Update on investigation report

Barking, Havering and Redbridge University Hospitals NHS Trust

Queen's Hospital

King George Hospital

June 2012

Contents

1.1 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; 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. The three areas have different demographic backgrounds. Havering has a population of around 232,000 and low levels of deprivation, Redbridge has around 264,000 people and average levels of deprivation, and Barking and Dagenham has around 172,000 people and high levels of deprivation.

Queen's Hospital at Romford is in the Havering local authority area, and is the main hospital for people from that area, while King George Hospital is in Ilford, and mainly serves people in Redbridge and Barking and Dagenham.

1.2 Regulatory background

The Trust had a history of poor performance under the previous regulatory framework, prior to CQC registration in April 2010. It has long-standing and escalating debts. There have been numerous changes at executive level.

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

CQC saw some signs of improvement, but its judgement was that continuing to tackle poor care on a case-by-case basis was not going to address deep-seated problems at the Trust. As a result, the Commission took the decision to launch a full investigation into the quality of care at Queen's Hospital and King George Hospital.

The investigation was designed to assess the systems and procedures the Trust had in place to ensure people were protected against the risk of inappropriate care and treatment. The CQC team focused on three care pathways – maternity, elective vascular surgery, and emergency care, and examined the Trust's governance and management systems. More details are available in the full investigation report (available on CQC's website www.cqc.org.uk), which was published in October 2011 and updated with further sections in November 2011.

1.3 CQC's investigation

This report is an update on progress against 81 recommendations which were made as a result of CQC's investigation.

A CQC investigation allows the regulator to make recommendations outside its scope – for example, to draw attention to service configuration and commissioning issues. These issues can have a direct or indirect impact on the provider's ability to deliver care that meets CQC's essential standards of quality and safety. Responsibility for implementing these recommendations sits with the provider and, where appropriate, with commissioners.

The full set of recommendations addressed a range of outcome areas covered by CQC's essential standards: respecting and involving people, care and welfare, safeguarding, cleanliness and infection control, management of medicines, equipment, staffing, supporting workers, assessing and monitoring the quality of service, records, cooperating with other providers, and complaints.

A Trust-wide action plan was introduced in response to the recommendations. A project board was appointed by the Trust in December 2011, chaired by the Trust's medical director, to ensure that the action plan was implemented and that progress against this was reviewed fortnightly.

The final section of this report assesses progress against each of the 81 recommendations. This assessment is partly based on the Trust and NHS London's views, but CQC's inspection findings have also been considered. Some of the Trust's views on progress have been modified where inspection evidence suggests otherwise.

Progress against these recommendations is not equivalent to compliance with CQC's essential standards. Where the recommendations have an impact on care outcomes that fall under CQC's core regulatory remit, compliance has been checked via inspection. As a result, this report includes a summary of recent unannounced inspections at the Trust. Full reports for these inspections can be found on CQC's website.

Several themes are highly significant in light of what CQC's investigation found – particularly issues around leadership and governance, maternity, accident and emergency care, and complaints handling. As a result, a brief section on each of these has been included in this report in summary.

2.1 Executive Summary

CQC's view is that Barking, Havering and Redbridge University Hospitals NHS Trust has made satisfactory progress against most of the recommendations made in its investigation.

The investigation has stimulated a clear improvement in the safety and quality of care in maternity and radiology services at the Trust. Governance and leadership structures have been overhauled as a result of CQC's recommendations. Work is underway to develop and embed a culture of patient-centred care that runs from the Board right through to the front line.

Action has been taken in the majority of areas highlighted in CQC's investigation, although a number of significant recommendations remain part-met and a small number unmet – in many cases, because the impact of changes in policy have not yet delivered better outcomes in practice.

Maternity has been the greatest focus for the Trust and commissioners, reflecting the level of concern identified by CQC. Recent evidence suggests this has resulted in a marked reduction in the risk of poor maternity care at Queen's Hospital. This view is supported by CQC's unannounced inspections, interviews with staff and service users, and information from other stakeholders. CQC made clear that it was prepared to restrict services – one of its strongest enforcement powers – if maternity did not improve and the Trust's response, supported by NHS London, has started to deliver results.

These improvements need to be seen in context. The direction of travel at the Trust is right, but the quality of care on offer is still unacceptable in some areas – particularly in accident and emergency at Queen's Hospital, where too many people are at risk of receiving poor care. More needs to be done in medicines management, in staffing across the Trust, and in making sure that the Queen's Hospital site is more patient-friendly. Complaints have increased (almost certainly because of the attention created by CQC's investigation) and the Trust is struggling to cope with the volume.

Whether the improvements seen so far can be sustained is a big question and the Trust's leadership is aware of this, as are those involved in making decisions about future configurations of services. For example, the positive changes in maternity have come about in part as a result of extensive support from commissioners. This kind of joint effort is tough to sustain, particularly when accident and emergency and maternity – two services facing huge demand at the Trust – need ongoing support and attention.

This report marks the end of CQC's investigation. Quality of care at the Trust will now be monitored through regular unannounced inspections. There are broader debates underway about the configuration of services in this part of London. If changes are made to services at this Trust, CQC's role will be to assess whether essential standards of quality and safety are met, however they are delivered.

2.2 Leadership, strategy and capacity

CQC's view is that there has been considerable progress at executive level in the Trust in terms of taking ownership of the problems found during and since registration in April 2010. It is early days, and the effort invested will take time to have a lasting impact on frontline care, but the direction of travel is promising. Given the Trust's history of poor performance and failure to take responsibility for its problems over many years, some of the most significant progress to date has been through the Trust acknowledging its challenges and opening itself to partnership working to create a climate that will promote improvement.

NHS London is supporting the development of a number of clinical fellows at the Trust as part of a clinical leadership and engagement programme. A new management structure based around clinical directors and associate directors has been introduced to bring in clearer lines of accountability and responsibility for the quality of care. A major programme of internal engagement is underway to try to build a stronger sense of shared purpose between management and staff to deliver better care.

The Chief Executive and members of the Board and Executive Team have been open and honest about the Trust's problems and have demonstrated clear ownership when seeking to tackle the challenges that lie ahead. The senior management tier has been reshaped with a strong focus on driving accountability, transparency and responsibility for quality into the structure.

