

Barking, Havering and Redbridge University Hospitals NHS Trust

Quality Report

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

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Summary of findings

Overall summary

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary of findings

- Ownership for improvement must be embedded at every level of the trust and the visibility of the Executive Team at Queens Hospital and King George Hospital must be improved.
- The trust needs to urgently focus on resolving problems in the A&E departments of King George and

Queen's Hospitals which are resulting in unsafe care. A clear and unambiguous protocol must be put in place for the transfer of patients between trust locations. All care must be documented.

- The trust must also address its discharge planning and patient flow problems which will require improved working with local partners.
- Infection control procedures must be implemented consistently in every ward and theatre across the trust.

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive to people's needs?

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

Are services well-led?

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

Summary of findings

What people who use the trust's services say

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

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

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

Areas for improvement

Action the trust MUST take to improve

- Ensure the Chief Operating Officer has appropriate management support to deliver improvements to patient safety and quality. The improvement plan should be agreed at Board level with progress monitored at each Board meeting.
- Ownership for improvement must be embedded at every level of the trust and the visibility of the Executive Team at Queens Hospital and King George Hospital must be improved.
- The trust needs to urgently focus on resolving problems in the A&E departments of King George and

Queens Hospitals which are resulting in unsafe care. Specialist doctors must attend patients in the A&E department within the agreed timescales outlined in the trust's policy.

- A clear and unambiguous protocol must be put in place for the transfer of patients between trust locations. All care must be documented.
- The trust must also address its discharge planning and patient flow problems which will require improved working with local partners.
- Infection control procedures must be implemented consistently in every ward and theatre across the trust.

Good practice

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

- The e-handover system in the medical services which allows doctors to manage their workload more effectively.
- Patients were positive about the care they received from staff, many of whom were positive about working for the trust.

- The virtual ward which was established in 2009 in the medical services. The ward allows patients to receive care at home and feedback from patients showed they valued the service.
- The inspection team was impressed with the care provided to patients who have had a stroke, with the trust performing well against a number of data indicators and was in the first (highest) quartile of all units.

Barking, Havering and Redbridge University Hospitals NHS Trust

Detailed findings

Hospitals we looked at

King George Hospital and Queen's Hospital

Our inspection team

Our inspection team was led by:

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

Background to Barking, Havering and Redbridge University Hospitals NHS Trust

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

The trust has two acute hospitals: Queen's Hospital and King George Hospital. Accident and emergency (A&E)

departments operate from both of these hospitals. King George Hospital was built in 1993 and is the main hospital for Barking and Dagenham and Redbridge. Queen's Hospital opened in 2006 and brought together the services previously run at Oldchurch and Harold Wood Hospitals. It is the main hospital for Havering.

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The trust was included in the first wave of the new CQC hospital inspection programme, as it had been shown to be

Detailed findings

at 'high risk' on several indicators in the new Intelligent Monitoring tool. Over recent years the trust has faced significant financial challenges and has been a persistent outlier on some key quality of care indicators, including:

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

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

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

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

The Chief Operating Officer with support from some senior medical staff is now trying to address these challenges, but progress has been slow mainly due to a lack of engagement and support from all senior clinical staff. The

longstanding history of the problems and lack of progress indicates that the leadership is inadequate to address the scale of the challenges that the trust is facing and additional support is required.

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

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

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Prior to the visit we reviewed a range of information we hold about the Trust and asked other organisations to share what they knew about the Trust. We carried out an announced visit from 14–17 October 2013. During the visit we held focus groups with a range of staff in the hospital,

nurses, doctors, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We talked with patients and staff from all areas of both hospitals including the wards, theatre, outpatient departments and the A&E departments. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held a listening event where patients and members of the public shared their views and experiences of the Trust.

Are services safe?

Summary of findings

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

Our findings

Incident reporting/never events

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

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

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

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

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

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

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

Cleanliness and infection prevention and control

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

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

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

Staffing

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

Are services safe?

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

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

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

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

Documentation

Nursing staff at both hospitals were not routinely documenting the care patients required or received.

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

Environment

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

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

Safeguarding vulnerable adults and protecting children

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

Are services effective?

(for example, treatment is effective)

Summary of findings

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

Our findings

Mortality rates

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

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

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

NHS Safety Thermometer

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

National guidelines

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

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

Clinical audits

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

Are services caring?

Summary of findings

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

Our findings

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

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

Staff attitude

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

Involving patients in their care

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

Privacy and dignity

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

Nutrition

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

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

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

Our findings

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

Waiting times

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

Discharge

At Queen's Hospital on occasion patients having day case surgery had to be nursed in and discharged from the recovery area rather than a ward due to bed shortages. The environment was not designed to accommodate patients who should be cared for on a ward. There was a lack of privacy, insufficient bathroom facilities and patients were served food while others were coming round from their anaesthetic. Elsewhere in the hospital we were told about delays in patients being discharged. Staff attributed some of this to care packages not being in place, doctors not completing discharge summaries 24 hours in advance and delays in getting medicines for people to take home. Pharmacists told us that they were often informed late in the discharge process which meant medicines weren't ready until late in the afternoon.

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

Cancelled operations

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

Outpatient appointments

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

Seven-day working

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

Complaints/patient feedback

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

In terms of complaints, the trust target for responding to complainants within the agreed timeframe (these are based on the complexity and severity of the complaint and range from 10 days to 80 days) in July 2013 was 85% and

Are services responsive to people's needs?

(for example, to feedback?)

the trust achieved 82%. Of the 11 departments, seven achieved the trust target with six achieving 100% response rate. Directorates that did not meet the trust target were Emergency Care, Acute Medicine and Surgery.

The trust was aware that between 15 and 20% of responses did not answer the questions raised in the complainant's original letter and has put a system in place for members of

the executive team to check the responses before they are sent out. Work is also being done with managers and clinical staff on how to conduct a thorough investigation and put together a good written response.

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

Are services well-led?

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

Summary of findings

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

Our findings

Leadership

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

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

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

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

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

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

Monitoring quality

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