



BHRUT's improvement programme and response to the CQC investigation

December 2011



Background on the investigation

- Investigation followed long-standing concerns and instigated over summer 2011 to investigate:
 - The quality and safety of care provided at King George and Queen's Hospitals
 - Whether BHRUT's systems and processes give the organisation enough support to tackle the challenges it faces
 - Reviewing an emergency care pathway, an elective care pathway (vascular surgery) and the maternity services care pathway.
- Involved interviews with staff, patients, stakeholders and site visits.
- Published on 27 October 2011, with further conclusions on working with partners and safeguarding following on 6 December 2011.



Summary of the CQC report:

- Although there have been some positive developments recently, patients remain at risk of poor care, particularly in maternity services.
- Need for improvement in patients' experience, the management of complaints, staff recruitment and the Trust's system of governance.
- Long standing concerns reported in maternity, identifying poor clinical care, abusive behaviour, lack of learning from incidents, disengaged staff.
- Difficulties in achieving the 4 hour maximum wait from the Emergency Department - need to consolidate recent improvements to reduce risk of poor care in the future.
- Real concerns about safety in the mid- to long term, despite short-term actions to mitigate risks in Maternity.
- 79 recommendations made.



BHRUT's response: overview

- BHRUT takes the investigation's findings extremely seriously
- Poor care described in the report is unacceptable and the Trust is sorry for the impact on patients and the confidence of the wider community
- We will be working with partners to implement recommendations as swiftly and effectively as possible
- The CQC has debriefed the Trust after each of its visits and during the course of the investigation
- We have taken immediate action as a result and some improvements have already been made
- Addressing all the recommendations fully will take some time
- We are committed to taking further action until we are providing the care our patients deserve and can restore the confidence of the regulator and the wider community.



Improvement actions: Leadership and culture

- Programme of staff engagement underway, with large staff briefings at both hospitals on the day of the report's launch
- In-depth meeting with a cross-section of staff the day after the report's launch to discuss what support staff needed from managers to implement the recommendations
- Training and support for managers to tackle poor performance and provide leadership
- Staff behaviour study in Maternity, to identify areas needing improvement
- Work of the new Chair, Chief Executive, Director of Nursing and Medical Director to lead cultural change.



Improvement actions: Maternity staffing

- Leadership has been strengthened with a new management team
- Recruited an additional 72 midwives to ensure one-to-one care for women in labour
- Enhanced staff rotas with high levels of experienced midwives available on every shift
- One of the best midwife to birth ratios anywhere in London (1:29)
- Queen's maternity service has one of the highest levels of senior doctor cover in the country and the highest level in London (98 hours)



Improvement actions: Maternity quality

- Improved clinical governance support, including quarterly conferences for staff to learn from incidents, two held already, and a regular briefing on learning from incidents and complaints
- Improved feedback from women using the maternity service, with real-time patient surveys and the involvement of local mothers through the Maternity Service Liaison Committee
- Work with professors from the Royal College of Obstetricians and Gynaecologists on how we can manage capacity most safely
- Work with staff to make sure they are delivering a caring and compassionate service, responsive to the needs of our patients
- Reduced delays in time to assessment and time for pain relief
- Regular, independent monitoring of performance every week with CQC visits and support from NHS London and NHS ONEL.



Improvement actions: Maternity – reducing pressure

- New system in place to ensure the unit is never too busy to provide high quality care to women in labour:
 - Short term action to move caesarean deliveries to the Homerton
 - Deliveries from Essex mothers-to-be commissioned from Essex hospitals until March
 - Women diverted to other local hospitals when threshold levels are met to help ensure no more than 20 births in a 24 hour period at Queen's, 7 at KGH
 - We will not refuse care to a woman presenting with urgent health needs or where there is no capacity in other hospitals.
- Plans to build a new midwife-led unit at Queen's, to improve capacity. Subject to funding, will have capacity for extra 8 women per day from the middle of next year.



Improvement actions: Emergency care

- Work with partners including local GPs, commissioners and social services to improve pathways from diagnosis to after-hospital care, so patients get the most appropriate care in the right place
- Action to reduce staff shortages in A&E: nurses fully recruited although A&E consultant and middle grade doctors hard to recruit
- Further work needed to ensure Emergency Care performance is consistently high, particularly as we enter winter
- Planning underway to expand the capacity of Queen's Emergency department and Critical Care, including extra capacity in Resuscitation and Intensive Care.

Delays in A&E often caused by poor patient flow across the hospital:

- Greater use of IT systems Jonah and Bedweb to track causes of delay and who and what can resolve them
- Action plans to reduce delays (for example in Radiology and Pharmacy) to reduce delays within hospital and for patients waiting for discharge.



Improvement actions: Quality and clinical governance

- Commitment to share learning from incidents more widely eg maternity clinical governance conference
- Improved records management – ending practice of reusing record files
- Best in the country for responding to NPSA safety alerts
- Hiring additional specialist staff to ensure quality, eg additional radiologists to ensure scans reviewed by expert clinicians & promptly reported
- Board Quality and Safety Committee to review incidents, complaints and safety concerns, monitoring and driving action.



Improvement actions: Patient experience

- New complaints system owned by clinical staff – to help them understand the cause of complaints and take action to address the causes of complaints and respond better to complainants
- Real-time survey on handheld devices and kiosks to identify patient feedback and act on it without delay
- Work with staff to ensure they get the support they need to deliver compassionate care, using nurse leadership, training, and staff engagement
- Programme of cultural change to improve staff behaviour, encourage responsibility and to deal more effectively with performance concerns amongst staff: zero tolerance for patient abuse and warning system for
- Work to improve the environment for patient eg improved signage and reduced delays in inappropriate areas.
- Support of our patients' fora, the Improving Patient Experience Group and Maternity Service Liaison Group, relationship with the LINKs and working with local people to improve.



Other issues

- Report recognises need for support from commissioners and NHS London
- Some issues require work with partners, for example, to improve capacity, finance and buildings
- Capacity issues need to be addressed by whole health economy, particularly on maternity
- Need to continue to develop relations with external providers and partners, particularly around adequate provision of rehabilitation services and appropriate admission and discharge practices
- Need to continue to develop joint working practices with partners on safeguarding
- BHRUT committed to addressing its own issues and working effectively with partners to address wider issues.



Decision on Health for North East London plans

- Need to address the quality and capacity of care at Queen's before any service reductions at King George
- Capacity plans, particularly the development of the Midwife-Led Unit and expansion of our Special Care Baby Unit, Critical Care and Emergency Department are being drawn up
- Finance will need to be agreed and capacity improvements not expected for many months (MLU could be ready for summer 2012 as a first step)
- Health for north east London strategy based on projections that length of stay in hospital would reduce significantly with improvements in and enhancements of out-of-hospital care – will require partnership with GPs and other services in the community
- Will be a number of moves of services to other locations and between sites eg sexual health from Queen's to Romford town centre
- Will be working closely with commissioners to prepare detailed implementation plans for the whole of the programme.



Conclusion

- Comprehensive action plan in preparation, bringing together our improvement programmes on a number of areas, for example, our Maternity Action Plans.
- Some improvement has already been made, however needs to go further and faster
- There is much to do, it will take time and will be challenging, particularly given our resource constraints and the scale of the cultural change we need to deliver
- We appreciate there is much work to do to rebuild public confidence in our services, and we are committed to being transparent and keeping you updated on the progress we are making.



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