The Trust recently announced that five members of the senior management team would be leaving or changing role. This has been explained as a move to support the clinical leaders and the change process, but the impact of this is not yet known. Once these posts are filled and a stable Executive Team is in place, the next challenge will be to ensure that the drive for improvement is embedded across the Trust. Given the amount of poor care seen in the CQC investigation that was attributable to management and culture, this is critical to the Trust's future success.

The Trust's interim Chair and Board are offering stronger challenge to the Executive and the interim Chair has explicitly said that care quality is their priority; the new governance structures should enable the Board to carry out their scrutiny roles more effectively, and as a result take on more accountability for quality within the Trust.

2.3 Maternity

The pressures on maternity services are such that the Trust has not been able to respond to CQC's regulatory challenge alone. Demand is huge and there was no sign of this reducing without active intervention. A combination of volume and the capacity of staff to deal with complex cases are behind many of the problems CQC and other bodies have seen (e.g. the Royal College of Obstetricians and Gynaecologists' report for NHS London at the Trust late last year).

Late in 2011, CQC made clear that it was considering a legal restriction on the number of births at Queen's Hospital. This led to an escalation in the improvement work underway and saw the Trust receive extensive support from commissioners.

NHS London's response has involved drawing on expertise and insight from across London, and looking at the challenges faced at the Trust in the context of demand and service provision the entire north-east London area. This has reflected the analysis of the 'Health for North East London' programme and has resulted in an ambitious plan to reduce demand on maternity at the Trust equivalent to some 2,000 births a year by the end of 2012/13, compared to pre-investigation levels.

The North East London and City cluster has taken on formal responsibility for implementation of this maternity plan, which will see decisions taken across the cluster to improve access to safe maternity care. This has already seen plans implemented (spring 2012) to move around 20 bookings a week from the Trust to Barts Healthcare, taking advantage of capacity elsewhere in the cluster (particularly Newham Hospital). These bookings will translate into births from November.

NHS North East London's proposed response to the challenges faced in maternity is wide-ranging, innovative and proportionate. The proof of the plan will be in its delivery. Success will mean primary care playing its part; GPs and community midwives have a critical role in ensuring that mothers-to-be understand the context in which birth options are presented to them.

Within the Trust, recruitment and retention of a suitable body of skilled and experienced midwives continues to be a challenge. The Trust currently has among the best ratios of staff to mothers in London, but this has only come about after six months of intense support from external partners. Holding on to midwife recruits in the London employment market is an ongoing challenge (and is not unique to this Trust). The NHS North East London plan to reduce demand is likely to be the only sustainable answer.

CQC will continue to assess the quality and safety of maternity services at this Trust, and in maternity units in other trusts taking part in this plan, throughout 2012/13.

2.4 Emergency Care

Emergency care remains the area of greatest concern to CQC. Demand on services is enormous and our original investigation and inspections since have found this service is consistently failing to meet essential standards.
A combination of demand, problems with staffing, challenges in streaming patients properly, and blockages elsewhere in the hospital mean the emergency department at Queen's in particular is struggling to deliver acceptable care.

Patients often face significant delays in admission, treatment and discharge. The lack of available beds across the hospital causes a backlog that has an impact on people arriving in A&E. The hospital continues to struggle to recruit middle grade doctors and there is reliance on doctors from locum agencies. This reduces the level of senior medical cover in the department, meaning it can be difficult to find people qualified to make decisions about treatment, which leads to delays in people being given access to the right care.

This level of concern about emergency care is corroborated by a range of external sources, ranging from information from patients and other stakeholders, through to performance data and other regulatory sources. A major programme of work is underway at the Trust, supported by external partners, to try to address this. More detail on this programme - and on our recent inspection findings - is in section 3.

2.5 Complaints

The Trust has seen a dramatic increase in complaints in recent months, from a typical level of around 40 a month to around 120 a month in early 2012. Staff attitude and communication are a key theme of many of these.

Trust response speeds have increased and complaints are now all signed off by an executive director. Patient feedback kiosks are going up across the Trust, and discussions have taken place about introducing an integrated electronic patient record. The approach to complaints handling looks to be much better, with far greater involvement of senior management and better processes in place to ensure lessons are learned from mistakes, but the increase in volume means the improved process needs to keep pace with a surge in demand.

CQC has seen a rise in information received about this Trust since the investigation was launched. Anecdotal accounts from stakeholders, including local MP's offices, indicate that they too have seen an increase in the volume of correspondence about the Trust. Some of these complaints pre-date CQC's investigation, although many are more recent. It is hard to know whether this increase is a result of more poor care, or a result of greater awareness about the Trust's challenges and therefore more willingness on the part of patients and their families to raise concerns.

This remains an area where the Trust's performance must improve. The Trust is in a challenging position given the volume of complaints it is now dealing with, but patients and other stakeholders have made clear they expect to see better performance in this area despite the increased demand.

3.1 Compliance activity at the Trust

CQC has carried out a significant amount of inspection activity in parallel with the investigation. The Trust was registered with CQC in April 2010 with eight conditions on its registration, setting out improvements that had to be made against eight essential standards. This was among the highest levels of concern identified during registration.

During the course of 2010/11 most of these registration conditions were lifted, but ongoing compliance monitoring raised further concerns – particularly in maternity and in accident and emergency at the Queen's Hospital site in Romford.

Warning notices were served on the Trust in March 2011 regarding staffing and care in maternity, in June 2011 regarding patient care in A&E, and in July 2011 regarding staffing levels. These compliance concerns triggered the investigation referred to above. In parallel to the investigation, unannounced inspections took place in September and October 2011 to assess compliance with these warning notices. Given the level of concern about maternity, weekly visits took place over eight weeks during October and November. Evidence from these visits – which included an independent midwife – was incorporated into compliance reports published in early 2012.

In these reports, CQC continued to have major concerns about care and welfare in A&E and in maternity and moderate concerns about staffing in maternity.

Throughout the period since the investigation, CQC has received regular information from people who use services at the Trust, from local MPs, from LINks, and from other sources including staff at the Trust. Information from these has been factored into compliance activity where appropriate.

CQC took part in a risk summit about the Trust on 6 February with NHS London, the cluster, and the Department to discuss the ongoing challenges faced by the Trust.

