



QUALITY ACCOUNT

Report for 2010/11



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

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CHIEF EXECUTIVE STATEMENT ON QUALITY

I am committed to ensuring that every patient receives high quality care, care that is safe, with good clinical outcomes and gives patients the best possible experience of our services. This second annual Quality Account has been produced to provide the public with useful information on the quality of our services at Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT). The report notes the achievements staff have made over the last year, and helps focus attention on key priorities for future improvement.

The Trust has worked hard to improve the quality of care over the last year. At BHRUT, we have a strong focus on quality 'from ward to Board'; identifying areas that need targeted attention to generate improvement. Our Matrons and senior nursing staff spend one day every week back on the wards, auditing the quality of care, supporting front-line staff, and listening to patients and staff suggestions. Groups have been set up to review pain assessment and management, to improve the promotion of continence and to improve patient experience and protect dignity. Dignity champions have been put in place to ensure that patients are treated with respect, and a Productive Ward scheme has been introduced which has seen the time nurses have to spend on direct patient care increase by 12%.

As a teaching hospital and centre of excellence in services such as neurosurgery, we want our patients to be benefiting from the latest innovations, most skilled staff and achieving the best clinical outcomes. For example, an additional 2.6 patients in every hundred brought to Queen's Hospital with serious head injuries are surviving compared to other neurosurgical centres. This is due in no small part to the early involvement of our Neurosurgeons, the care given by specialist staff in our neuro critical care unit and the excellent facilities we have to rehabilitate patients.

Our staff are proud of our progress in the reduction of stroke mortality and the overall hospital mortality rate and the immense organisation change that occurred during 2010/11 to centralise our breast and vascular services ensuring better outcomes for our patients.

We also seek the views of our patients and the wider community, and have recently introduced a handheld device for patients to give their feedback in 'real time'. The input of our Local Involvement Networks and the Trust's Improving Patient Experience Group has proved extremely valuable, as well as feedback on our services and suggestions for improvement from patients and visitors.

New ways of treating people have also been introduced. With the Ambulatory Care Centre and Virtual Ward, many patients can leave hospital earlier while still benefiting from care from a matron and consultant specialising in the patient's specific condition, and 24/7 assistance if it is needed. Higher levels of patient satisfaction, faster recovery rates and improved clinical outcomes are the result.

Elderly care has been a key focus for the Trust, with a new Acute Elderly Unit opening in August 2010 to give dedicated care to older people at both Queen's and King George Hospitals. Patients on the unit are seen by an elderly care specialist on arrival and there are therapists on site to help with rehabilitation. The number of falls for these patients has been cut by half, the number of pressure ulcers has reduced by 30%, and the recording of patients' vital signs has gone up by 35%. Elderly patients are recovering so well in the Acute Unit that in the first nine weeks the average length of stay fell by two days.

The Trust was registered with eight conditions by the Care Quality Commission (CQC) in April 2010. These conditions have been helpful in focusing our efforts in making key improvements, and this report addresses the areas of conditions in detail. Despite several of these conditions now being lifted by the CQC and evidence of improvements in all areas, there is no complacency at BHRUT about the need to improve quality, and to continue to deliver quality care in every clinical area. This is particularly the case in our Maternity Services, where attracting and retaining sufficient trained staff is a continuing challenge. The CQC issued a warning notice requiring improvements in Maternity in March 2011, and we are working with staff and local women to ensure that the concerns of the regulator are addressed so that we can rebuild confidence in the quality of our services.

Financial pressures are also an ongoing challenge for BHRUT, but I am clear that there should be no compromise between quality and cost-savings. We continue to recruit front-line clinical staff and to improve our nurse to patient ratios in key areas to ensure we are offering high quality care. We are particularly focusing on reducing reliance on temporary or locum staff, to improve the continuity and quality of our care while using public money more cost-effectively.

During the year we have had some senior level changes. I have recently taken over as Chief Executive from John Goulston, and Edwin Doyle replaces Sir David Varney in the role of Chairman of the Trust. Divisional Director of Surgery Stephen Burgess has been appointed Acting Medical Director, replacing Dr Ian Abbs who joined BHRUT on secondment. I would like to thank both the outgoing Chief Executive and Chairman, and Dr Abbs, for their hard work on behalf of the local population.

The Trust Board and I are very clear that whilst the Trust has areas of excellence there are significant challenges still to be resolved. We are determined that in partnership with our staff those challenges can be met, particularly the concerns raised by the Care Quality Commission; we will continue to develop solutions that ensure sustainable improvements. Therefore our key priorities will be to enhance Maternity Services to achieve the best health outcomes for mothers and the newborn; to provide timely care to patients seen in the A&E Department, and to improve patient experience in all areas.

This report covers a wide range of topics important to patients, their carers, patient groups, commissioners and local authorities. We look forward to working with our partners throughout the year in showing progress in all areas identified within the Quality Account and I look forward to being able to report back on how we have met our challenges.

The Trust Board and I are confident that the content of this report is, to the best of our knowledge, correct.

Averil Dongworth
Chief Executive





LOOKING FORWARD
Our Priorities for Improvement

PATIENT SAFETY

| | Our quality priorities | Why we chose this | What success will look like | Where we will monitor and report progress |
|-----------------------|------------------------------------|---|--|---|
| Patient safety | Care Quality Commission conditions | To meet the remaining conditions on BHRUT's registration. | Remaining conditions lifted and evidence of sustained improvement provided | The Audit Committee is the principal monitoring committee, reporting to the Trust Board. Updates on progress will be included in the 2011/12 Quality Account |
| | Safety Express Programme | BHRUT is taking part in this Department of Health initiative to deliver harm-free care by reducing pressure ulcers, falls, catheters, urinary tract infections and blood clots. | Embedding this tool for monitoring and reporting, and collecting evidence of improved rates of harm-free care. | The weekly Visible Leadership Programme will audit implementation with reports made on progress to the Nursing & Midwifery Board and, by exception to the Quality & Safety Committee. |

1.1 Care Quality Commission

The Trust completed the Care Quality Commission's (CQC) registration process in April 2010. The locations and regulated activities it is registered for are shown in our Statement of Purpose, available on the Trust's website. These were agreed after discussion with the CQC and an in-depth internal self-assessment process. Registration was granted with a number of conditions. The CQC has made a number of unannounced visits to the Trust during the year to review various aspects of patient care and our progress against the conditions placed on our Registration. The actions taken by the Trust to make the necessary improvements are summarised below:

Resuscitation Training

During the period prior to April 2010, uptake on resuscitation training throughout the Trust was poor leading to the CQC condition being issued in May 2010 requiring a 100% compliance rate amongst clinical staff to attend resuscitation training during that year. A deadline of 31st December was placed on this condition.

