agreed action plan does require that there should be a consultant anaesthetist present on Queen's Hospital labour ward from 08:00 to 20:00 Monday to Friday and on-call at other times. There has been a delay in implementing this, and the proposal is currently being consulted on. As noted previously, the trust is aware that women are not always receiving epidural pain relief in a timely fashion due to a lack of anaesthetic cover.

We were told, for example, that there are currently problems with the number of interventional radiologists. With an establishment of six, there are five in post, but with one interventional radiologist on maternity leave and another on long-term sick leave, the trust has had to seek support from other organisations in the London area. There are also concerns over the lack of paediatric nurses in the emergency department. Another group of staff where there appears to be too few, are porters. Staff across both sites commented that this integral role

often has too few staff in post, and that accessing them can be difficult. This group of staff are not directly employed by the trust but are provided by an external company as part of the contractual arrangements put in place when the new Queen's Hospital was built.

We were also told of vacancy problems with allied health professionals. The trust is aware of this and has taken steps to recruit allied health professional staff. A recent bid for a vascular physiotherapist and assistant has been made, as an audit completed by the therapists demonstrated the clinical effectiveness of extra therapy input into the vascular pathway.

We were told that additional therapy staff were employed in older people's care during the last year as there were too few staff. However, this meant that there was an over spend of £0.5m, as the original plans for Queen's Hospital included the closure of a number of medical wards which had not all occurred.

We were told that there are only two speech and language therapists for Queen's Hospital, though they are provided by another NHS trust, and the trust now realise that, as capacity has not reduced, a staffing increase of around 50% is required in this department.

A large number of staff raised concerns over poor support from human resources for example a lack of support and/or training for managers to assist them in dealing with staff performance management or disciplinary hearings. There is also the perception among staff of a reluctance to discipline poor performing staff and dismiss them where appropriate, because the pressure of high vacancies meant that there was reluctance to use disciplinary procedures. We were told that if performance measures were commenced against staff, they would often take a grievance out against the manager, which would then take considerable time to be concluded. This is not an unfamiliar claim, but should not detract from its relevance.

The trust has provided evidence that there has been an increasing number of staff suspended over the last three years, and that it has been dealing with a comparatively high number of formal procedures against staff compared with other trusts. The trust has also indicated that it provides a variety of training for managers, and has introduced a probationary period for some staff recruited from overseas to ensure they are able to perform competently in their roles. We were also told that since the new chief executive has been in post, a number of nursing, midwifery and medical staff have been suspended.

Some staff and stakeholders raised concerns over whistle blowing at the trust. We were told by one staff member in midwifery that they have not raised their concerns over skill mix in maternity services as they believed that they would be victimised. The staff member told us that she was aware of other colleagues who had raised concerns and this had happened to them. We were also told by a stakeholder of concerns that had been raised with them in 2010 by a member of staff in a department at Queen's Hospital, and that they became aware from this individual that the trust was attempting to discipline staff as a result of the whistle blowing.

Concerns were also raised regarding mechanisms to link complaints made about clinicians with their overall performance. We were given a number of examples where complaints had been made about clinicians either internally or externally, which had not been linked in any formal way with HR processes when such linkage would have been appropriate. For example we were told of a clinician who was performing diagnostic tests that were outside local and National Institute of Health and Clinical Excellence (NICE) guidance. Two colleagues had managed to raise their concerns, but were frustrated that it was difficult to raise issues such as this and as far as they knew no resolution to the problem had been achieved. While the trust has outlined how complaints made in this way are handled, it was apparent that this did not work effectively in all instances.

## **Recommendations for the trust**

### **The trust must:**

- Continue to review its human resource information systems and ensure that accurate data is available for the entire organisation, so that a clear and comprehensive understanding of vacancies can be established.
- Continue to review its workforce strategy to ensure that it meets the needs of the organisation and reflects the reality of service delivery.
- Undertake systematic skill mix and staffing needs analysis to ensure that they have the right staff with the right skills at the right locations and that trust is receiving value for money.
- Continue to recruit appropriate permanent staff to ensure that it reduces its reliance on agency and locum staff improving the quality of care, and have in place effective retention strategies.
- Develop and improve the human resources support for the divisions so that managers can take effective action against staff where there are performance concerns.
- Explore and develop strategies for delivering services with different staff groups so that reliance on difficult to recruit staff groups is reduced.
- Support a skills escalation programme in the emergency department that seeks to develop nurses who have already successfully completed an emergency nurse practitioner or advanced clinical practitioner course and reduce reliance on them undertaking traditional nursing duties due to shortages of staff.
- Ensure that its whistle blowing systems and processes allow staff a route to raise concerns early so that quick action can be taken and staff feel empowered to raise concerns.

## Supporting workers (Outcome 14)

The trust is a university hospital and as such has links with a number of education establishments. There is a large well structured education and training department, led by the director of human resources, and is an integrated structure between nursing, medicine and allied health professionals. Structurally, beneath the director of human resources there is a director of education and a director of medical education, and a number of other education and training posts in the clinical directorates and within specialist departments that help to deliver education and training across the trust.

There is an education board that has representation from staff at different levels of the organisation. There are a variety of sub-committees under the education board, whose role is to understand the training needs analysis of staff and ensure that it is commissioned appropriately. The sub-groups have representation from all directorates and allied health professionals. The same approach is applied to medical education, where a variety of sub-groups cover undergraduate, post graduate and consultant level education and report into the education board. The trust produces an annual education and learning report and the most recent report to March 2011 outlines the successes and areas for improvement across the trust.

There is a generic study leave policy which staff can access. The trust has a variety of education centres and was successful in attracting funding to open a simulation training centre in 2011. A variety of training opportunities are provided for staff internally, and there are links with the trust staff bank to ensure that bank staff have access to appropriate induction training.