Information received during this period and CQC's assessment of risk led to further inspection activity in 2012, specifically:

- An unannounced inspection of maternity services at Queen's Hospital from 19 to 21 March
- An unannounced inspection of A&E services at Queen's Hospital on 28 March
- An unannounced inspection of radiology services at Queen's Hospital on 28 March, with a follow up on 4 April

- An unannounced visit to stroke rehabilitation services at King George Hospital on Saturday 17 March, in response to patient concerns raised with CQC

We received information after the maternity inspection alleging that staff and equipment had been moved between sites to try to influence our judgement. As a result, we went to both the Queen's and King George hospital sites for a simultaneous unannounced inspection on the night of 4 April to confirm that evidence gathered during our initial inspection was robust (see below).

These compliance reports have been published alongside this update and can be found on CQC's website.

3.2 Queen's Hospital, Romford, and King George Hospital, Ilford (maternity services)

We carried out an unannounced inspection of maternity services at Queen's Hospital on 19 March. This covered a three-day period and CQC had support from a maternity expert from the Nursing and Midwifery Council. We looked at three of CQC's essential standards: 'care and welfare of people who use services' (outcome 4), 'equipment standards' (outcome 11), and 'staffing' (outcome 13).

The changes that have been introduced in maternity are detailed elsewhere in this report. All new mothers we spoke to gave largely positive feedback about their stay, including the support received from midwives and the pain relief available. Staff told us care had improved as a result of several factors – a significant increase in anaesthetist cover, achieving 100% in one to one care in established labour, increased paediatric care on the postnatal ward to improve discharge, some improvements in triage times, the moving of the antenatal ward to next to the labour ward, and a reduction in births that had helped the service's ability to deal with demand. The sustainability of these improvements will be assessed over time.

Equipment raised some concerns at Queen's; while staff were not aware of it being moved between sites, and there was a general view that there was enough equipment, it was not always easy to find. The Trust has improved policies for checks on equipment, but we found evidence that these were not always carried out.

The Trust vacancy rate for midwives has reduced from 17% to around 11%. Recruitment and retention is a constant challenge and the Trust is now targeting UK midwives after a significant number hired from overseas left. The Trust currently has more midwives in place than is indicated as a result of a 'birth rate plus' assessment. Midwives generally felt that staffing was much better, although they expressed concern about sustainability and the skills mix when so many midwives were newly qualified or new to the Trust. Midwifery care assistants (MCAs) had more significant concerns about shortages, which were supported by daily records. Staff told inspectors that they generally felt supported by management and that morale was better.

After our first inspection we received concerns from a member of staff suggesting staff and equipment had been moved between hospital sites to mislead inspectors. We returned to the Trust, again unannounced, on the evening of 4 April to speak to members of staff on both day and night shifts at the Queen's Hospital and King George sites. We found no evidence to substantiate the concerns at either hospital other than those already covered above, although we did receive confirmation that members of staff were sometimes moved when another site was short-staffed. No member of staff thought this had put patients at risk.

3.3 Queen's Hospital, Romford (accident and emergency services)

CQC carried out an unannounced inspection of accident and emergency at Queen's Hospital on 28 March 2012. We looked at one of CQC's essential standards: 'care and welfare of people who use services' (outcome 4).

Major concerns were identified in this service during our last inspection. The Trust has made several changes as a result of these, but the department continues to fail in meeting quality indicators and patients remain at too high a risk of receiving poor care.

These issues were being picked up by the Trust – the introduction of a rapid assessment and treatment process was welcomed by nursing and ambulance staff, a recruitment strategy is in place to address the high number of vacancies, and the deanery is increasing the number of specialist registrars from two to five from August 2012 – but progress has been challenged by the level of demand.

Staff told inspectors that they felt there was a 'whole hospital' approach to improve discharges and hospital-wide support for A&E. They did, however, also say that the key problem is too many people 'coming through the doors' and questioned whether more could be done externally to reduce demand.

CQC's level of concern about this area of care has remained high since the Trust was registered. The RESET programme (see 3.4) represents a watershed opportunity to introduce sustainable improvement to manage demand in A&E by addressing performance challenges throughout the hospital. CQC will be seeking further assurance that it is having an impact in the near future.

3.4 The RESET programme at the Trust

The Trust, with external support funded by NHS North East London, has put in place an intensive improvement programme for emergency care. The 'RESET' (Rapid End-to-end Sustainable Emergency Transformation) programme's aim is to deliver rapid and sustainable improvements in the emergency care pathway. The full patient pathway is in scope, with a priority on the urgent care centre, emergency department, medical and elderly wards. This programme was underway when CQC carried out its latest unannounced inspection.

RESET has identified that performance in the emergency care pathway is worse than 2011, as evidenced by failure to reach the four-hour A&E target. Queen's hospital is the focus of the programme because they have two-thirds of attendances (113,000 at Queen's, 78,000 at King George), but almost four out of every five breaches.

The RESET programme identified many challenges that CQC has picked up through its compliance work – high use of locums and agency staff, ineffective bed management, and poor discharge – but has gone into a far more detailed diagnosis of underlying issues.

This analysis includes highlighting inconsistent triage, poor use of the urgent care centre, a lack of accountability and effectiveness in bed management, discharges taking place late in the day (peaking at 4pm) rather than at 11am as needed; and long lengths of stay, largely driven by factors within the Trust's control. Length of stay across the Trust is variable (around 48% of patients exceed the expected date, for internal and external reasons) and long-stay patients are a challenge in elderly care and general medicines. All these create significant strains across the care pathway.

Staff have contributed to the RESET programme and it is clear that many feel under a great deal of pressure, whether from too much work, high patient-to-nurse ratios, through to only hearing negatives in the media and the constant airing of the Trust's problems in public. RESET aims to both improve performance and (through this, in part) build a better working environment for staff.

A broad programme of work is underway through RESET with emergency department performance and flow, continuity of care and discharge rates in the medical assessment unit, and discharge, best practice care for complex patients, and effective care for elderly patients being prioritised. Initial results made available to CQC indicate an improvement in A&E waiting times and week-on-week falls in the number of breaches, although these results must be sustained to demonstrate that this has taken root.

The number of discharges per day has increased since the introduction of a board round in the medical assessment unit. Planning for the following day's discharges is now taking place at 3pm the day before with a senior nurse lead and doctor in attendance. Consultant support has been increased to tackle issues with care of the elderly and length of stay; more ward rounds have been introduced and lengths of stay are being reduced to more effective levels. More clinical nurse specialists have been introduced to improve the specialist response to cases coming from the medical assessment unit and emergency department.