Education and Learning worked with clinical staff to increase the profile of resuscitation training and ensure that staff were released from the clinical areas to attend. Sufficient places were provided during 2010 to ensure all clinical staff could attend training and extra sessions were sourced from an external contractor towards the end of the year to achieve the required compliance rate.

From an initial poor compliance rate, by December 31st 2010 we had trained 93.32% of the clinical workforce. Arrangements were put in place for the New Year to continue the momentum and sessions were arranged to capture those staff still needing to attend resuscitation training. Monthly compliance reports continue to be escalated to Divisional Leads to ensure we maintain this level of compliance throughout the coming year and sufficient training sessions for clinical staff have been advertised for 2011.

This condition has now been removed.

Appraisal

The CQC set a deadline of the 31st December 2010 for the Trust to ensure all staff had received an appraisal within the last 12 months. In January 2010 the appraisal compliance rate was a poor 33.9%.

The Education Department has continued to provide appraisal training and courses were run for staff new to the process and also refresher updates to clarify the documentation, which had been revised to make the process simpler.

Some courses were run for groups of staff from a particular department to enable learning as a team. Information, advice and guidance were provided on an individual basis either face to face or by telephone to answer queries regarding the process. The Divisional staff appraisal Key Performance Indicators (KPI) for 2010/11 was provided by HR Workforce, with a target rate set at 100% compliance for those who were eligible for an appraisal. A monthly report on appraisal was provided to each Division and completed appraisals were recorded centrally on the Electronic Staff Record (ESR) providing detailed lists of individual employee's current appraisal status.

By the CQC deadline the Trust had improved its appraisal rate to 94.7%. The remaining small proportion of staff were either on long term sick leave, maternity leave or new to the Trust and would be followed up appropriately. The condition has been removed by the CQC

Discharge Planning

In order to address the CQC condition that discharge plans were started on admission, monitored and updated for the duration of a patient's stay in our hospitals, the Trust developed a Complex Discharge Partnership Board that reports to the Emergency Care Taskforce. This is a Board where all community partners come together to jointly examine and solve discharge issues; working together to ensure people are discharged in a timely and safe way. This partnership approach ensures that those people who are fit are discharged and we can make beds available for those patients that are acutely ill and who need hospital care.

A more robust system has also been introduced where all complaints about discharges are investigated, responded to and used to learn where we can improve. This year has seen the full implementation of the electronic recording system called JONAH that ensures all patients are given a planned discharge date. Any deviations from that date are investigated.

The Trust was able to satisfy the CQC that its discharge planning process had been strengthened and the condition, that had a deadline of the 30th June 2010, has now been removed.

Pressure Damage

When people are ill, do not eat well, have underlying health problems or are incontinent, they can be at risk of getting pressure damage. Patients can develop this before they enter hospital and, on occasion, after admission. It is one of our priorities to ensure that as few patients as possible develop pressure damage whilst in our care.

The Trust was aware there were difficulties in this area and was starting to address them when the Care Quality Commission made the topic the subject of a Condition of our Registration with a deadline of the 31st December 2010. The additional impetus of having to demonstrate to our patients and the CQC that improvements were being made has helped us focus on providing more resources for staff, increasing the number of specialist nurses trained in tissue viability. New documentation called a Skin Bundle has been developed to assess and record patients with pressure damage which guides staff through the steps needed to provide good quality skin care. Patients are risk assessed on admission and reviewed regularly to ensure their skin health is closely monitored. Further information on pressure damage initiatives in the Trust is included in section 1.2.

This condition has been removed.

Staffing

There were two elements to the staffing condition placed on the Trust, the first related to nursing staff with a deadline of the 30th September 2010.



Some of our newly recruited Nurses

This condition has been removed by the CQC following the submission of a range of evidence including information on a number of recruitment drives and campaigns.

The critical care campaign held in June 2010, resulted in recruitment to 82 positions within Maternity, Surgery and A&E.

There were three campaigns to recruit general nurses with a One Stop Recruitment Services, with 85 nurses appointed to various positions across the Trust. Forty-four healthcare assistants were appointed in two campaigns.

The second staffing element related to staffing levels in our Maternity & Midwifery service with a deadline of 30th November 2010; this condition remains outstanding. Following CQC visits to Queen's maternity department in January 2011 the Trust was issued with Warning Notices relating to the major concerns they had around both staffing levels and the standard of care and welfare offered to women. A number of moderate concerns were also highlighted by the CQC that women were not as involved in their care as they should be; that there were not appropriate levels of training and supervision of midwives, and that health records were not being securely managed. A third Warning Notice relating to equipment was downgraded from a major concern to a moderate concern.

The Divisional Director of Women's & Children's Services took immediate action reviewing all elements of the CQC's concerns and developing a comprehensive action plan to address the issues. Staffing levels were improved to ensure each area has appropriately trained staff in place.

Implementation of the action plan is ongoing and is overseen by the Trust's Executives, the CQC and NHS London. Wide ranging steps have been taken including changing the maternity triage system, changes to working rotas and a review of Consultant job plans to strengthen cover

arrangements. A new Bed Manager post was introduced to more appropriately manage women through their different stages of labour ensuring they are placed in the safest area for their care. The action plan includes the designing of new antenatal education programmes, carrying out patient satisfaction surveys and developing new ways of working for community midwives.

The maternity service is being constantly reviewed and although there have been some and deeply regretted high profile incidents highlighted in the media, improvements are and will continue to be made to ensure that we can offer a safe service to labouring women. Next year's Quality Account will provide more detail on the improvements anticipated to result from the actions being taken now.

Child Protection Training

The condition to ensure that all midwives had received the relevant level of child protection training has been removed by the CQC as they were satisfied with the evidence provided to them to meet their deadline of the 31st July 2010.

The evidence described the work carried out by the Maternity Education Lead who reviewed the midwives existing training status and needs, and who subsequently developed and delivered a comprehensive child protection training programme to ensure we could meet the CQC's expectations. Additional administrative support was provided to ensure that accurate recording of attendance on a dedicated database was available to enable close monitoring by the Trust's Safeguarding Children Committee.

However, with children accessing all areas of the Trust, safeguarding children training is vitally important for other staff too and the Safeguarding Team provide Safeguarding Children multi-disciplinary training sessions throughout the year as follows:

Level 1

Since 2006, all staff within BHRUT has received level 1 training on induction. This includes a basic awareness of what to do if they have a concern regarding safeguarding children and how to identify abuse. By 31st December 2010 96% of nursing and midwifery staff had received level 1 training.