There were mixed views from staff on access to mandatory training; the majority of staff indicated that they had received mandatory training, while others indicated that such opportunities were not available to them. We heard that this usually correlated with staff vacancy problems.

Data from the trust, though focusing on the three clinical pathways that form part of this investigation, indicate that while many staff do receive mandatory training some do not. For example, only 61% of staff in the surgical division have received mandatory training for moving and handling people.

The majority of staff we spoke told us that they had access to training. The greatest difficulty was time, and this was especially so in areas that had staff vacancies. For example, allied health professionals raised concerns about access and this tended to correlate to a lack of staff. The same issue was seen in areas such as the emergency department and maternity. We were also made aware that maternity services have operated in isolation regarding education and training from the rest of the trust. We were told that the education and training division were not involved in the recruitment of midwives from overseas, despite the obviously large impact this would have on education for these new staff. We were also told that senior managers were offering midwives the

opportunity to undertake master's level education; but that this did not meet the trust's study leave policy and was therefore inequitable to other staff in the trust.

As a university hospital trust, there is large number of medical training posts with a total of 366 whole-time equivalent (WTE) training posts at the trust during 2010/11, ranging from foundation year one doctor's through to specialist training posts. As part of their information submission, the trust provided CQC with a range of visit reports from the deanery and speciality schools, the results from the most recent postgraduate medical education and training board (PMETB) survey of junior doctor's experience at the trust, and the trust's responses to recommendations and requirements made by the schools/deanery visits. In addition to this we interviewed a range of medical staff from across the trust, and spoke with stakeholders.

In the surveys, the trainees expressed concerns that high workload and work intensity was a potential risk to patient safety, with this being particularly evident in anaesthesia and emergency medicine (the medical admissions unit and acute medicine especially). These workload pressures are being caused by vacancy and recruitment difficulties at the trust, resulting in trainees being used to deliver activity at a detriment to their training experience.

There were also problems raised with the hospital at night system where:

*'Concerns were raised about paediatrics, with a responsibility for crash calls and neonatal nights from day one, especially as the rota is shared with more senior staff.'*

There were also a number of positive aspects identified, with 18 out of 24 foundation year one doctors at Queen's Hospital and all foundation year one doctors at King George Hospital saying they would recommend the programme. Among the foundation year two staff, all but one at Queen's Hospital and all at King George Hospital would recommend the programme, although the medical admissions unit was noted by both groups as being particularly difficult. The deanery annual quality liaison visit also praised the handover arrangements, the trust level induction, the recently introduced "learning opportunities" database, and the increased presence of consultants at speciality training committees.

A more recent external review outlines the problems at the trust, but also recognises that:

*'While there remain problems with training in some departments important changes in PGME... (post graduate medical education)... has taken place in others and there is a change programme in place that is likely to produce further significant improvements.'*

Some concerns were raised within obstetrics and gynaecology and in anaesthetics, where concerns were found that 'several consultants were not interested in teaching', and staff grades who acted as a 'buffer between trainees and consultants out of hours' with the perception that several (consultants) 'are unwilling to help trainees in acute situations'.

This is in line with the outcome of a number of interviews CQC undertook and is outlined within this report.

The above information correlates with the views of medical staff who we interviewed, the majority of whom felt that although workload could be high there were reasonably good opportunities for education and learning. Where we found less positive responses was within obstetrics, where we were told a lack of middle grade staff reduced the number of learning opportunities for trainees.

Two other concerns were raised with us regarding training in maternity services. Firstly, a series of skills and drills training has been introduced to help train all maternity staff and forms part of the clinical negligence scheme for trust's (CNST) requirements. However, we were told that this has been arranged for a Saturday and medical staff were not consulted on its introduction. This has meant that not all medical staff are attending the training that, by its very nature, needs to be multidisciplinary and is a requirement of the CNST standards. It is unclear why this time was chosen or what action had been taken to encourage attendance.

The second concern was over training to try and deal with the long standing problems over the incorrect interpretation of cardiotocography (CTG) readings (a method for recording fetal heartbeat and uterine contractions during labour). This has been an area of concern since at least 2007, and contributed to a number of serious untoward incidents in 2010/11. By June 2011, only 65% of midwives were up to date with their CTG training. We were told that 100% of doctors were up to date; this is what was reported on the performance dash board. However, we were also given evidence from July 2011 that showed many consultants had never logged on to the computer system to undertake their training, which we were told was the only way of undertaking the training, and of those that had logged on, a number had not completed the training. It is, therefore, unclear how the performance dashboard information was verified.

Supervision is a problem in some areas of the trust. There is an ongoing issue with a lack of supervisors of midwives. A review carried out in 2007 by the Royal College of Obstetricians and Gynaecologists found that the ratio of supervisors to midwives was 1:23, despite a nationally agreed standard of 1:15. The review reported that day-to-day supervision (especially in the labour ward) needed to improve. Some junior midwives and doctors were very inexperienced and likely to need closer support. The issue was unresolved at the time of their 2008 follow-up review. Another external review in 2011, however, found that the ratio was 1:26 and stated that it would improve to 1:20 by May 2011. However, this does not appear to be borne out by the trust's data, which shows a ratio of 1:24 from February to June 2011. One midwife told us:

*'There are some very good supervisors but they carry the rest of the team. I don't think anyone values them. They cannot challenge management. Supervisors are also fearful to challenge midwives, especially those who have been here a long time.'*

We were also told that many supervisors were also working in their own time to ensure that supervision was being provided to all midwives.