Plans are in place to try to ensure that these improvements are sustained and built upon. Selected initiatives are due to be rolled out to King George. CQC will seek assurance that RESET is having an impact via unannounced inspections at some point in the months to come.

3.5 Queen's Hospital, Romford (radiology services)

CQC's original investigation identified serious concerns with radiology services and these unannounced inspections, which took place on 28 March and on 4 April, were designed to assess whether improvements had taken root. The CQC team included radiology experts, who also helped review our report. We checked three of CQC's essential standards: 'care and welfare of people who use services' (outcome four), 'staffing' (outcome 13) and 'assessing and monitoring the quality of service provision' (outcome 16).

Details of the Trust's work to improve clinical management, audit and staffing are included later in this report. We were presented with evidence that showed a weekend rota to reduce the backlog from A&E; a new 'hot reporting' rota has sped up the process and weekly checks on turnaround times for x-rays and scans. Turnaround times have significantly improved and people referred for CT scans from A&E have exceeded national targets. Compliance with a National Patient Safety Agency (NPSA) alert from 2007 has improved.

A new role of clinical director for radiology has been created and radiology became a department in its own right on 1 April. Radiology leads with responsibility for care pathways have been introduced. Trust documentation verified that vacancies in radiology are now minimal and new posts have been created through extra activity and better financial management. Staff have been given support to develop their reporting skills and a quality and safety audit for newly-qualified radiographers has been introduced. Anaesthetic support has increased.

A new Trust audit form and process has been introduced, but planned audits had not always been carried out and the clinical director and general manager for radiology indicated not enough audit had taken place.

3.6 King George Hospital, Ilford: Beech Ward (specialist stroke rehabilitation)

We carried out an unannounced visit of Beech Ward on 17 March as a result of concerning information about privacy and dignity, use of call bells, and staff behaviour that we had received from current and former patients. We checked two of CQC's essential standards; 'Respecting and involving people who use services' (outcome one) and 'Staffing' (outcome 13).

The inspection took place on a Saturday afternoon and evening. We talked to patients and relatives about the care they had received and to staff about issues on the ward. Patients and relatives had mixed views; while some were positive about the care they had received, others told us that staff were sometimes abrupt and a bit rough, and that patients had to wait a long time to have continence pads changed or to be taken to the toilet.

Staff told our inspectors that they were stretched because of shortfalls in staffing and that this had affected their ability to deliver good care. We found evidence that shifts were not staffed in accordance with rotas, and that not all staff had attended stroke training (particularly a problem on night duty).

Management and staff were aware of and seeking to tackle these concerns. CQC has set a deadline for the Trust to address these and will be following up to check whether enforcement action is necessary.

4 CQC's recommendations – monitoring of progress against the CQC action plan

The following pages set out the recommendations made in CQC's investigation report and include an assessment by CQC of whether these appear to be met, part met or not met. This assessment is based on the Trust's reporting of progress to NHS London against its 'CQC Action Plan', and where appropriate is informed by CQC's compliance activity. In some cases, the Trust may have taken measures to improve procedure but CQC has not yet seen a marked improvement in care quality. This will be followed up through our core regulatory work.

Please note that this assessment (met, part met, or not met) is not equivalent to a statement of compliance or non-compliance with CQC's 'essential standards' – the regulations and illustrative outcomes published in the CQC 'Guidance about compliance'. For the latest view of compliance, please refer to CQC's inspection reports.

Progress against recommendations: summary

Page	Area	Met	Part met	Not met
16	Strategy and capacity	0	3	0
17	Maternity	9	6	1
21	Leadership	1	4	0
23	Respecting and involving	2	1	0
24	Care and welfare - Emergency	0	2	1
25	Radiology	1	2	0
26	Discharge	0	3	0
27	Surgery	2	0	0
28	Cooperation	1	2	0
29	Safeguarding	3	0	0
30	Cleanliness	1	2	0
31	Medication	0	2	0
32	Premises	1	5	1
34	Equipment	2	0	1
35	Staffing	2	5	1
38	Supporting staff	1	1	0
39	Quality monitoring	1	5	0
41	Complaints	0	3	1
43	Records	0	2	0
	Total	27	48	6

4.1 Strategy and capacity

1. The Trust, in conjunction with NHS London, should seek appropriate external expertise to support a programme of organisational change and service improvement.	**Part met**

The Trust has introduced 10 clinical fellows and four midwifery clinical fellows as part of a clinical leadership and engagement programme, supported by NHS London. Commissioners are offering support at executive level in the development of the Trust's programme management board to coordinate the transformation programme. Health for NEL, Skills for Health, and the RESET programme in A&E are evidence of the Trust's willingness to engage external support.

2. 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.	**Part met**

The Health for NEL proposals and estates reconfiguration plan for the Trust should see demand reduce significantly over the next two years to address capacity issues. This includes seeing demand on maternity fall by 15-20% (between 1,500 and 2,000 births a year) by April 2013 through effective use of alternative maternity resources in North East London. Success depends on partnership working and ongoing commissioner engagement, including the role of primary care in making sure that people are aware of the treatment choices open to them.

3. 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.	**Part met**

A range of work is underway to address this – bed mapping, revised length of stay, reviews of decisions to admit, care pathways in place for emergency and gynaecology care. The RESET programme in A&E is designed to ensure stronger visibility and accountability of care pathways throughout the hospital, from admission to discharge. Progress in this will be carefully monitored both within the Trust (including at Executive and Board level) and by external partners.

4.2 Maternity

4. 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.	**Part met**
Work with NHS London in the short-term and in the longer term via Health for NEL, has so far and should address the highest risks to safety for mothers. Improved audit and reporting on c-sections is in place. An audit of 1:1 care in established labour saw the Trust achieve 100%. CQC's inspections have confirmed that improvements have been made and are so far being sustained.	

5. Ensure that it configures its maternity services wards and departments appropriately to improve the quality of antenatal and postnatal care at Queen's Hospital.	**Met**
Antenatal and postnatal wards have been moved to ensure a better patient flow. Incidents and complaints about the design of the ward are being acted upon.	

6. Ensure that there are suitable numbers of midwives to provide one-to-one care for all women during established labour.	**Met**
Audit so far has indicated 100% success; the target for the year is to achieve an average of 98% across 2012.	

