**Title:** CQC Inspection Report

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<tr>
<th>Report of the Chief Executive</th>
<th>For Decision</th>
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<tr>
<td>Open</td>
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<tr>
<td>Wards Affected: NONE</td>
<td>Key Decision: NO</td>
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<th>Report Author:</th>
<th>Contact Details:</th>
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<th>Accountable Director:</th>
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<tr>
<td>Fiona Taylor, Head of Legal and Democratic Services</td>
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<th>Summary:</th>
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<td>The Care Quality Commission’s (CQC) report into Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) - based on its investigation in October last year - was published on 18 December 2013. The report confirmed that despite some improvements, longstanding performance issues remain. As a result of the findings and judgments of CQC the Trust has been placed into ‘special measures’.</td>
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Averil Dongworth (Chief Executive) will be attending the Health and Adult Services Select Committee meeting to field questions and comments from Members on the CQC’s findings and their implications for BHRUT.

Information provided by BHRUT is attached at Appendix 1. This information will be supplemented by a presentation at the meeting.

The report overleaf provides further background information for Members on the inspection process and CQC’s findings. It also highlights issues of concern for possible exploration by Members and outlines Barking and Dagenham’s involvement in the sector/system response to the problems and challenges that BHRUT is facing.

<table>
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<th>Recommendation(s)</th>
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<td>Members of the Health and Adult Services Select Committee are recommended to:</td>
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<td>1. Discuss the findings of the CQC inspection with BHRUT and explore any issues that have arisen from the inspection report, such as poor patient feedback and record keeping (Section 2 and 3).</td>
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<td>2. Ask BHRUT to update Members on staffing and recruitment at BHRUT, particularly the recruitment of consultants in A&amp;E (Section 3).</td>
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<td>3. Highlight Barking and Dagenham’s involvement in the sector/system response to the</td>
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challenges that BHRUT is facing. Members may particularly wish to explore the assertion made by CQC that BHRUT is not working effectively in partnership with the three local authorities concerned, including Barking and Dagenham (Section 6).

1. About the inspection

1.1. BHRUT were inspected 14 - 17 October 2013 as part of the first wave of the new hospital inspection regime undertaken by the CQC. The changes to the CQC regime ensure that it is a more robust assessment undertaken by a larger inspection team, who are selected for expertise in the services being reviewed. BHRUT were selected as one of the first Trusts to undergo this new type of inspection because they were seen to be at ‘high risk’ - facing significant financial challenges and seriously underperforming on key indicators over the last few years.

1.2. The findings of the CQC’s inspection were published on 18 December. The full inspection report can be found at this link: [http://www.cqc.org.uk/sites/default/files/media/reports/20131213_-_cqc_quality_report_barking_havering_and_redbridge_university_hospitals_nhs_Trust_final.pdf](http://www.cqc.org.uk/sites/default/files/media/reports/20131213_-_cqc_quality_report_barking_havering_and_redbridge_university_hospitals_nhs_Trust_final.pdf)

2. Summary of findings

Under the new inspection regime CQC ask five key questions. The CQC’s judgements against those questions are summarised below.

I. Are services safe?

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

II. Are services effective?

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

III. Are services caring?

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

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

V. **Are services well-led?**

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

3. **Issues of concern**

In light of the headline findings above, and in exploring the detail within the CQC’s report, Members may wish to raise or consider the following issues when discussing the inspection results with Trust representatives:

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**Poor patient feedback**

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

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

**Poor discharging**

Poor discharge planning and capacity planning is putting patients at risk of receiving unsafe care and causing unnecessary pressure in some departments.

There are delays in discharging patients from the ITUs at both hospitals. Between April 2012 and April 2013, 50% of patients experienced a delayed discharge from the ITU and 64 patients were transferred to other hospitals for non-clinical reasons.

**Record keeping**

Nursing staff at both hospitals were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen’s and King George Hospitals with transfer checklists not always completed which meant staff at both hospitals may not be aware of a patient’s needs or requirements e.g. whether patients are diabetic or allergic to a certain type of medication or food.

**High weekend mortality**

The Trust was identified as having higher-than-average mortality rates for patients with pneumonia, septicaemia and most cancers and reviews have been carried out. In June 2013, information showed that elective patients who were
admitted over the weekend were at a higher risk than those admitted during the week.