Concern with supervision is not limited to midwives; inadequate supervision of medical staff has also been raised on numerous occasions in internal meetings, and two recent SUI reports cited inadequate supervision of junior doctors as a contributing causal factor. Concerns about lack of supervision have been raised at maternity risk management meetings, supervisors of midwives meetings, and the obstetrics and gynaecology board (concerns that major obstetrics procedures are being carried out by registrars unsupervised).

The majority of clinical directorates are not meeting the trust's target of 100% of staff having had an appraisal. However, there are a number of divisions that have attained over 80% of their staff having had an appraisal, and data from the emergency department at King George Hospital indicated that around 95% of staff had received an appraisal. During interviews with staff, a lack of appraisal was not raised with us as a major concern. Data from the national staff surveys also indicates that, while there are many concerns raised by staff, one area that has seen improvement is with regard to staff receiving an appraisal.

## **Recommendations for the trust**

### **The trust must:**

- Continue to develop and deliver training for staff to support the development of quality services, seeking alternative solutions where staff have difficulty accessing training due to staffing constraints.
- Ensure that appropriate supervision is provided to medical staff and that more junior medical are not left without appropriate support, especially at weekends and at night.

## Assessing and monitoring the quality of service provision (Outcome 16)

Governance systems in the trust do not appear to offer sufficient assurance to the board that they are effective. There is a lack of linkage between clinical directorates and the board and there is a lack of learning from incidents. There have been numerous changes at executive level, and in the last financial year we were told that of £1m savings at a corporate level, £145,000 were from the governance department alone. This has directly impacted on the number of staff who work within that department and the department's ability to function throughout the organisation in effectively embedding systems and good practice.

There has been a focus on finance at the trust in recent years. While this is understandable given the trust's financial difficulties, the lack of focus on quality and patient care is not. We were told that at board level there was previously a lack of challenge by non-executive directors. We were told that this is beginning to improve with the new non-executive directors, but there appears to be inequality with non-executive workload, with some non-executives involved in a large number of committees and others not. There is also an underdeveloped corporate governance structure that further impedes the functioning of the board and trust and again limits assurance.

The trust has in place governance structures in terms of staff. There are a range of staff that work corporately including the clinical governance director, risk manager, legal services manager, and clinical governance facilitators. Each division then has a clinical governance lead and some divisions also have audit leads.

However, from the information supplied by the trust a number of concerns were identified.

Since June 2011 the trust's governance reporting structure has changed. The quality and safety committee (QSC, previously the clinical governance committee (CGC)) and the audit committee (AC) are directly accountable to the trust board. From the evidence submitted by the trust, 10 sub-committees feed into the QSC, including the safeguarding committees, the clinical risk management committee and the nursing and midwifery board. The only group to feed into the AC is the statutory safety committee. The AC also monitors the board assurance framework and risk register.

However, from the evidence submitted by the trust, lines of communication are unclear; there is a risk of duplication or of issues being missed. The clinical governance reporting structure for June 2011 indicates that there are 13 committees or boards that report (directly or indirectly) to the trust board. However, there are others, such as the productivity efficiency and quality board (PEQ), education board and 'implementation groups' which are not included in the structure (although the *'Education and Learning Directorate Annual Report'* indicates that the education board reports through the quality and safety committee) and so it is not clear who they report to. For example, according to

the clinical audit process flowchart, divisions provide assurance of compliance to the clinical audit committee (CAC), which in turn reports to the audit committee (AC). The structure then indicates that the AC then reports to clinical governance and on to the trust board. However, according to the clinical governance reporting structure, the CAC directly feeds into the QSC not the AC. The trust is beginning to address these concerns and began implementing a new structure during the investigation. In July a new trust executive committee began and replaced a number of other committees that were previously in place, for example the productivity, efficiency and quality board.

The purpose of the quality and safety committee is to make recommendations to the board in relation to trust objectives and developing strategies and plans. The terms of reference state that the committee is responsible for ensuring the board assurance framework is core to identifying and managing the organisational risks. However, according to the clinical governance reporting structure (June 2011), the board assurance framework and risk register inform the audit committee. Since January 2011 and the development of a performance dashboard, the meetings of the QSC have become more focused on risk. Each division provides updates on identified risks at both the QSC and AC. While it is on a rotational basis at the AC, there is a potential for the same issues to be discussed and actions already agreed elsewhere to be duplicated or made redundant. Overall, there appear to be overlapping remits and a lack of cohesion.

This complex system was highlighted by one incident we were told of, where a statutory stakeholder had requested information on an incident in maternity but received a response that indicated the incident had not occurred (when in fact it had). When we followed this up, we were told that the response had been as such because the incident was still caught up in the trust's reporting systems and hadn't reached the respondent before they replied. This was compounded by the fact the staff spoken to in the women's and children's division regarding the incident were not aware of it either.

The trust has been slow to implement changes and drive improvement. This can be attributed to the variation in the effectiveness and quality of its committees. The Quality Account for 2010/11 outlines the trust's current situation with CQC, what it believes it has done well and what it has not done so well. The problem areas highlighted are surgical, emergency and women and children; all have a reliance on temporary medical and nursing staff, among other issues. The same three areas are the focus of the trust's priorities for 2011/12. The Quality Account demonstrates that trust management has an overall understanding of the key issues; however some issues were identified a year previously, yet improvements have been slow.

The May 2011 governance briefing produced following the quality and safety board meeting, stated that there was a failure across the trust to close the audit loop by producing and implementing action plans. No action had been taken by the women and children's board despite the number of outstanding audits highlighted at the January and March 2011 board meeting.

The notes for the women and children's board are brief and appear to be more of a 'message board'; issues are listed, but no actions or deadlines are documented. In April 2010 the women and children's division presented at the audit committee, summarising the actions taken over the past year. The risks identified in this presentation were also identified by CQC in early 2011, so despite the presence of an action plan, improvements had not been made and positive outcomes could not be evidenced.