7. Ensure that learning from incidents in maternity services takes place to reduce the risk to women of unsafe care.	**Met**
'Lessons learned' sessions are now part of mandatory training days and near-miss meetings. A newsletter is in place to disseminate learning. More supervisors of midwives have been recruited and this material feeds into their meetings.	

8. Take appropriate steps to ensure that all women can receive adequate pain relief when they need it.	**Met**
This is audited weekly by the cluster; cover has been extended from 8am to 8pm, with out of hours cover needing to be increased. CQC's inspections have identified a clear improvement in this area.	

9. Further improve the maternity triage process with the introduction of regular monitoring and learning to ensure that services improve for all mothers.	**Part met**
New pathway implemented with monitoring in place; performance reported weekly to NHS London; triage working group in place. Performance levels need to improve.	

10. Take appropriate action to ensure that babies are not transferred to the neonatal care unit unnecessarily.	**Not met**
Policy and guidelines in place but being reviewed; Trust audit has recently taken place. Performance outputs not meeting required levels.	

11. Ensure it uses all staff and systems effectively to improve the discharge process.	**Met**
Increase in qualified midwives allows better discharge; improved process and audit in place with regular reporting.	

12. Undertake a skill mix review in its maternity services, for example Birth Rate Plus.	**Met**
Birth Rate Plus review undertaken in addition to Trust's own review of skills mix.	

13. Continue with its recruitment plans in maternity services to ensure that it has suitable numbers of qualified staff across all service delivery departments.	**Part met**
Recruitment is on target to deliver a 1:29 ratio, with higher numbers of substantive staff in post. CQC inspections have identified some concerns around midwifery care assistant staffing levels. Trust has faced challenges in recruitment and retention, although these are not particular to this Trust alone.	

14. Review the clarity of its reporting processes with regard to cardiotocography (CTG) training in maternity services.	**Met**
All new doctors receive CTG training on appointment; attendance figures are audited on a monthly basis as part of the maternity dashboard.	

15. Increase the level of training on the interpretation of CTGs, so that all staff have undertaken this.	**Part met**
All midwives were due to have completed training by end of March 2012, although the maternity dashboard showed 84% complete. Regular audits of attendance are in place.	

16. 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.	**Met**
Additional supervisors of midwives have been recruited and are in place; ongoing review and recruitment should deliver a 1:16 ratio by September 2012.	

17. Improve the quality of record keeping and records management in maternity services.	**Part met**
Training for staff and a maternity records tracker and audit process are in place, but some problems with implementation and targets not being met to date. More that 50% of staff have now been trained in appropriate governance.	

18. Assure itself that it has the right managers and leaders in maternity services to deliver high quality safe services for women.	**Met**
Director of midwifery joined the Trust in March 2012, review of previous allegations of abusive / rude behaviour completed, new allegations proactively investigated. 'Role play' training in place to ensure staff listen to and act professionally with women in labour, and their birth partners at all times. Senior maternity managers, midwives, clinical directors and consultants aim to act as role models to drive home message on zero tolerance of abuse and rudeness from staff at any level in the Trust.	

19. Ensure that maternity audit processes are integrated with the rest of the Trust.	**Part met**
While a clinical audit plan is in place and infection control is being audited, an audit midwife has only recently been recruited. The full set of policy and process measures are in place but performance is not meeting expected levels as of the time of writing.	

4.3 Leadership

20. 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.	**Part met**
The Trust Board has completed its review of the Executive Team, leading to appointments of chief operating officer and director of transformation. A new management structure is in place based around clinical directorates, led by clinical directors and associate directors. Recent information indicates that there are several changes being made to senior management at the Trust and the impact of this will need to be assessed. Significant staff engagement process is underway to consult on wider implementation of new structure.	

21. 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.	**Part met**
Building blocks are in place – 'Big Conversation' underway with staff engagement group set up and several staff engagement meetings held. Executive team now dedicate one day a month to take on a front line role in order to increase understanding of care challenges and improve management visibility and accessibility. Conflict resolution training is being delivered for managers; BHRUT Code being reviewed with significant staff input, including seeking clear examples of acceptable and unacceptable practice. Consultants are carrying out an analysis of team working and practice in women's services.	

22. Develop a culture of whole systems working across all divisions to reduce 'silo' working and the combative nature of bed management.	**Part met**
Weekly operations meeting, with directorate managers, is now in place; multidisciplinary working being pursued as part of RESET project. New bed management structures is in place, with all divisions and specialities attending; Matrons working together to ensure effective discharge process.	

23. Develop a programme of support for managers so that staff with the capability can be freed to undertake their managerial roles effectively.	**Met**
Staff engagement process is underway; appraisal rates for managers have improved and monthly performance reviews now being introduced.	

24. Explore how to improve its communications both internally and externally so that perceptions of poor communication can be reduced.	**Part met**
Internally, significant staff engagement is underway; externally, meetings have taken place with LINks and Improving Patient Experience Group (IPEG); stakeholder briefings being disseminated; stakeholder event with commissioners, CQC, LINks, IPEG and local authorities took place in May. Some feedback to CQC suggests there are further improvements that could be made, particularly in terms of engagement with MPs.	

4.4 Respecting and involving people (outcome 1)

25. 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.	**Met**
Annual report on findings is to be produced to coincide with national survey; Board now receiving quarterly reports to update on learning. Six-monthly reports for Hospital Life and the Link on improvements achieved as a result of real-time surveys. Feedback from NHS Choices and Patient Opinion is to be acted on bi-monthly from February 2012.	

26. 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.	**Met**
Revised patient experience strategy in place, with divisions to develop and implement six-monthly patient engagement forums. Links with IPEG will provide two-way information channels. Real time survey is being rolled out across wards through 2012; the first report from this went to the Quality and Safety Committee in February 2012.	

27. Make sure that proactive and mandatory training and education regarding dignity, respect and tolerance is delivered to all staff.	**Part met**
Dignity and respect benchmarking has been done; compliance reports on non-attendance are being reviewed and a mandatory training programme is being developed. A leaflet for new staff about the Trust's expectations of behaviour has been drafted and is due to be reviewed with the staff engagement group before roll out. The BHRUT Code is being reviewed and will be issued to all new starters with contract. Quality of Care audits of dignity and respect have been carried out in December and March so far and will continue in order to audit feedback from the real time patient survey. Bank managers to ensure that competence of all temporary clinical staff in this respect is monitored; if concerns are raised about temporary staff they should either not be booked again or only done so with documented supervision.	