— **Waiting times in A&E (4 hour target)**

BHRUT’s performance against this key performance indicator remains below the 95% target. Although there has been a gradual upward trajectory, performance fluctuates. Latest figures from January 2014 show performance is at 91.48%, for the year to date performance falls to 87.74%.

Members should note that the Urgent Care Board agreed on 27 January 2014 that Winter Pressures money should be reallocated in order to mitigate the number of breaches of the 4 hour A&E target.

— **Staffing and recruitment**

The Trust faces significant difficulties in recruiting medical staff for A&E, and has done so since 2011. The College of Emergency Medicine recommends that, for the number of patients seen in the A&E at Queen’s Hospital, it should have 16 consultants to provide cover 16 hours a day, seven days a week. The Trust has eight consultants in post out of an establishment of 21 to cover both A&E departments at Queen’s and King George Hospitals. At the Urgent Care Board on 27 January 2014 it was discussed that the number of consultants had reduced to approximately six. The heavy reliance on locum staff is putting patients at risk of receiving suboptimal care. Joint work with other Trusts has not achieved the desired results and additional work is underway, including recruiting staff from overseas.

At the Health and Wellbeing Board on 10 December 2013, Stephen Burgess (Interim Medical Director) reported that the Trust had recruited 18 middle grade Doctors, 10 middle grade Anaesthetists, and 2 Consultants for the Emergency Department. Members may wish to ask how many of these appointments are in post and on the wards.

— **Utilisation of the Urgent Care Centres**

Utilisation of Urgent Care Centres is at 27.57%\(^1\) for the month of January 2014 (target is 40%)\(^2\)

— **Financial position**

The financial position of the hospital remains a critical issue as BHRUT continue to operate at a substantial annual deficit. The NHS Trust Development Authority (NTDA) is working with BHRUT on this, but there appears to be no concrete plan for resolving it. Money to offset the costs of the PFI is dependent on other quality indicators improving. Members should be concerned that the Trust’s financial position constrains and delays its recovery.

4. **‘Special Measures’ and its implications**

4.1. The Chief Inspector of Hospitals, Sir Mike Richards, stated that the scale of challenges faced by BHRUT were the highest that he had seen. Although it was acknowledged in the CQC report that the Trust Board were starting to work together as a team to address the longstanding issues at BHRUT, the report stated that the

\(^1\) Integrated Performance Report – BHRUT Board Papers (8 January 2014)
leadership was ‘inadequate to address the scale of the challenges that the Trust is facing and additional support is required.’

4.2. The NHS Trust Development Authority has therefore put the Trust into ‘Special Measures’ on the advice of the CQC. In particular, this means:

- A focused regime to deliver improvement over a 12 month period, at which point there will be another inspection and the Chief Inspector will review whether ‘Special Measures’ continues;
- Developing an improvement plan (better than the existing one);
- Reviewing leadership and governance of the Trust in the next month;
- Linking with a high-performing Trust as peer support; and
- Appointing an Improvement Director to work with BHRUT executive team.

4.3. The Trust is required to develop an improvement plan to address the need to:

- Improve clinical and management support to deliver improvements to patient safety and quality, and improve ownership of improvement activity at every level of the Trust;
- Resolve problems in A&E departments of King George and Queen’s Hospitals, which are resulting in unsafe care;
- Put a protocol in place for the transfer of patients between Trust locations;
- Address the Trust’s discharge planning and patient flow problems, including improved working with local partners;
- Implement infection control procedures consistently in every ward and theatre across the Trust.

5. Capability and Governance Review

5.1. Following being placed into special measures the Trust was required upon request of the NTDA to review its leadership and governance. Sir Ian Carruthers\(^2\) was appointed to lead this process and a session was held on 15-16 January 2014 to which the three CCGs and three local authorities were invited to participate. Anne Bristow (Corporate Director, Adult and Community Services) and Graham Farrant (Chief Executive) represented LBBD.