The notes for the emergency board paint a similar picture. In October 2010, new incident reporting books were *'being chased'* and this was still the status in March 2011. Incidents and complaints are regularly discussed and it is acknowledged that the number of complaints has been *'creeping up'*. However, there are no actions listed in the minutes and results of investigations do not appear to be shared with the board. In the October 2010 meeting, concerns were raised about which drugs anaesthetists were using when they came to resuscitation area in the emergency department. It was not until March 2011 that it was agreed it needed to be included on the risk register. In February 2011 the emergency division provided an update at the audit committee. The minutes imply that members of the audit committee were frustrated by the presentation as it gave a lot of information, but the presenters were *'asked several times what was the department doing to off-set the risks'*.

The trust collects a lot of performance information, but this is not presently used effectively to drive change. Based on the evidence reviewed, the trust has extensive data from external reviews, national and local audits as well as action plans from governance groups and independent work streams. An external board review report, however, states that while the organisation is *'data-rich'* it is *'light on meaningful information'*. The quality and effectiveness of the committees vary, as does the information they feed upwards and there is a potential for management to be overloaded with information. The QSC discuss numerous documents submitted prior to meetings, and an external review found that information was often too long and lacked systematic follow-up of issues and recording of outcomes.

The trust board itself commented in May 2010 that the trust appears to be *'dependent on external reviews and visits, rather than its own internal quality system'*. In February 2011, the QSC highlighted that the trust needs to examine how findings from external reviews are being captured. Furthermore, it is slow to respond to external findings. At the safeguarding adults meeting in June 2010, it was reported that the findings from an external review that took place in 2009 had only just been shared with the trust board. The minutes acknowledge that the trust had not been proactive in following this up.

While CQC has been provided with a range of evidence that specialities and directorates undertake audit and discuss risk and incidents, hold multidisciplinary team meetings and discuss mortality and morbidity, there is evidence that lessons are not learnt and that some staff do not understand incident reporting. For example while tracking one patient we discovered that there had been complications following an interventional radiological procedure. This had resulted in the person bleeding profusely and had required the

insertion of a central line (a catheter which is placed into a large vein in the neck, chest or groin. It is used to administer medication or fluids, obtain blood tests and directly obtain cardiovascular measurements such as the central venous pressures). The insertion of the central line caused a pneumothorax (a collection of air or gas between the chest wall and lung), but none of this was reported as a clinical incident. The majority of staff we spoke to told us that they document any incidents that occur, but that they do not hear of any actions or feedback once these forms have been passed on to the risk management team.

There is a lack of learning and sharing across the organisation. We were told that, following the death of a mother and her baby at the trust in 2011, only the staff from the antenatal ward were involved in learning from the event as this is where the incident occurred. Staff from other wards in maternity services expressed frustration to CQC that they were not actively involved in this learning to ensure that these tragic events were not repeated. The independent investigation into another death in maternity services at Queen's Hospital more recently identified concerns and issues that have been raised elsewhere in this report, including poor communication, an on call consultant that did not attend the hospital, lack of anaesthetic involvement, poor documentation and lack of recognition of the seriousness of the woman's condition. Many of the staff we interviewed told us that they did not get feedback from reported incidents and that they believed that there was a lack of learning at the trust.

## **Recommendations for the trust**

### **The trust must:**

- Ensure that it has adequate systems of governance to promote high quality care for patients and to deal with concerns about performance in an effective and timely manner.
- Develop a system of governance that offers it accurate and real time information that translates into an effective assurance process.
- Carry out a comprehensive review of all corporate and clinical governance systems across the organisation to ensure that effective and streamlined systems and reporting structures are in place to provide robust assurance to the board.
- Ensure that it has systems in place that allow effective sharing and learning across the whole organisation.
- Ensure that the incident reporting system for the whole trust is operating effectively and all staff are learning from incidents rather than simply reporting incidents.
- Ensure that it has appropriate levels of staff in place to allow its governance systems to function effectively and that these staff are embedding appropriate systems in clinical services.

## Complaints (Outcome 17)

The trust's ability to deal with and respond to complaints was described to CQC as '*awful*'. In fact the level of distress it caused to some patients and relatives who spoke to CQC was as bad as the poor care experiences they were complaining about in the first place.

Certainly the majority of stakeholders and especially MPs and local councillors condemned the complaints process and this was one of their biggest complaints about the trust apart from the quality of care.

The trust frequently misses its own targets for timeliness in response. Some patients and relatives wait weeks simply for an acknowledgement of their complaint. Others told CQC that they simply hadn't received any response. The poor timeliness of responses is compounded by a process that simply does not answer the complainant's questions and in many cases leaves the complainant with more questions. This is partly due to many of the responses seen by CQC simply providing an overview of the care someone received, which from the complainant's perspective does not match their recollection of events and does not answer the concerns they raised.

The trust received 665 complaints in the year 2010/11. This places it in the top 10 most complained about trusts in England. There are a high number currently being investigated by the Parliamentary and Health Service Ombudsman. The investigation reports from the Ombudsman highlight a number of recurring themes, including the complaints process being inadequate, poor initial investigation by the trust, lack of communication between staff, the patient and relatives, staff failing to spot warning signs of deterioration in patients and acting quickly enough, and a lack of learning by the trust.

A number of these themes are also identified in the serious untoward investigations following recent deaths in maternity services. Indeed data submitted to CQC regarding maternity services indicated that the target for the number of complaints received in the unit is less than four per month, but 10 were received in February 2011 and 14 in both April and May 2011. In addition to this we were told that, as obstetric records are not tracked on the same system as the rest of the trust, it is often difficult to locate these records especially when answering high risk complaints or legal requests for information.