4.5 Care and welfare of people who use services (outcome 4)

Emergency department

28. 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.	**Part met**
The 'Discharge JONAH' tool is being implemented to focus on discharge and length of stay. Daily meetings, weekly performance reviews, and the RESET project mean there is frequent and in-depth scrutiny; this will be met when outputs match the aspirations in a sustainable way.	

29. 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.	**Not met**
The appraisal process for emergency department staff has been reviewed; all staff in this area have personal development plans. Hourly vital signs checks are underway and monthly spot audits are being carried out to ensure staff feel empowered to challenge poor performance. Patient satisfaction surveys are in place and staff are reminded of the importance of challenging poor practice as a standing item on A&E team meetings. Audit results do not yet support the processes that have been put in place.	

30. Ensure that all staff, both permanent and temporary, follow hospital policy and procedures.	**Part met**
As noted, the appraisal process for emergency department staff has been reviewed; spot audits of elective surgical consent have indicated some issues with consistency; not all emergency patients receive all the information they need about procedures; and a new information leaflet on anaesthesia risks is being developed. Performance indicators are still negative.	

Radiology

31. Develop its planning and bed management processes to ensure all patients are cared for in appropriate facilities.	**Part met**
Matrons and ward sisters are monitoring this but the Trust has not yet established how best to measure success in this area. The X-Ray department has introduced appropriate checklists for ensuring patients are properly prepared.	

32. Put in place clear protocols for the management of interventional radiology patients with audit and improvement cycles to ensure standards are attained and maintained.	**Part met**
Audit processes are in place and are monitored at interventional radiology meetings and at the Divisional Board. SOPs are in place and are being implemented for each procedure in interventional radiology. CQC's compliance activity supports the Trust's assessment of significant progress in this area, although more audit activity needs to be delivered for this to be considered fully met.	

33. Ensure that it fully implements the 2007 NPSA alert regarding radiology imaging results being communicated and acted on as a matter of urgency.	**Met**
A distinct operational and clinical policy is in place, supported by cyclical audits; a longer-term measure will be a reduction in incidents by March 2013.	

Discharge

34. 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.	**Part met**
A single discharge policy is now in place with clear roles and responsibilities established and six discharge specialists employed to help with complex discharges. The RESET project is playing a crucial role in ensuring that discharge is managed across all relevant pathways and wards. The Discharge JONAH project and accompanying audits are in place. Daily meetings with matrons and senior nursing staff review the bed position and delays. The underpinning processes and policies are in place here, but CQC's inspections and other performance measures make clear that delivery needs to improve to match the Trust's aspirations.	

35. 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.	**Part met**
The Trust has suitably robust guidance and policies, which is reaffirmed at induction. Pharmacy is meeting dispensing targets, but better monitoring and audit needs to be introduced to ensure that treatment is appropriate and supported by suitable information. This has also been linked into the RESET project. The Trust's Visible Leadership programme has included a focus on this area of care, with reports to the Nursing and Midwifery Board and Quality and Safety Committee.	

36. Review and rationalise the discharge and bed management information systems to ensure that the most effective and accurate system is fully utilised.	**Part met**
The Discharge JONAH tool has been rolled out as per above; this is linked in with the RESET project. As mentioned, the underpinning measures are in place but performance is yet to meet expectations.	

Surgery

37. Develop its day case surgery service to ensure that appropriate patient flow is maintained including effective pre operative assessment.	**Met**
Admission times are being staggered to reflect the theatre list and restrict the pre-surgery wait to four hours where possible; admission letters now refer to appropriate time of arrival and likely delays. Revised audit processes are in place to monitor progress.	

38. Improve standards of care for obstetric patients who undergo minor surgical procedures.	**Met**
Improved patient satisfaction and flow is being monitored; some elective patients do risk missing treatment due to over-extension of theatre lists, but this process is under close scrutiny and review to make sure the risk of this is minimised and patients – where affected – are informed. Emergency procedures are prioritised to minimise waiting times and avoid harmful delays.	

4.6 Cooperation with other providers (outcome 6)

39. Continue to engage, and develop effective working relations, with external providers and partners.	**Part met**

Regular stakeholder briefings have been introduced and the Trust has set up a regular programme of meetings at patient representative groups, OSCs, and briefing to media. CQC recently attended a stakeholder meeting at the Trust and feedback from local authority partners and the Improving Patient Experience Group was that communications with stakeholders had significantly improved.

40. Work with partners to ensure adequate provision of specialist rehabilitation services.	**Met**

Discharge partnership boards are held on a bi-weekly basis to discuss complex discharges and the relationship between all relevant organisations. Access initiative meetings are held with Barking and Dagenham, Redbridge and Havering. All site managers across acute and community services use a single electronic bed system, which is helping discharges. A community bed review is underway in line with the Health for NEL programme.

41. Work with social care partners to develop robust working practices to ensure appropriate admission and discharge practices.	**Part met**

A programme director is working at the Trust with funding from the Cluster to liaise between the acute Trust and borough and community services. This post will currently run until October 2012. There is now a central point for escalation and consideration is being given to allocating a budge to the programme director to allow them to make spot purchases to resolve complex discharge problems. Work is underway to streamline processes across all boroughs to access community services. Gaps in acute Trust resources are being identified to improve discharge to community services; early data indicates reduced length of stay.

4.7 Safeguarding people from abuse (outcome 7)

42. Complete the recruitment of senior staff into safeguarding roles.	**Met**
Staff have been appointed to fill the relevant posts for safeguarding adults and safeguarding children.	

43. Ensure that all staff are able to access and receive the appropriate level of safeguarding adults and safeguarding children training.	**Met**
A safeguarding training strategy is in place with data on staff trained collected and reviewed centrally.	

44. Continue to develop its joint working practice with external partners.	**Met**
The director and deputy director of nursing now attend a range of external safeguarding meetings; external stakeholders sit on the Trust's own safeguarding meetings, chaired by the Director of Nursing. Named nurses now sit on external sub-committees as necessary.	

4.8 Cleanliness and infection control (outcome 8)

45. Ensure that all equipment and disposable products are stored appropriately.	**Part met**
Ward managers have completed risk assessments of equipment management and storage facilities. A new Trust environment / equipment disposal policy is in place. Weekly walkabouts with facilities and estates have been implemented and an action log is in place.	