5.2. The following issues were raised at the session:

- NELFT was not invited despite the inextricable links with the services they provide, nor were they invited to the CQC Quality Summit back in December.
- Local authorities refute criticisms of partnership working and support to aid BHRUT recovery (this is further explored in section 6)
- The implementation of ‘special measures’ should not be seen as an attempt to “start again” in the development of the improvement plan. Instead, it is crucial that all partners build on the progress that the health and social care economy has made.

\(^2\) Sir Ian is the Chair of the Healthcare UK Governance Board which is a joint initiative between the Department of Health, NHS England and UK Trade and Investment (UKTI) to promote the UK healthcare sector abroad.
— There is a need to develop and maintain a single integrated improvement plan for the issues at BHRUT as there is insufficient resources available to deliver and contribute to multiple plans.

6. **Support from LBBD and other partner organisations**

6.1. CQC have made assertions within the inspection report that BHRUT is not working effectively in partnership with the three local authorities and that this may have contributed to hospital discharge delays. Members should be assured that the Council, along with the wider health and social care economy, is committed to supporting recovery at the Trust.

6.2. The Council is working well with BHRUT, NELFT, the CCGs and the local authorities concerned to address problems at the Trust and feel that we have effective partnership relationships in place. Whilst there may be operational difficulties at times, there is very clearly both the appetite and the systems in place to ensure that these are jointly resolved (please see below under 6.3). The latest monthly statistics show that social care in Barking and Dagenham were responsible for none of the delayed transfers of care (DTOC) in October or November 2013. The Council has worked hard to reduce average DTOC figures and the average now stands at 0.9 DTOCs per 100,000 population for the year so far, in comparison to 4.5 last year. Patient flow issues within the Trust itself are currently thought to be causing the majority of the discharge issues: for example, delays in the dispensing of medicine within the pharmacy, or the arrangement of passenger transport for patients.

6.3. Additionally, there are several important elements of partnership working that are not picked up in the briefing supplied by the hospital which Members may wish to explore with BHRUT:

— **Integrated Care Coalition (ICC)**

Senior leaders across health and social care in Barking Havering and Redbridge have committed to working together in a coalition of strategic partners to develop a joint approach to integrated care to build a sustainable health and social care system. The ICC brings together senior leaders in the BHR health and social care economy to support the three CCGs and the three LAs in commissioning integrated care and ensuring a sustainable health and social care system. The Coalition is chaired by Cheryl Coppell (Chief Executive, London Borough of Havering).

— **Urgent Care Board (UCB)**

The UCB was established in June 2013 as an advisory Board, following agreement at the Integrated Care Coalition that there was a need to bring together senior leaders in health and social care in Barking and Dagenham, Havering and Redbridge to drive improvement in urgent care at a pace across the system. The UCB was established in the context of poor A&E performance at BHRUT and the recognition that getting this part of the system fit-for-purpose is crucial for system effectiveness and the strategic aims of the sector. The UCB is focussed on six priority areas:

1) A&E recruitment
2) Urgent care centre utilisation
3) 7 day working
4) Primary care improvement
5) Discharge arrangements
6) Frail elderly services

— **Joint Assessment and Discharge Service (JAD)**

As part of our work on the Urgent Care Board, LBBD is leading on the design and implementation of a Joint Assessment and Discharge (JAD) service responsible for the safe and timely discharge of patients from acute settings. The JAD service has been agreed to be jointly funded and resourced by BHRUT, LBBD, Barking and Dagenham CCG, LB Havering, Havering CCG, NELFT and Redbridge CCG.

— **7 day working**

Hospital social care teams within the Council have been working seven days a week as standard since November 2013 to ensure that essential care and support services are in place when patients leave the hospital setting.
1. Introduction

1.1. The Care Quality Commission’s report into Barking, Havering and Redbridge University Hospitals NHS Trust - based on its investigation in October last year - was published on 18 December 2013.

1.2. The report highlighted where the Trust has made positive changes over the last few years - in particular the high standard of patient care provided. It also identifies issues, some of which are long-standing.

1.3. As a result, the CQC placed the Trust into special measures.

1.4. The Trust is disappointed at this outcome on the back of such a positive report. However, as a Trust we have been asking for support for some time to tackle our financial deficit and to improve waiting times in our emergency departments.