The Trust's PFI partner, Sodexo, which employ the domestic, catering and portering staff, provides level 1 training for its entire staff and reported 96% compliance by the 31st December 2010.

Level 2

All clinical and non-clinical staff that has infrequent contact with parents, children and young people is required to undergo level 2 training. By 31st December 2010 81% of relevant Trust staff had received training.

Sodexo staff working in designated areas access level 2 training provided by the Trust's safeguarding children team; of the required staff, 95% have been trained as at 31st December 2010.

Level 3

All staff working predominantly with children, young people and parents are required to undergo level 3 training. By 31st December 2010 91% of relevant Trust staff had received training.

In September 2010 the Intercollegiate document *Safeguarding Children and Young People: roles and competencies for health care staff* was updated. The Trust Training Strategy for 2011 has been updated to reflect the recommendations of this document and training programmes reviewed to ensure that all required areas are included.

Nurse Mandatory Training

A Registered Nurse annual three-day mandatory programme was introduced in the Trust in March 2008, with regular revisions to the programme to ensure national and local priorities are met.

During the period of this report, the annual programme changed to a two-yearly mandatory programme. Following further revisions and changes to the programme in 2011, a new combined programme for mandatory training was introduced.

This new programme has Registered Nurses, Healthcare Assistants and Operating Department Practitioners coming together to receive their mandatory training on a three-day programme.

Sufficient programmes have been arranged to meet staffs' two-yearly mandatory training requirements. More than 87% of these staff groups have completed their mandatory training for the last two-year period (March 2009-February 2011)

The revised process has been accepted by the CQC as sufficient evidence was presented to remove the condition placed on this topic.

Treatment Rooms

The CQC applied a condition relating to the inappropriate use of treatment rooms to the Trust's Registration at Queen's Hospital following an unannounced visit. A deadline of the 30th April 2010 was given.

There are no treatment rooms at King George Hospital. The treatment rooms are where patients are taken in their beds to have a procedure or dressing undertaken on the ward. They are equipped with piped oxygen and air, and with suction equipment. The rooms also have hand-washing facilities but do not have en suite bathrooms or toilet facilities.

The CQC identified that bed capacity issues meant that patients were being placed in treatment rooms and other areas not designed to accommodate inpatients. As a result, equipment and stores normally kept in these rooms had also been moved into inappropriate storage areas.

Immediate steps were taken to move patients out of treatment rooms at the earliest opportunity. A Rapid Stabilisation Protocol was developed to ensure other patients were not placed in unsuitable areas and risks - such as infection control, nutrition and visiting arrangements - were appropriately assessed. The Trust was able to assure the CQC that contingency areas were no longer in use during a further unannounced visit in June where staff and documentation was reviewed. The CQC concluded that the Trust had made significant progress and the condition was lifted.

Unfortunately the Trust has no direct influence over the number of patients arriving in A&E and at times the pressure on beds increases. A robust risk assessment process is now in place to ensure that treatment rooms can only be used in extreme circumstances, and only for low risk patients who do not require high levels of nursing. This has been discussed with the CQC as the safest option for patients as it reduces the risk of seriously ill patients being kept in A&E longer than is necessary or safe.

The Trust's Executive Team are fully conscious that the improvements made must be sustained and ongoing compliance against these conditions is reviewed frequently at senior level meetings to ensure performance does not fall below expectations.

In addition, the Trust is Registered with the CQC for the *Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*. The Trust's original registration came into force on the 1st April 2009 and continued compliance is monitored by the Director of Infection Prevention and Control and the Infection Control Committee. Ensuring

that we continue to comply with the Code remains a priority for the Trust and progress is reviewed by the Infection Control Team.

1.2 Safety Express Programme

The Department of Health has established *quality, innovation, productivity and prevention* (QIPP) as the guiding principles to help the NHS deliver its quality and efficiency commitments. To take this initiative forward, a Trust Steering Group has been set up with the aim of delivering harm free care by reducing pressure ulcers, falls, catheters and urinary tract infections and the number of blood clots experienced by patients (VTE).

To measure progress with these four targets, a new NHS tool called the Safety Thermometer is being used to collect information, allowing a complete picture to be established for patients that may be at risk. The tool also allows improved monitoring and reporting, which in turn allows staff to tailor patient care more closely to their individual needs.

Falls

As reported last year, following the Patient Safety First campaign and the local Productive Ward initiative, reducing high impact falls for patients in our hospitals continues to be a top priority. To ensure patients that have suffered a fall at home, or have fallen whilst in our care receive appropriate treatment the Trust has piloted a new set of documentation called a Care Pathway. Staff assess patients for their risk of falling when they are admitted and agree a plan of care. We have also piloted a more detailed method for capturing data on patient falls, which is helping the Falls Prevention Group and the Nursing Directorate understand how, when and why patients suffer falls so that appropriate action can be taken to prevent them and we can monitor whether the actions being taken are making a difference.

The Falls Prevention Committee has designed and introduced a Patient Information leaflet aimed at helping patients and their relatives identify potential fall trigger points for people with mobility problems.

The Trust has bought a supply of slippers suitable for use on the wards and in people's own home for patients who may not have suitable footwear for moving about or who have no relatives to bring in slippers for them.

In addition to running a further Patient Safety First Campaign, the Trust's Health & Safety Team, together with our partners Sodexo and Parkhill Audit Agency, have held other events such the one highlighting European Health & Safety Week.



European Health & Safety Week

Urinary Tract Infections

Reducing healthcare associated infections through indwelling urinary catheters is one of the Department of Health's High Impact Nursing Actions to ensure patients are protected from infection. Commissioners have also included improvements for these infections as part of the CQUIN (Commissioning for Quality and Innovation)¹ programme.

Nationally, a new definition relating to these infections is expected from the Department of Health but has not yet been received. To protect patients, we are following best guidance that patients should not have an indwelling catheter for longer than 28 days, unless it is a specialist long-term

¹ See section 2.6 for more details about CQUINS

catheter. An action plan has been put in place that aims to reduce the use of indwelling catheters and catheter associated urinary tract infections. Progress will be audited regularly with data on the number of cases collected and reported to NHS London monthly.