The trust has a high number of contacts with its patient advice and liaison service (PALs), and has seen a rise in the number of complaints this year (2011/12). We were told that the reason for the increase in complaints this year was that a decision was taken in the previous year to reclassify certain complaints under a new category. This category was 'PALs serious'; and the complaint was then dealt with by the PALs team. We were told that the reason for doing this was to be able to report a drop in the number of complaints that the trust received as issues dealt with by the PALs team were not classified in the same way. We have been told that when changes to the complaints team

were made last year and responsibility for complaints changed to another person, this practice was stopped immediately. A report highlighting this concern, along with the need to have an open and accessible process for dealing with the outcomes of Ombudsman's investigations, has been shared with the board.

Stakeholders and complainants alike both state that the trust's approach to complaints management is defensive, and obfuscating. This was supported by staff who indicated that time is often spent collecting data and information for people to be able to '*cover their backs*', rather than being used objectively to focus on improving services. There is some reporting to the board on the number of complaints, but we were told that trend analysis does not take place due to a lack of staff working in the governance department.

The trust has recently undertaken a review of its complaints processes. In its review the trust recognises that its complaint processes are poor and that during 2010/11 it only responded to 64% of complaints within 30 working days, whereas the target was 80%. The trust also recognises that there is no effective trend analysis or learning from complaints, which is a common theme throughout the evidence gathered. The trust outlines in its review how it intends to improve its complaints handling. There is a staged process to place complaints management back into the clinical directorates, and for corporate services to handle the overall management of the complaints process to ensure time frames are met. The trust has also restructured its response templates to try and ensure that they are more effective in answering the complainants concerns. These changes are being put in place at present; however, we were told by a variety of patients, relatives and stakeholders that the problems outlined above are still occurring. Some stakeholders did indicate that they had seen some improvement in the last three to four months, but this is clearly not yet systematically embedded in the organisation.

## **Recommendations for the trust**

### **The trust must:**

- Continue to develop and improve its complaints handling systems to ensure that complaints are responded to fully and in a timely manner.
- Develop and support staff to ensure that open transparent investigations take place, that complainants are involved as necessary and that culturally complaints are seen as opportunities to learn and improve the quality of care.
- Ensure that any staff identified in a complaint are involved in resolving the complaint and the resulting learning, but where there is a complaint about an individual there is appropriate separation of the investigation from the individual.
- Develop its reporting mechanisms to ensure that the board are fully informed of all complaints, that detailed trend analysis takes place and that the board can assure itself that learning is taking place, and repetition of themes is reduced.

## Records (Outcome 21)

During the course of the investigation we spoke to a number of staff regarding record keeping, as well as reviewing case notes and tracking patients across the trust at both hospital sites.

The quality of records that we looked at was generally in line with established standards. However, there were a number of examples where staff had not completed all elements of the assessment record, especially in the medical admissions unit, and where discharge information was missing for patients discharged from the emergency department. There were also various omissions in records such as drug charts unsigned, missing or no risk assessments, and missing discharge information and other incomplete assessments.

Concerns were raised about the number of record systems that are in use in the trust. For example, maternity services have their own tracking system for records and this does not link with the rest of the organisation. The emergency department also has its own system and staff told us that they didn't use the trust's patient administration system (PAS). We were told that this can lead to difficulties if women present in the emergency department who have recently given birth. If the patient is unable to tell the emergency staff about their condition, for example because they are unconscious, then staff in the emergency department would not know of the recent maternal episode of care.

Another concern that was identified in a number of records reviewed was a lack of chronological ordering, and case notes that were in danger of physically breaking apart. Staff also told us and we saw from some of the records we reviewed that patients can have multiple sets of records. Some patients we reviewed were on their third set of temporary records. We were told that tracking records was difficult and, in some of the multiple notes we saw, there were transcribing errors for data such as name and date of birth. Staff also told us that gaining access to records stored off the hospital site was difficult. It appears that this is a long-standing problem at the trust and has been noted in other reports.

In addition to this, we saw examples of where health record binders were being reused for different patients. We saw examples where new front sheets were simply stapled over the front cover of the records, having previously been used for another patient. This could lead to the wrong notes being in the wrong file. This possibility was illustrated to us by a parent who told us that his wife had been questioned by social services staff as their baby's health records contained information that may suggest that the baby was at risk of abuse. However, it transpired that the records of three babies had been mixed up and that another baby's record had been placed within the wrong records. We were told that it had taken over two weeks for the issue to be rectified, and was very distressing for the parents concerned.

Staff at King George Hospital told us that porters were now used to collect records out of core working hours. This was having an impact on the availability

of porters to undertake other duties, and we were told that no information governance training had been provided for staff undertaking this role.

The poor records tracking system in maternity services results in problems in tracking down records to assist in responding to complaints or requests for copies of health records. We were also told that some maternity incidents have not been investigated as the records cannot be found. Patients and stakeholders also reiterated the difficulty in getting access to maternity records and the time the trust took to arrange this. The risk of maternity records being lost or misplaced was rated high risk on the unit's risk register in both June and December 2010, when it was noted that a new systems was being looked into. Also on the register is a historical risk that care plans are not being documented or completed. However, this was still rated as high risk on the register in December 2010. In December 2010 it was also noted that CTG recordings were '*still going missing*'. The standard of record keeping has been on the register for some time, and in December 2010 it was stated that there was no evidence that this was improving. It was noted at maternity risk management meetings between May and October 2010 that MEOWS (modified early obstetric warning score) charts were not being used in the antenatal ward. In May 2011 it was stated that maternal observations were not going immediately into the charts, meaning that trends could not be immediately identified.