46. Ensure that all public toilets are kept clean especially in areas of high usage.	**Met**
A site review of all public toilets has taken place and cleaning schedules have been reviewed in terms of frequency and content to ensure compliance with the National Standards of Cleanliness 2007 / PEAT standard. A rapid response team is in place for ad-hoc cleaning. Audits are in place, spot checks by senior executives have been introduced, and patient and public feedback is monitored.	

47. 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.	**Part met**
The staff uniform and dress code policy is being reviewed to ensure standards are understood and remedial actions are available. An infection control annual plan is in place and is reported against to Infection Control Committee every other month.	

4.9 Management of medicines (outcome 9)

48. Reinforce its policy on medication prescribing, dispensing and administration, ensuring that all staff are aware of their roles and responsibilities.	**Part met**
A briefing for clinical staff explaining the importance of this policy and setting out accountabilities for prescribing and administration has been prepared; this is due to be rolled out shortly. A Policy Ratification Group has been set up to ensure policies are corporately signed off, published on the intranet, with summaries added to the Link to raise awareness of changes and expectations around compliance. Trends and issues relating to prescribing and medicines are reported in the Link, with a bimonthly prescribing newsletter in place to ensure a strong focus on medicines safety. An ongoing audit programme has looked at omitted drugs in the MAU, pharmacist errors, and is looking at a range of other relevant issues.	

49. Ensure that the results of learning from medication errors are widely publicised across all services in the organisation.	**Part met**
Safe Medicines Practice Group in place and produces a summary of incident themes and serious incidents to be used in directorate meetings. Pharmacists and wards receive monthly reports on medicines and prescribing. Error trends are fed back to relevant directorates and are published on the intranet.	

4.10 Safety and suitability of premises (outcome 10)

50. 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.	**Part met**
Working group involving patients, non-execs and staff set up in December 2011 to set signage standards; main signage reviewed with specialist input and new signs commissioned to arrive in June 2012. Leaflet and map under review to ensure signage is in context of better overall patient information.	

51. 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.	**Part met**
Paediatric waiting areas reviewed and funding agreed to improve observation of sick children; project group set up to implement Health for NEL redesign of paediatric services.	

52. 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.	**Part met**
Review of x-ray services including department layout linked to Health for NEL programme; project group set up with dedicated project management support. Current process of caring for patients in waiting area addressed via a short-term solution using a mobile x-ray device to limit patient waiting times.	

53. Ensure that appropriate waiting facilities are available for patients and relatives in the urgent care centre.	**Part met**
As above, these waiting facilities are being reviewed as part of the Health for NEL programme.	

54. 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.	**Met**
Natural light bulb pilot is underway to address areas where natural light is not accessible. All patient-access areas where neither natural light nor ventilation is available are being identified. All reviews of capital improvement now include consideration of the environment in which care is delivered, and any opportunity to provide access to natural light and ventilation will be taken.	

55. 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.	**Not met**
The 'hourly staffing of wards' element of the Safer Nursing Care Tool and other tools are being used to try to ensure there is suitable observation of patients, although concerns about staffing levels suggest there is room for improvement.	

56. Develop appropriate facilities to ensure the day case surgical patients are cared for in appropriate environments at Queen's Hospital.	**Part met**
The use of overnight recovery has been reviewed and works are underway to improve facilities subject to funding. There is a plan in place to develop a 23-hour facility in the day surgery unit and allow space in Recovery to be used as a 'day of surgery' admissions area, but these are pending the outcomes of the bed-modelling work stream.	

4.11 Safety, availability and suitability of equipment (outcome 11)

57. 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.	**Met**

A matron-led audit of equipment took place in November 2011. This showed areas where equipment was above the current register and highlighted some shortfalls. The latter have been picked up via business cases (expenditure of £240k was approved for immediate procurement in March 2012) and shortfalls are routinely considered at the Medical Devices Committee. A manual equipment loan process is in place to keep track of equipment (an electronic system was considered but was too expensive). This is supported by a colour-coding system which was introduced via a successful pilot. The existence of four separate contracts for therapy equipment (Trust and three local authorities) means accessibility issues will remain until contract renegotiations can take place. There are no barriers to clinical areas obtaining stationery at any time it is needed. The Medical Devices Policy has been reviewed, signed off and published; a new escalation process is in place to address faulty equipment, including matrons / managers addressing governance issues with staff where reporting has not taken place.

58. Ensure that systems are in place in all clinical areas so that sufficient disposable equipment is available.	**Met**

A medical devices audit has been completed and business planning for equipment for 2012-13 reflected its findings. A process for monitoring, ordering and administering disposable equipment is well-established and subject to audit; this is supported by the colour-coding and loan equipment protocol.

59. 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.	**Not met**

This will be audited by monitoring complaints on availability of equipment and regular equipment audits; a business case may be considered for a dedicated medical devices coordinator / trainer if the need is firmly identified. CQC's inspections suggest this remains a serious issue that needs to be addressed.

4.12 Staffing (outcome 13)

60. 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.	**Not met**
The Trust has introduced a phased programme to consolidate establishment data against the electronic staff record, including cleansing the record of posts that are no longer in use, and with finance support. There have been challenges in aligning the HR ledger data with the electronic record. Further work is needed and there is, as yet, no formal process in place or agreed for managing establishment control. The move to electronic staff change / termination forms has been difficult to implement, and there has been a delay in getting fully accurate reporting on vacancies and establishment.	

61. Continue to review its workforce strategy to ensure that it meets the needs of the organisation and reflects the reality of service delivery.	**Part met**
A review of the Workforce Strategy has been completed and is now being tested via the staff engagement group.	

62. 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.	**Part met**
Skills for Health are supporting the Trust in this, funded via NHS London Financial Support. Pilot work in the Emergency and Maternity Departments is underway. Future phases are heavily dependent on the success of the pilot analysis and capacity to roll its findings out across the Trust and this will only be able to be assessed in the longer term. CQC compliance activity continues to suggest that the Trust faces challenges in terms of building a sustainable workforce with the right skills mix.	

63. 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.	**Part met**
An accelerated recruitment project and reduced use of agency staff have been put in place, with recruitment needs assessed on a monthly basis. Exit interviews are now in place as part of KPIs and are reviewed by Directors. The Trust has introduced suitable procedures here, but CQC compliance activity has identified ongoing challenges around locum use, particularly in A&E.	