Venous Thromboembolism (VTE)

In March 2010, it was announced that Trusts would need to provide national data on risk assessments for venous thromboembolism (VTE) - a condition where a blood clot forms in a vein and causes blood flow to be reduced, leading to pain and swelling, usually of the lower leg. If part of the clot breaks off and lodges in the lung, VTE can lead to death. In order to comply with the national initiative, the Trust carried out a survey of medical and surgical patients to find out how many were being appropriately risk assessed and then receiving the correct treatment (normally low molecular weight heparin) to prevent VTE, on admission to hospital. The results showed that less than 20% of the Trust's patients had documentation proving they were being correctly risk assessed, and receiving the correct intervention. Data from our pharmacy department contradicted the survey, indicating that usage of low molecular weight heparin was considerably higher. As a result, it was concluded that the quality of VTE documentation was poor and there was no clear data available to assure the Trust that the process was being managed appropriately.

The Thrombosis Committee was set up to oversee improvement which has resulted in all patients being assessed for their risk of blood clots on admission and drug charts have been revised to include the risk assessment tool. Information is also being gathered on appropriate use of VTE prevention strategies, including low molecular weight heparin, and root cause analysis of all hospital-acquired VTE events is undertaken. Since the start of this work the number of patients who are risk assessed, and receive appropriate intervention is over 90% - above the national average and in line with NICE quality standards.

This work remains a priority and progress will be monitored not only by the Steering Group but by the Trust's Commissioners as VTE is a CQUIN target. The next step is to introduce an electronic recording system to enable the Trust to submit data to the national database via the work done by the coding department.

Pressure Damage

There are no national benchmarks for pressure damage although there are a number of relevant national initiatives that fall within the 'Energise for Excellence in Care' initiative that incorporates other pieces of work that the Trust is involved in. For example the Trust carried out root cause analysis on every community and hospital acquired pressure ulcer with a category rating of 2-4².

The Trust's Director of Nursing, Divisional Nurse Directors, Senior Nurses and Matrons all spend every Monday on the wards reviewing care including ulcer prevention and management alongside a range of other topics as part of a Visible Leadership programme where progress is audited as part of a 13-week rolling programme. Where shortfalls are identified the nursing staff must develop an action plan and its implementation is closely monitored by the Director of Nursing, Matron and Divisional Nurse Director.

Patients particularly enjoy being involved in this process and giving their views.

Patient Comment:

Patient care at King George has been exceptional. The staff are very attentive and have the time to talk to us on a regular basis. That is so important when you are away from your family.

Julie Halliday

² High Impact Action, Dept. of Health, 2009

As mentioned previously, the Trust is participating in the Safety Express national improvement programme that has a specific aim to 'reduce by 80% all category 3 and 4 pressure ulcers by December 2010'. To ensure we can make the necessary improvements the Trust aims to reduce the number of hospital acquired category 3 and 4 ulcers by 30% in the next 12 months³ after which a further target will be set.

Following the introduction of the Visible Leadership programme in 2010, audits of pressure ulcers have indicated a steady improvement in the prevention and management techniques used; this has been identified by observation of care given in the clinical setting, the quality of documentation on pressure damage, talking to patients to understand their experience and a review of decision making to ensure it was appropriate. The Visible Leadership audits are showing that from the August 2010 baseline of 65.25% the performance has improved to 87.53% in April 2011.

CLINICAL EFFECTIVENESS

| | Our quality priorities | Why we chose this | What success will look like | Where we will monitor and report progress |
|-------------------------------|---|---|--|--|
| Clinical effectiveness | Divisional improvements | Each division has identified the priority areas for improvements in clinical effectiveness, with the input of staff and patients. | Action plans are fully implemented, and improvements monitored. | Each Division has its own senior level Board to monitor progress with their priorities. Progress will be monitored by to the Executive Programme Board with exceptions to the Quality & Safety Committee |
| | NICE Quality Standards and Clinical Audit | So that BHRUT is providing high quality care in line with guidance, and has robust processes for clinical audit. | Staff providing evidence of reviews they have undertaken resulting from audit and action plans implemented. | The Evidence Based Practice Committee monitors NICE compliance and the Clinical Audit Committee monitor audit activity. Both committees report exceptions into the Quality & Safety Committee. Reporting is also included in the Quality Account schedule. |
| | Relicensing and revalidation | To ensure doctors are able to provide evidence they are meeting high professional standards as required by statute | Training rolled out to staff to undertake the strengthened appraisal process. | The Trust's Workforce Committee monitors this topic with onward reporting to the Trust Board for any issues of concern. |
| | Quality care 24/7 | The need to improve care for people whose health worsens outside the normal working week. | Increase in the number of doctors, including senior doctors, available outside the working week and improved critical care outreach nursing. | The work on the project is overseen by the Medical Director with any exceptions reported to the Quality & Safety Committee. |

1.3 Divisional Reviews

Each Trust Division was asked to identify areas where they did well and areas they did less well. They were also asked to provide information on their priorities for the coming year. Actions on these priorities will be reported internally and to our Commissioners and NHS London. Where appropriate, progress will be shared with partners and the public through the local authority Health Scrutiny Committees, Patient Experience Committee, Improving Patient Experience Group, the Local Involvement Network meetings or the Trust's patient magazine *Hospital Life*. This information is summarised in the following table.