## **Recommendations for the trust**

### **The trust must:**

- Improve its systems for records management to ensure that notes can be retrieved effectively and expediently, and reduce the risks associated with multiple sets of temporary notes and poor data handling.
- Develop integrated patient administration and information systems to ensure that, where ever a patient is being treated within the trust, their full healthcare history can be accessed by all staff.

## Leadership

The trust has experienced frequent changes to its board. Since February 2011 there has been a new chief executive in place. Since the chief executive was appointed, a medical director has been appointed following a number of years where non-permanent staff have provided this function. A number of new non-executive directors have also been appointed and an interim chair has been in place since 2010.

Despite the short time that the new chief executive has been in place, there was almost universal praise for her. Staff commented that they felt they were being listened to and that for the first time in many years they believed that progress could be made to improve the quality of care and standing of the organisation. Staff also praised the leadership of the nurse director and medical director and noted that this triumvirate of individuals were demonstrating good leadership across the trust. Some staff were positive about working at the trust. One nurse told us that *'I'm proud to work here. I love this place and want to make it good'*. However, this was often an isolated voice among many staff who articulated a widespread defensive culture among some senior staff, with poor leadership and a lack of vision.

Some staff also raised concerns about the lack of a director of operations or chief operating officer and noted that the absence of this post has had a negative impact on the trust and its ability to drive forward improvements. We were told that the lack of this role and the culture of the organisation was such that the chief executive has a large number of senior staff all directly responsible to that one individual, which can risk there being a loss of focus for the chief executive; and culturally we were told that this meant that the chief executive would have individual meetings with separate executive directors and not as a whole group. Since the appointment of the current chief executive, this approach to individual executive director meetings has ceased, and a director of operations has commenced in post in October 2011. Staff commented positively on the visible leadership programme that has been introduced across the trust by the director of nursing.

External stakeholders described a culture at the organisation that is defensive, denied problems existed and not open in discussions with them. Although stakeholders that we spoke to told us specifically that, when they raised concerns with the trust during the winter period of 2010/11 with regard to accessing emergency care at the trust, they were told that there were no problems in the department, evidence from the trust indicates that there was contact with stakeholders and through the media regarding the difficulties being experienced in the emergency department. Stakeholders did acknowledge the positive impression that the new chief executive was making, but also felt that they needed to see sustained improvements as so much had been promised before but not delivered by previous boards of the trust.

So many of the staff we spoke to talked about an ingrained culture of blame and uncaring professionals, though this was predominantly in maternity services

where around 25 of the staff we interview raised concerns of this nature. Staff also told us of a learned helplessness of many staff who did not see it was their responsibility to tackle poor practice or issues raised with them, or who had grown tired of seeing a lack of management action to tackle these problems that they no longer saw it as their issue.

The attitude of some midwives has been raised with CQC on numerous occasions. One midwife told us that she had overheard a colleague say to a woman in labour *'hurry up or I'll cut you'*. Another midwife told us that she was ashamed to work at the unit and hadn't realised how poor practice was until she observed care at another hospital. We have outlined other examples of the unacceptable attitude of some midwives elsewhere in this report. What is of concern is that this culture in maternity services has been prevalent for a number of years.

This is compared with an example of how senior staff dealt with poor staff attitude on one surgical ward. The manager had received a number of complaints about the attitude of staff, so arranged for some of the complainants to meet with all the ward staff and explain how their attitude affected the quality of their hospital admission. This was followed up with the introduction of a yellow card scheme, which is used to warn staff when they are heard by colleagues behaving inappropriately to patients; this has led to improved behaviour as a consequence.

We were told that maternity services operate in isolation from the rest of the trust; in a *'silo'*, with separate bed and site managers, on call structures and clinical governance arrangements. There was some acknowledgment that signs of change had been witnessed recently, for example the trust does two hourly bed checks and maternity staff now take part in this system. We were told the role of midwifery supervisors was one of frustration and lacked authority. We were told that not all supervisors performed to a high standard, but that their poor performance was not being dealt with; and of management decisions being made with no involvement of other senior midwifery staff.

Staff and patients told us that poor staff attitudes are also prevalent in other clinical areas; one patient told us that while an inpatient at King George Hospital they listened to medical staff shout to the patient in the next bed to him: *'Mr xxx your blood test was so fatty, that we could not get anything from it'*.

We were also informed of poor examples of medical leadership. One doctor we spoke to described a recent serious incident where there was a lack of support for junior medical staff following the death of a patient. We were also told that some consultants do not like to attend the hospital at weekends when they are on call, and of *'undermining behaviours by consultants'* at the trust.

There is also a lack of cohesion across the trust, with different clinical directorates and staff not working together but almost as if in competition. We were told that bed management meetings have often been combative, with directorates simply not engaging to ensure the flow of patients around the trust is as effective as possible. We were told that it took a great deal of time and effort by staff in the emergency department to change the systems for patients from the ear, nose and throat (ENT) service to receive a wound dressing

change. Prior to this change, staff in the ENT service would simply send their patients to the emergency department to have their dressing changed, when this was not appropriate, and meant that staff in the emergency department were diverted away from caring for acutely ill patients. This has been resolved and the ENT has set up its own dressing clinic, but was another example of directorates not working together to improve patient care.

One final issue raised by staff was over what they perceived to be poor external communications by the trust. The perception of staff is that the trust did not seem proactive in telling a more positive side to the organisation. This was also echoed by some stakeholders and patients. While the trust acknowledges that staff and others may hold these views, it has provided a range of evidence to demonstrate how it endeavours to communicate the positive side to the organisation. This can be evidenced for example on the trust's website, and via its newsletter *Hospital Life* (also available on the trust's website).