1.5. Special measures have been recommended for the Trust as support for our management team to help them tackle some of the major issues. Day-to-day frontline services will be unaffected, with services continuing as usual.

2. Positive Feedback

2.1. Patient care

Patients were positive about the care they received from staff, and this was reflected across all eight of the core service areas.

The inspection team was especially impressed with the care provided to patients who have had a stroke, with the Trust performing well against a number of data indicators.

2.2. E-handover

The CQC praised the e-handover system in the medical services, allowing doctors to manage their workload more effectively, which benefits patients.

2.3. Maternity services

The Trust's maternity services, which have undergone a huge transformation over the last two years, maintained the improvements following the transfer of the delivery unit from King George Hospital last year.
2.4. **Virtual ward**

The feedback from patients about the virtual ward – allowing people to be cared for at home - showed they valued the service.

2.5. **End of life care**

Patients received safe end of life care. They had support to make decisions about their care and staff working in the service were experienced, knowledgeable and passionate about providing good care outcomes for patients. Patients and their families had positive views about the end of life service.

3. **Areas For Improvement**

3.1. **Emergency care**

People experienced excessive delays in being assessed, reviewed, and treated. On some nights there are too few full-time doctors on duty, and at other times there are too many patients in the department. Patients were also not seen and treated effectively by specialist staff, and were waiting too long to be either admitted or discharged.

3.2. **Surgery**

Nursing documentation was inconsistent. Where patients had been transferred between the hospitals, there was no documented handover and staff were not always aware of a patient’s medical history. At KGH patients were put at risk of infection in theatres due to inadequate cleaning and poor practices by staff.

3.3. **Sepsis**

The CQC asked several nurses how they would recognise sepsis and how they would respond to this, but none knew if a guideline was available or were able to clearly define what sepsis was.

3.4. **Note taking**

Some of the nursing staff observed on both medical and surgical wards were not routinely documenting the care patients required or received. Discharge plans, along with nursing notes, were not up to date. Many patients were transferred between Queen’s and King George hospitals with transfer checklists not always completed.

3.5. **Discharge**

Delayed discharges, particularly in medical services, and high occupancy rates meant that the service could not be as responsive as required, and this put unnecessary pressure on departments and increased the risk of poor outcomes.

3.6. **Outpatients**

The outpatient service did not always provide safe and effective care. Patients received treatment and follow-up appointments, although these were not always held in appropriate private locations. Patients were able to ask questions to help understand their treatment and monitoring plans but sometimes this could be rushed. Some clinics were very busy and patients had to wait, but staff were caring and waiting times were displayed, although some patients felt they were not kept informed.
Some clinics were not managed efficiently and areas of the service needed to improve.

4. **CQC actions**

4.1. Ensure the Chief Operating Officer has clinical and management support to deliver improvements to patient safety and quality. The improvement plan should be agreed at Board level with progress monitored at each Board meeting.

4.2. Ownership for improvement must be embedded at every level of the Trust and the visibility of the Executive Team at Queen’s Hospital and King George Hospital must be improved.

4.3. The Trust needs to urgently focus on resolving problems in the A&E departments of King George and Queen’s Hospitals which are resulting in unsafe care.

4.4. A clear and unambiguous protocol must be put in place for the transfer of patients between Trust locations. All care must be documented.

4.5. The Trust must also address its discharge planning and patient flow problems which will require improved working with local partners.

4.6. Infection control procedures must be implemented consistently in every ward and theatre across the Trust.

5. **Next Steps**

5.1. A draft compliance plan has been developed, this will feed into the overall improvement plan focussing on issues raised in the CQC Report and recognising a number of existing work plans.

5.2. Sir Ian Carruthers undertook a capability and governance review on 15 and 16 January 2014. His report and recommendations to the Chief Executive of the NHS Trust Development Authority (NTDA) will form the basis of a Board to Board meeting between the Trust and the NTDA. We await confirmation of the date. The final improvement plan will be agreed at that meeting.

5.3. An Improvement Director, Steven Russell, joined the Trust on 13 January 2014.

5.4. The Trust has established a Rapid Improvement Group, Chaired by Dr Ian Hosein, to develop, oversee and monitor progress with the improvement plan.

5.5. For all other staff, focus will be on providing the best care for patients as always.