³ Nurse Sensitive Outcome Indicators, Dept. of Health, Nov 2010

Reflecting on our Performance

| Division | What we feel we have done well | What we feel we have done less well |
|----------------------|--|--|
| Medical | <ul style="list-style-type: none"> We have introduced dedicated time for senior nurses to review care on the wards through the Visible Leadership programme. The introduction of the Acute Elderly Unit has reduced the length of stay for patients. We hope to expand on this success. The development and introduction of the dementia patient care pathway has helped identify patients early and allows for targeted appropriate care and support. | <ul style="list-style-type: none"> We have not always responded to patients' complaints as quickly as we would like. There has been a small increase in the number of patients acquiring MRSA whilst in our care. We aim to address inconsistency in care through better workforce planning and the reduction in agency and locum doctors and nurses. |
| Surgical | <ul style="list-style-type: none"> The percentage of patients admitted on the day of surgery has been improved at both hospitals. Better pre-operative assessment and access to theatres within 24 hours was established for ortho-geriatric trauma patients. The care pathway is now managed by the Ortho-geriatricians 72 hours after the operation. The number of operations cancelled for non-clinical reasons has reduced through the introduction of a Theatre Management System. Neurosciences were successful in achieving the standards for its acute stroke services and have succeeded in implementing a thrombolysis service at Queen's Hospital. Service reconfiguration resulted in the centralisation of Vascular and Breast inpatient services. This will improve the care available to our local population. | <ul style="list-style-type: none"> Recruitment to vacant nursing and medical posts has not been as successful as we would like, so there has been a reliance on the use of temporary nursing and medical staff. The process for managing pathways for patients in the urology and breast specialties, that are high volume specialties, has contributed to the Trust being unable to meet the 62 day treatment standard for cancer patients. |
| Emergency | <ul style="list-style-type: none"> The Ambulatory Care/Virtual Ward has been successful in helping to avoid admission for some patients and reducing the time other patients stay in hospital. | <ul style="list-style-type: none"> We have not been particularly good at offloading patients from ambulances at our A&E departments which has resulted in delayed assessment and treatment for patients. There has been high use of agency medical and nursing staff that can lead to variation in the level of care given to patients. |
| Women's & Children's | <ul style="list-style-type: none"> We have improved the organisation of care at King George for women having babies to allow partners to stay following delivery. We have developed a strong partnership working with local women via the Maternity Services Liaison Committee. We have improved the consultant presence for paediatric patients between 9am and 7pm with a dedicated consultant for paediatric A&E. The Sexual Health and HIV department was able to offer patients access to their service within 48hrs in 98% of cases. | <ul style="list-style-type: none"> Our triage system for maternity was not working well resulting in a number of complaints from women and a case reported in the media. We have been slow to recruit to our midwifery vacancies during the year. This has impacted on our ability to provide 1:1 care in labour. We continue to have vacancies for middle grade and junior doctors in paediatrics/neonates and gynaecology/obstetrics. Patients are unhappy with the responsiveness of our call centre for sexual health and HIV. |

| | | |
|-------------------------|---|--|
| Clinical Support | <ul style="list-style-type: none"> We have increased the access to MRI and CT scans, now providing a routine service for 12 hours a day, 7 days a week. We have supported the Acute Elderly Unit with increased therapy provision. We have improved our response times to patients' complaints and seen a reduction in the number of complaints. | <ul style="list-style-type: none"> We have not been as responsive with our Radiology reporting as we would like which could lead to delays in patient care for both in-patients and patients in A&E. We have had a high level of vacancies across the division which has led to a higher usage of agency staff. This is now being addressed. |
|-------------------------|---|--|

Divisional Priorities for 2011/12

| Division | Priorities |
|-----------------|---|
| Medical | <ul style="list-style-type: none"> <u>Ambulatory Care Expansion</u> We will be concentrating on improving ambulatory care pathways for patients and will be reviewing with our partners how patients can avoid hospital admissions. We will set up a local implementation group, led by a doctor, to undertake this work. Patient safety will be improved because patients will be treated quickly without the need to admit them, reducing the risk of them getting a hospital acquired infection. Improvements would also free up beds for other acutely ill patients. <u>Chronic Obstructive Pulmonary Disease (COPD)</u> The Trust's commissioners, that purchase care for local residents, have included improvement in the care and treatment of COPD patients as part of their CQUIN programme. To meet their targets, we will be developing an action plan to ensure patients with COPD are seen in the right place, at the right time by the right clinician. <u>Consultant Involvement in Patient Care</u> Consultant job plans will be reviewed as part of the Trust's Internal Professional Standards that have been developed for each Division. Progress will be monitored by auditing the number of patients that receive a Consultant review 5 days a week and through the embedding of Consultant review of admitted patients within 12 hours. Success with this initiative will see a reduction in the length of stay for patients and regular senior medical review of their care. |
| Surgical | <ul style="list-style-type: none"> <u>Enhanced Recovery Programme</u> The Enhanced Recovery Programme stalled during 2009/10 and we are now prioritising the programme for colorectal, urological, orthopaedic and gynaecological patients. A local implementation group will be established with a clinical lead. Successful implementation of the programme will improve patient safety post-operatively as their progress will be monitored against specific criteria. This work will also aid rapid recovery and reduce the length of time patients stay in hospital. <u>Vascular and Stroke Network Standards</u> We want to improve our performance against the Vascular and Stroke Network Standards and will need to gather evidence from patients' medical records. We will be taking the work forward through the operational team meetings and progress will be monitored through the Vascular and Stroke Board meetings. Success will maximise the potential for recovery for these patients. <u>Infection Control</u> All Divisions will be looking to improve their infection control performance, but in the Surgical Division we will be tackling staff training, carrying out hand-washing audits and auditing the practice of managing cannula to reduce the number of MRSA bacteraemias and Clostridium difficile infections. Patients would benefit from faster discharges and better mobility and there would also be a reduction in mortality sometimes associated with these infections. <u>Cancer Referral to Treatment Performance</u> We need to make improvements to ensure patients are tracked effectively on the database and their care and treatment is progressed appropriately by specialty teams. This will help us to achieve the 18 week referral to treatment target and other cancer treatment targets, including the 62 days to treatment standard. With improved tracking we will be able to minimise the delays in treatment and increase earlier detection of cancers. |

| Division | Priorities |
|----------------------|--|
| Emergency | <ul style="list-style-type: none"> • <u>Rapid Access and Treatment</u> Our priority is to improve emergency access for patients through our A&E departments to ensure they are treated quickly and safely and on the most appropriate care pathway for their needs. The service will be looked at together with our assessment units by a Local implementation Group that will be set up to develop and implement changes; the group will be led by a doctor. Improvements in access will help us to tackle the problems sometimes experienced when ambulances cannot offload patients because of pressures in the department. • <u>Review of Bed and Site Management</u> We intend to reconfigure the Trust's bed and site management functions. A review will be undertaken by the Divisional Nurse Director to focus on allocating patients to the most appropriate bed for their care. A similar review of the discharge team will also take place to ensure that the Trust's discharge processes are robust. • <u>Urgent Care Centre</u> The Trust is in discussions to take over the management of the Urgent Care Centre and a complete review of the current processes will need to be carried out to ensure that patient safety, outcomes and experiences are maximised and the service is in line with the governance arrangements in the rest of the Trust. |
| Women's & Children's | <ul style="list-style-type: none"> • <u>Paediatric and Neonatal Care</u> Our priorities for paediatric care include introducing a 24-hour short stay assessment facility, setting up a 'jaundice pathway' to enable babies with jaundice to be fast tracked to the ambulatory care centre for assessment, bypassing A&E. We also want to introduce a GP hotline to enable GPs to talk to our Doctors regarding paediatric patients, referring them when required to a dedicated 'hot clinic'. We will do our best to avoid closures of the neonatal unit by monitoring the number of hours the unit is shut due to infection, staffing levels or capacity and we will ensure that all babies are ready to go home within 24 hours of the decision to discharge them. • <u>Gynaecology Patients</u> Improving care for gynaecology patients is a priority and we plan to introduce a walk-in emergency service to enable early recognition of problems. This will see patients triaged within 15 minutes of arrival. Diagnostic ultrasound will also be made available for all emergency patients within 12 hours of admission to enable early diagnosis and appropriate treatment to be started. We also hope to reintroduce the Hyperemesis Day Unit for these patients. • <u>Obstetric</u> As we have reported above, our triage system for women in labour was not working well and we have also included information about responding to the CQC condition in relation to maternity services. We intend to ensure that women in labour are triaged within 15 minutes of arrival, that these women will be transferred from the antenatal ward to the labour ward within 15 minutes of the decision to transfer being made and that 95% of women will receive 1:1 care in labour. All women will be transferred to the appropriate postnatal setting within two hours of delivery if their condition allows. In order to achieve these, the sustained recruitment of midwives is essential. The aim is to maintain the momentum of the recruitment strategy realised at the end of 2010/11. • <u>Sexual Health and HIV</u> We would like to ensure that 60% of all GPs receive a letter on their HIV patients and that patients are notified of their positive results and placed on appropriate treatment within 14 days. We also intend to review all community clinics and particularly the young people clinics in Redbridge. |