Staff also have the same perception regarding internal communications. Some staff, especially in the maternity unit, were frustrated that when incidents occurred, they sometimes only heard about them through the local press and not via internal communications. Staff also felt that greater emphasis should be placed on sharing positive news internally and more actively. For example, while some staff were aware of the various awards schemes that are in place in the trust, it was clear from staff interviews that these do not have a high profile with many. While the trust acknowledges that staff may hold these views, it has provided a range of evidence to demonstrate how it endeavours to communicate with staff across the organisation. For example, there is a weekly newsletter and monthly team brief as well as messages from the chief executive.

## **Recommendations for the trust**

### **The trust must:**

- Ensure its board assures itself that it has the right leaders and managers in place to develop the trust and improve the quality of services.
- Put a cultural change programme in place across the organisation. The programme of change needs to engage all staff so that the trust can clearly articulate what the expectations are of individual staff, what a high performing organisation feels like to work in and be clear of the penalties for staff they should not behave appropriately.
- Develop a culture of whole systems working across all divisions to reduce 'silo' working and the combative nature of bed management.
- Develop a programme of support for managers so that staff with the capability can be freed to undertake their managerial roles effectively.
- Explore how to improve its communications both internally and externally so that perceptions of poor communication can be reduced.

## Capacity

Issues of capacity at the trust were not part of the initial terms of reference. However, the terms of reference under section 2 state that CQC retains the right to consider *'any other matter which CQC considers arise from, or are connected with, the above matters'*.

CQC recognises that it is for the Secretary of State to agree any recommendations that are presented as part of the independent review of the configuration of services in outer north east London.

However, we were presented with a number of concerns by staff, patients, members of the public and stakeholders, and these concerns are highlighted below.

One concern that was consistently raised with us by both staff and stakeholders was that of capacity, and specifically the over utilisation of Queen's Hospital and the under utilisation of King George Hospital. We were told that the current high level of activity in maternity services at Queen's Hospital means that women are discharged too quickly and that the quality of care is often poor.

Since the opening of Queen's Hospital, many services have been moved from King George Hospital. For example, vascular surgery is now only carried out at Queen's Hospital, all high risk pregnancies are managed at Queen's Hospital (which means that of around 10,000 births each year, 7,500 to 8,000 are at Queen's Hospital and 1,500 to 2,000 at King George Hospital), along with stroke services and trauma services.

Many staff at the trust and stakeholders told us of their concern about the level of activity in maternity care at Queen's Hospital. Staff told us so many women attend maternity services at Queen's Hospital that they are *'simply pushed through the system as quickly as possible'* and that is one of the reasons for the poor quality outcomes that some women are experiencing in that service. An independent review of maternity services at the trust was undertaken at the beginning of 2011, which concluded that *'Capacity at Queen's is of major concern to the review team'*. The recommendations from this review included the need to develop measures to ease the capacity at Queen's, including *'an impact assessment of the changes at KGH. It should also include an updated Escalation Plan, with clear indicators relating to capping numbers at Queen's and temporary closure if required in the interests of patient safety'*. In addition to this, the report made a number of other recommendations for services at Queen's Hospital, including the development of the departure lounge and the improved use of telephone triage, day case assessment and an increased use of community midwives. However, as has been explored in this report, while the trust has implemented a number of these recommendations, some have not had a wholly positive effect on the quality of the maternity experience for many women.

Concern was also raised over the transfer of vascular care to Queen's Hospital in 2011. An external review carried out prior to the centralisation of services on the Queen's Hospital site highlighted concern with access to intensive care beds for major vascular surgical patients.

Similar concerns were raised with regard to emergency care and the ability of Queen's Hospital to deal with the levels of attendees at the trust. Many staff would describe the emergency department at Queen's Hospital as 'chaotic'. Since Queen's Hospital opened in 2006, the trust has had difficulty in meeting the four-hourly access targets (the national target is to admit, discharge or transfer all patients within four hours of arrival at the emergency department). Staff and stakeholders both alluded to the fact that the emergency department at King George Hospital is under utilised while Queen's Hospital is over utilised. Some of the additional utilisation is due to the centralisation of services on the Queen's Hospital site such as vascular and neurosurgical services, as well as the trauma services; and indeed the pace of the emergency departments was very different during our site visits. Staff indicated that the design of the emergency department at Queen's Hospital didn't assist with the flow of patients and caused bottlenecks, which in turn led to delays in patient transfer and long waits.

There are capacity issues at Queen's Hospital emergency department as there are many examples of patients waiting for long periods of time. The systems and processes adopted within the emergency department at Queen's Hospital and King George Hospital have until recently reflected a traditional model of care delivery, where patients are pushed along a pathway that can often appear uncoordinated and punctuated with a whole series of non-value adding waits and queues that make little or no sense from the patient's perspective. Capacity issues elsewhere in the urgent care pathway have been shown to affect this experience, leading to poor care and unsafe working practices. This creates the cycle of shortage of cubicles, an inability to review patients, capacity bottlenecks and then a spiral of increasing delays, decreasing patient safety and variable compliance with the four-hour target and the new clinical quality indicators.

Staff at the trust have begun to address the problems associated with the flow of patients through the emergency department. At Queen's Hospital, a rapid assessment team (RAT) initiative within the 'majors' stream has commenced for core working hours, where a team, led by a senior clinician, quickly assesses all 'majors' patients soon after their admission to the emergency department. This initiative, along with improved flow through the medical admissions unit, has resulted in some improvements to the flow of patients which was also recognised by paramedics that we spoke to.

An audit of the effectiveness of the RAT system has been carried out and has shown some improvements; patients who have been assessed in this way are less likely to wait over four hours for admission, are referred to other specialities more quickly, and will be assessed more quickly by an emergency department clinician, though the time to treat patients does not differ much after this first assessment from those who have had a rapid assessment.