64. Develop and improve the human resources support for the divisions so that managers can take effective action against staff where there are performance concerns.	**Met**
Mediation training has been delivered to support managers; performance management policies and processes are in place for 2012-13 to support managers in taking early action against poor performance. Revised policies have been approved by staff and HR performance is reviewed at directorate level on a monthly basis.	

65. Explore and develop strategies for delivering services with different staff groups so that reliance on difficult to recruit staff groups is reduced.	**Met**
Job descriptions are being reviewed to ensure they reflect the need for flexibility; provisions for this within current contracts are being reviewed. A flexible working policy has been agreed with the staff and take up is being monitored as part of recruitment KPIs.	

66. 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.	**Part met**
A review of the A&E workforce has been completed and the unit has been benchmarked against other comparable trusts. A review of the skills mix, current roles, and supporting roles has been undertaken and budgets reviewed in light of this. Current staff are taking part in an ongoing training programme to ensure staff update and refresh their skills. CQC's compliance activity has identified ongoing staffing challenges in A&E and the longer-term impact of this review work will need to be assessed at some point in the future.	

67. Ensure that its whistleblowing 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.	**Part met**
The Trust's whistleblowing policy has been revised and communicated to staff through Team Brief, the Link and the intranet. Staff feedback on the effectiveness of the policy is now part of the staff engagement strategy and new starters will be audited after six months to see if they are aware of it. Delivery of this recommendation is contingent on cultural change embedding itself across the Trust (although it should be noted that CQC has usually found staff open and willing to talk frankly about challenges during inspections, whether in confidence or openly).	

4.13 Supporting workers (outcome 14)

68. 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.	**Part met**
An annual training needs analysis is carried out and new mandatory and statutory training programmes are in place. Staff education is supported by specialist trainers and compliance is reported to the Trust's Education Board. Recording of training attendance has been improved and should be reported to line managers. Better reporting and benchmarking is needed to consider this met.	

69. 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.	**Met**
The Trust's supervision policy has been reviewed by a working party (part of the Post-Graduate Medical Education Committee) to include KPIs and introduce accountability to this area. Benchmarking and audit will ensure this is sustainable.	

4.14 Assessing and monitoring the quality of service (outcome 16)

70. 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.	**Part met**
Clinical and committee structures have been reviewed and a new Clinical Governance Structure has recently been considered by the Trust's Board. Expanded central data collection for the Quality and Safety Committee has been proposed. A central monitoring and evidence database has been introduced for Serious Incidents, with Trust-wide audits being introduced and KPIs introduced for reporting and completion of investigations. A web-based incident reporting system is being introduced across the Trust after a pilot in maternity.	

71. Develop a system of governance that offers it accurate and real time information that translates into an effective assurance process.	**Met**

72. 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.	**Part met**
Clinical and committee structures have been reviewed and a new Clinical Governance Structure has recently been considered by the Trust's Board. A complete review of Trust corporate committees has been completed and was recently put to the Trust Board. A complete review of maternity clinical governance was completed by October 2011 to ensure full integration with the Trust's main governance structures. The review also led to Divisional managers taking on responsibility for alerting clinical governance teams to all external quality and safety recommendations (reinforced through stringent audit and reporting), with regular reporting between HR and Clinical Governance to ensure joint management of patient safety issues.	

73. Ensure that it has systems in place that allow effective sharing and learning across the whole organisation.	**Part met**

Existing guidance on learning from serious incidents has been reviewed and KPIs for implementation have been introduced. A bi-monthly 'Lessons Learned' group meets to generate shared learning. This includes using the content of Ombudsman action plans to ensure learning points are appropriately extracted and shared. A rolling programme of articles in the Link is supporting learning. Directorate Boards now review Serious Incident reports and action plans to ensure timely implementation. Clinical Directors are sent details of each relevant Serious Incident and these are agenda items for directorate clinical governance meetings until they are responded to in a suitable way. This recommendation will only be fully met when success can be demonstrated over time. CQC and other stakeholders not only expect to see evidence that Serious Incidents are being dealt with internally, but also to see commissioners and other external organisations being informed when relevant.

74. 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.	**Part met**

As noted above, a web-based incident reporting system is being introduced across the Trust after a pilot in maternity. If the proposed clinical governance structure is introduced as planned, directorate boards will take on responsibility for regular reviews of learning from incidents. Learning from incidents is now integrated into the ward staff meeting structure, and better structures have been introduced to ensure learning is shared between staff across divisions. Again, this will need to be demonstrated over time.

75. 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.	**Part met**

Following the review of governance, suitable staff have been identified to ensure its recommendations are properly implemented. As above, proof of success will be seen through delivery.

4.15 Complaints (outcome 17)

76. Continue to develop and improve its complaints handling systems to ensure that complaints are responded to fully and in a timely manner.	**Part met**
A review of outstanding Ombudsman complaints has taken place; a dedicated manager has been appointed to follow up compliance with action plans or to report non-compliance to the Director of Nursing. Complaint numbers and trends are reported to the Quality and Safety Committee. PALS processes have been reviewed to try to address patient concerns at an earlier stage. CQC is aware that the Trust has seen a significant increase in complaint numbers since the investigation was published last year; as a result, while the underpinning systems have been improved, they are struggling to cope with an unprecedented surge in numbers.	

77. 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.	**Part met**
NHS London has supported the Trust to undertake a root cause analysis training campaign for senior management to ensure the importance of timely investigation of complaints is fully understood. A report of trends and themes aggregated across the Trust is reported every other month, including identification of trends and hotspots.	

78. 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.	**Not met**
A revised policy has been drafted and is awaiting senior management approval; it is currently available to staff but will only be considered on its way to being met when it is implemented and progress audited.	

79. 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.	**Part met**
The Trust Executive Committee and Board now receive a monthly complaints analysis; reporting is discussed at the bimonthly Quality and Safety Committee. The Patient Experience report to the Quality and Safety Committee includes a full analysis by directorate and highlights key issues. Reporting began in April 2012	

4.16 Records (outcome 21)

80. 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.	**Part met**
The Trust's Medical Records Committee has been re-established with new Terms of Reference; training levels for healthcare professionals are discussed at this Committee on a regular basis. Weekend transport for transfer of notes has been reintroduced and a nursing documentation booklet has been piloted across several wards and will be fully implemented by the autumn.	

81. 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.	**Part met**
A procurement process is underway to introduce an effective system to enable access to patient histories. Funding challenges have slowed introducing of a full electronic patient record.	