- Access to Radiology

To speed up the time it takes for our doctors to receive CT and MRI scan reports, we will be establishing, through the Radiology Board, a review of our processes and the development of patient pathways based on the 24 hour turnaround of results.

- Outpatient Department

We intend to take a radical look at how we use our resources in the department to improve the time it takes for new referrals to receive their follow-up appointments and, ultimately, to be discharged back to their local GP or referrer.

- Clinical Pathology Accreditation

We have an action plan in place to clear areas where we are not complying with this external accreditation of our service. We will be targeting this as a high priority to ensure we are conforming to Quality Assurance Standards and reassure patients that we are providing safe and effective testing.

1.4 NICE Quality Standards and Clinical Audit

The National Institute for Clinical Excellence has issued new Quality Standards that define what constitutes high quality care. Each standard contains 5-10 statements of quality. Currently four Standards have been published for stroke, dementia, venous thromboembolism and specialist neonatal care. Nine more standards are in development.

Although complying with the Quality Standards is not mandatory, the Department of Health makes it very clear that the Commissioners of services are likely to use the standards as an indicator in association with incentive payments such as CQUINS.

Within the Trust, when these Quality Standards are received they are distributed to the Divisional Boards and appropriate Clinical Directors. General Managers are required to review the Standard and report levels of compliance and work in progress. This information is collected and collated on the Trust's NICE database.

The importance of clinical audit is high on the national agenda and also on that of the Trust. We collect a wide range of information relating to our clinical audit activity, both national participation and local studies that is collated on the Trust's Clinical Audit database. Staff are expected to provide evidence of reviews they have undertaken, reports or presentations that have resulted from the audit and copies of resulting actions plans. **Appendix A** contains further detail of all the clinical audits in which the Trust participates. To improve the reporting centrally of the closing stages of audit a change in process is being introduced to formally notify the relevant Clinical Director of the outstanding issues with the audit allowing for discussion during appraisal and verification against their mandatory declaration. The Trust has registered 421 clinical audits in total, of which 72 were re-audits, checking progress and improvement.



Audit Competition Winners 2010

The Trust participated in 2 NCEPOD studies; these were 'Peri-Operative Care' and 'Cardiac Arrest'. We also reviewed 2 NCEPOD reports - 'A Mixed Bag' dealing with parenteral nutrition and 'An Age Old Problem' that referred to emergency and elective surgery in the elderly. These reports were circulated to appropriate clinicians for them to carry out a self-assessment of compliance with the report's recommendations.

To encourage a culture of audit within the organisation for other staff we have organised and run audit competitions. Last year the Nursing Directorate took the Tony Fuller Memorial Cup prize for their Visible Leadership programme.

During the year the Trust ran a Management Course for senior doctors in training run by the Deanery. The participants had to undertake an audit of either a clinical, management or educational subject, participate in management activities e.g. shadowing or observing a senior management meeting and maintain a reflection log.

Each trainee was assigned a mentor for the duration of the course. The final part of the programme was a filmed presentation of their clinical audits that included change management. The trainees praised the course as a most worthwhile and interesting experience.

Management Course Participants



1.5 Relicensing & Revalidation

BHRUT has been busy preparing to meet the statutory Relicensing and Revalidation requirements for its doctors. Each doctor's license to practice must be approved by the General Medical Council. To achieve this, the doctors need to be able to provide a range of evidence as part of a Strengthened Appraisal to ensure they are meeting high professional standards as detailed in the government's white paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*.

The Medical Director has been responsible for monitoring a number of initiatives such as the setting up a dedicated appraisal e-portfolio. Revalidation will be formally implemented in autumn 2012 and the Trust is developing an action plan to ensure that all its doctors are helped through this process. Targeted training has taken place to ensure the Trust's medical Appraisers have the correct knowledge and skills to undertake the Strengthened Appraisal process properly.

1.6 Quality Care 24/7

The Trust wants to ensure that high quality care is provided 24/7 and that no patient is disadvantaged by being admitted 'out of working hours'. The Quality Care 24/7 project was started in August 2010 to improve the care given by medical and surgical specialty doctors to patients attending hospital outside of the traditional working week. The aim is to increase the seniority of the doctor seeing the acutely unwell patient out of hours, and to increase team working by combining the skills of different specialties to achieve better care for patients that need more than one specialism of care.

The project has looked at the following specialties: Internal Medicine, General and Specialist Surgery, Oral and Facial Surgery, Stroke Medicine, Trauma and Orthopaedics and care within High Dependency and Intensive Care Medicine.

Health needs fluctuate, and demand on services can be uneven and unpredictable with one speciality or area busy while another has capacity at certain times. Out of hours a structure to promote team working between the junior doctors, who are generalists and not specialists, has previously been lacking. This team working can deliver quicker care to patients by separating acute care from day to day care.

The project also aims to establish a 24/7 critical care nurse undertaking an outreach service. This brings some of the skills of intensive care wards out of the intensive care and direct to patients on other wards or in the Emergency department.

What has been achieved so far?

In Medicine a new rota for registrars and other junior doctors has seen a dedicated team of doctors formed to attend to acutely unwell patients. This team has been freed from normal clinical commitments. Patients on the wards will therefore see better continuity of care by junior doctors who are not distracted by also treating acutely unwell patients in Accident and Emergency. Patients in Accident and Emergency will have a team of doctors who can focus on new admissions without being called away to see inpatients.