There are plans to implement the RAT system at King George Hospital once workforce issues have been addressed, and there remains a number of issues that still need to be addressed in terms of improving patient flow, including better working relations with other clinical specialities, improved discharge management and bed management, and reducing processes that add built in delays to patients admissions. For example, when a patient is assessed in the emergency department by an emergency department clinician and a decision to admit is made, some specialities then require a junior doctor from that speciality to undertake a further assessment of the patient, rather than accepting the clinical decision of the emergency department clinician.

The three local authorities that are served by the trust raised concerns over the provision of maternity services, and where they are currently sited. The Barking and Dagenham and Redbridge local authorities both told CQC that they have expanding multicultural relatively young populations and high levels of teenage pregnancies. In contrast, we were told that in Havering a third of the population is over the age of 65 and this raises different health issues for the population in that area.

Why this was raising concerns with these stakeholders was the fact that King George Hospital is geographically located for the populations of Barking and Dagenham and Redbridge, whereas Queen's Hospital is geographically located for people living in Havering, and yet provision for maternity services was predominantly from Queen's Hospital. What was compounding this from the stakeholder's perspective was historically poor transport links between the two areas (though stakeholders did note that the trust had ensured a bus stop was built outside Queen's Hospital). It should be noted that poor transport links between the two areas was also raised on numerous occasions by patients, relatives and other stakeholders. We were told that, depending on where someone lived, it could take around one and a half hours to travel from the Ilford area where King George Hospital is based and where the population is growing to Romford where Queen's Hospital is based. We were told that, due to higher levels of poverty in the Barking and Dagenham and Redbridge areas, people relied on public transport more and these poor links had a detrimental effect on access to health services for people.

## **Recommendations for the trust**

### **The trust must:**

- Improve the flow of patients not only in the emergency department, but across the whole hospital to ensure that processes that do not add value are removed and patients are seen and treated in a timely fashion.

## Appendix A: Terms of reference for the investigation

1. The Care Quality Commission (CQC) has the power to conduct an investigation into the provision of NHS care under s48 (1) (2) (a) of the Health and Social Care Act 2008. The criteria under which CQC will conduct an investigation are at Appendix A of the enforcement policy. The exercise of this power would permit CQC to raise concerns with the Secretary of State for Health under the formal power under s48 (5) of the Act. CQC in this instance is relying upon the exemption Section 81(4).
2. CQC is concerned about the outcomes for patients using the services of this trust. It will carry out an investigation into the systems and procedures that are in place to ensure that people are protected against the risk of inappropriate or unsafe care and treatment, these will include:
  - a. Reviewing an emergency care pathway we will investigate the systems for admission (including emergency), internal transfer, discharge and external transfer of patients, including working in conjunction with other stakeholders.
  - b. Reviewing an elective care pathway we will consider the system for admission
  - c. Review the maternity services care pathway.

The pathway investigations will identify and assess:

- The systems for ensuring that at all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying out the regulated activity.
- The systems for respecting and seeking the views of people using the service and their representatives.
- The systems for seeking the views of staff.
- The systems for assessing and monitoring outcomes for people.
- The systems for ensuring appropriate standards of cleanliness and hygiene and prevention, detection and control of the spread of health care associated infections.
- The systems for ensuring equipment is properly maintained and suitable for its purpose.
- The systems in place to develop the culture of the organisation, in particular individual responsibility and whole trust working.
- The ability of the organisation to deliver a high quality teaching environment contingent with its role as a teaching hospital.
- The systems in place to support management for medicine.
- Systems and processes for identifying, assessing and managing risk and their effectiveness.

- The analysis and learning across the organisation from board level down of incidents that resulted or had the potential to result in harm to people.
  - The systems for service improvement by learning from adverse events, incidents, errors and near misses. This should also include using information from safeguarding concerns to identify non-compliance or risk of non-compliance and decisions made to return to compliance.
  - The procedures followed in the management of abuse and the systems to monitor these.
  - The overall effectiveness of governance structures (including committee structures and reporting mechanisms).
  - Any other matters which CQC considers arise from, or are connected with, the matters above.
3. The investigation will involve speaking to patients, relatives and frontline staff and observing care delivered at this location. It will also involve gathering evidence through examination of records, speaking with internal and external stakeholders and requesting written statements. When appropriate CQC will work in partnership with other agencies to gather evidence, this may include the SHA and the PCT.
  4. An investigation under the Act gives CQC the option to look at the provision of health care across a local system. In order to ensure that recommendations made are deliverable to enable the trust to secure ongoing compliance against essential standards.
  5. CQC may take enforcement action at any time during the investigation if there is evidence of major concerns and risks to people.
  6. The Regional Director will act as the sponsor of this investigation and will use the findings to inform the ongoing monitoring of compliance. This will ensure that any evidence and recommendations made will feed into a review and the appropriate regulatory actions can be taken, this may include enforcement action if required. The investigation team will be independent of the compliance team and will therefore review the effectiveness of previous compliance actions.
  7. The investigation will focus on the periods from the date of the trust's registration under the 2008 HSCA.  
This will ensure that evidence in any improvements will be clearly identified from the date of registration.
  8. The evidence gathering period, including preliminary site visits, of the investigation is planned to run over a period of not more than eight weeks.
  9. CQC will publish a report on the findings of the investigation, and will make recommendations as appropriate to the trust and other relevant bodies.



### **How to contact us**

Phone us on: **03000 616161**

Email us at: **enquiries@cqcc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at:

**Care Quality Commission**

**Citygate**

**Gallowgate**

**Newcastle upon Tyne**

**NE1 4PA**

Please contact us if you would like a summary of this document in another language or format (for example, in large print, in Braille or on audio CD).