By better rota planning Queen's Hospital has been able to double the Registrars onsite at the weekend between 8am and 9pm. In Surgery a new rota will see an increase in the number of Senior House Officers to care for emergencies at Queen's. In Trauma and Orthopaedics a new rota separates emergency care from elective care. The rota will coordinate with the surgical rotas to ensure that patients with trauma that require both Surgery and Orthopaedic input will have a team that is used to working together. The night time ENT service will remain consultant led. However, direct delivery of emergency care at night and at the weekend will be by Registrar level staff rather than SHO level staff to increase seniority.

In Stroke, there is improved partnership working between out of hours emergency stroke services and emergency medical services. In HDU and ITU there is a review of the seniority of night time staff attending to both routine care and emergency care. There has been a direct increase in the seniority of medical staff at night in the regional neurology and neurosurgical HDU.

Critical care outreach nursing is continuing to recruit staff so they can extend their day time service. The long term aim is to provide 24/7 Critical Care nursing support. This project will continue to develop new initiatives over the coming year to improve patient safety and staff satisfaction.

PATIENT EXPERIENCE

| | Our quality priorities | Why we chose this | What success will look like | Where we will monitor and report progress |
|--------------------|--------------------------------------|--|--|--|
| Patient experience | Real-time patient survey | To monitor patients' experience of different services and wards in 'real time', enabling rapid feedback to staff so that improvements can be made or noted. | Full roll-out of the survey to all wards at both hospitals, improved completion rates and analysis fed back to staff. | Corporate level monitoring of the output from the surveys will be incorporated into the Visible Leadership Programme with reporting to the Improving Patient Experience Group, the Patient Experience Committee and the Nursing & Midwifery Board. |
| | Patient views of their experience | The results of patient surveys have shown that patients feel that major improvements are needed, particularly on the sharing of information, giving them choices and treating them with privacy and dignity. | Action plans prepared for each division, fully implemented and providing evidence that patients' concerns are being addressed and patient experience is improving. | Our individual Divisional Boards will monitor how well patients feel their specialty staff have performed in this area. Overall monitoring will be to the Quality & Safety Committee with various other committees such as the Nursing and Midwifery Board kept updated. |
| | Working with patient representatives | To ensure the concerns of patients who may not be able to feed back themselves are represented and to ensure all patients' views are heard. | Strengthened relations with the local LINKs, regular meetings of the IPEG and input from other patient groups into Trust decision making. | The Trust holds regular meetings with the north east London LINKs. Members from the LINKs and IPEG participate in the Patient Experience Committee that monitors patient concerns and satisfaction. |

1.7 Patient Involvement

The priority areas to improve the patient experience across the Trust for 2011/12 are:

Implementation of the real time patient surveys and acting on the results

To monitor patients' experiences on an ongoing basis, we have introduced real time patient surveys across the Trust. Surveys are conducted using portable, hand-held electronic devices, or fixed terminals/kiosks. Patients can complete the survey on the hand-held device or the kiosk, depending on whether they are on a ward or in an outpatient area.

The surveys are voluntarily completed by patients at the end of their journey and are confidential with no patient identifiable data being collected. Patients also have the option of completing the surveys at a later date using the Trust's website.

The surveys will provide valuable information about the care and experience that patients have had to gain a better understanding of the areas of good practice and areas where we need to improve. Where patients raise concerns, or offer praise for the care they have received, this can be fed back to the ward staff quickly.



Completing the Real Time Survey

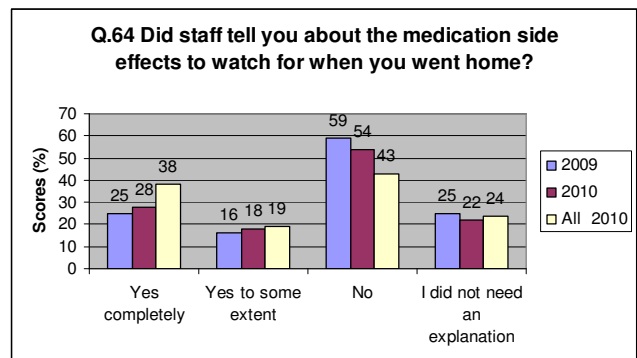
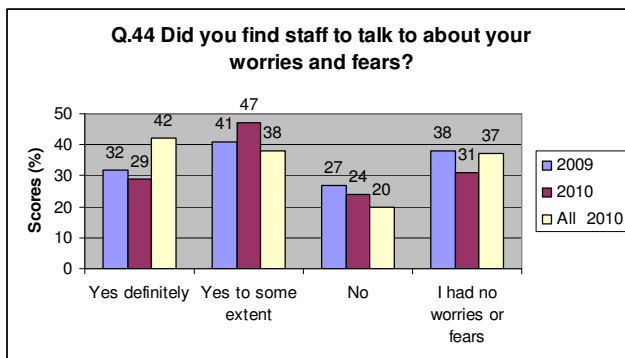
Patients' Views of our Trust

The 2010 National Inpatient Survey was carried out for the Trust by Quality Health between September 2010 and January 2011 and surveyed 850 patients randomly chosen from those discharged during June, July or August 2009 that had been in hospital for at least one night.

Only 41% of Trust patients responded to the survey and, overall, the results showed that the experience of patients using our inpatient departments have mostly remained unchanged. There was less than 5% movement in the answers in 46 of the 77 questions; improvement in 9 questions and a significant decline in the result of 3 questions which were:

- The hospital room or ward was very clean (down from 63 to 54%)
- Nurses always gave understandable answers to important questions (down from 60% to 51%)
- Hospital staff did everything they could to help control pain (down from 63% to 56%)

The following graphs give a further flavour of some of the areas where patients responding to the survey felt we need to make improvements.

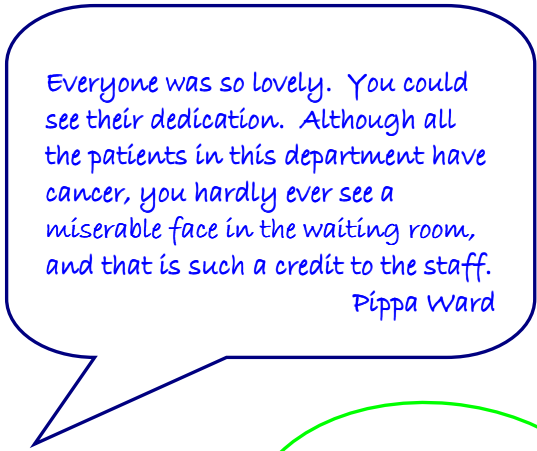


We are concerned that patients' views of our organisation are poor resulting in us scoring in the lowest 20% of Trusts nationally. The themes common to our Inpatient Survey, Maternity Survey

and Cancer Survey together with the internal findings from a learning disability survey show that our patients feel that we are poor at:

- Communicating with them; both our verbal explanations and the quality of any written information.
- Giving them choices about their treatments and referrals.
- Protecting patients' privacy and dignity.

Overall, patients responding to the surveys have lost confidence in the Trust and our staff. These are serious concerns and to address them the Director of Nursing will work with the Patient Experience Working groups, focusing on ensuring patients' experiences are improved in the future. Our Divisions have also been asked to produce their own patient experience action plans which will help embed a culture where a patient's experience is considered alongside their clinical care and treatment. However, not all experiences are poor as seen in some of the patient comments expressed below:



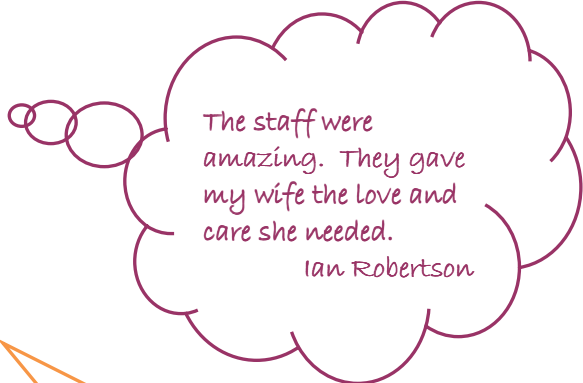
Everyone was so lovely. You could see their dedication. Although all the patients in this department have cancer, you hardly ever see a miserable face in the waiting room, and that is such a credit to the staff.
Pippa Ward



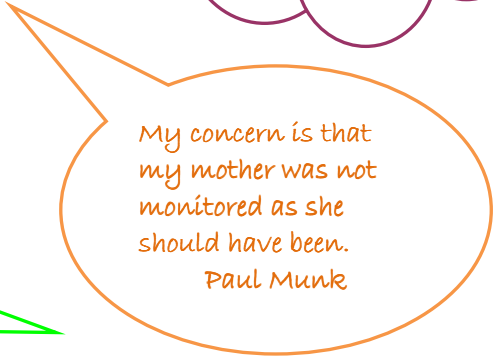
The care my son received in ITU at Queen's was fantastic.
Darrell Halford



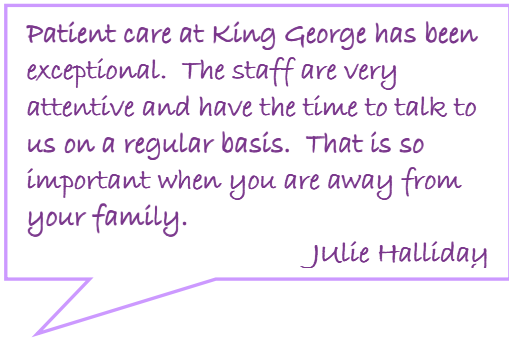
I feel the hospital has let my family down.
Kitty Mhango



The staff were amazing. They gave my wife the love and care she needed.
Ian Robertson



My concern is that my mother was not monitored as she should have been.
Paul Munk



Patient care at King George has been exceptional. The staff are very attentive and have the time to talk to us on a regular basis. That is so important when you are away from your family.
Julie Halliday

The Trust will continue to work with the Local Involvement Networks (LINKs) on priority areas including the Enter and View procedures. The Trust's Patient Experience Committee and Improving Patient Experience Group (IPEG) have been helping the Trust to review a whole range of topics from the patient's perspective and we are grateful to the Chair of IPEG in particular for providing us with clear feedback on the Trust's strengths and weaknesses and highlighting their views on the priorities we need to tackle in the coming year as shown overleaf.

Patient Experience Priorities for 2011/12

- Raise issues from a patient's perspective to help improve services for the benefit of everyone. We will feed back experiences and patients' comments to senior management in a constructive way and make sure that the patients' views are heard.
- It is important that when decisions are made that the patient is always represented and included. We will make sure that we represent all patients in a way that gives them the best possible care and experience whilst they attend hospital.
- We will respect senior management whilst being a critical friend and challenging poor service and treatment of patients.

What we think the Trust does well

- We feel that the Trust is now involving IPEG a lot more and inviting us to join committees. We have, as a group, been invited to the Hyper Acute Stroke Unit and the Acute Elderly Care Wards, which we were impressed with.
- We can see that in some departments there is an excellent service and patient care and dignity is more of a priority.
- IPEG is pleased to have seen and been involved in work around medication including drugs to take away (TTAs) and developing information leaflets on drugs. Also the introduction of the Real Time Survey and the work on the Ward Panels to help patients easily identify staff, curtain signs to prevent inappropriate entry to a patient's bed when an examination or treatment is underway, and the use of private rooms to talk to patients, are excellent improvements which we have been involved in. These have all been issues that patients have complained about and the Trust have looked at and acted upon.
- The Trust has realised by listening to IPEG and patients, that many complaints are about small basic things which can be addressed quite simply and it has been involving us on behalf of patients to help address these issues. Often senior managers are so involved in their jobs they do not see what is going on at ground level, but the Trust has accepted that we are an important addition to meetings and I think IPEG is respected for what it has to say. The Trust is doing very well in making sure we are included as much as possible.

What we think the Trust does less well

- IPEG still find communication a major problem, from answering phones to returning calls. Many of our members' concerns are that it is hard to get through to the appointment centre and that appointments are often cancelled or changed.
- Low numbers of staff is an issue, especially in Maternity. When we get feedback we are told that things are improving and the figures are out of date, but newspaper headlines and personal experiences tell us differently.
- We also feel that many staff have the wrong attitude for the job they do and that it is 'just a job' to them and too many are not prepared to go that extra mile any more. The words 'it's not my job' are said all too often.
- We feel that patients aren't kept informed of what is happening to them and you are often left waiting for tests or results and no one tells you what you are waiting for. It is easier to deal with any delays if you are kept informed: once again poor communication.
- Outpatient clinics are another example of bad communication. Boards are not always updated and Consultants/Doctors are frequently late starting clinics and the patients are not informed of the reasons for delays or how long the delay may be. It is not difficult to keep these boards updated.
- Staff forget the patients are watching them all the time and listen to what they are saying. Too often conversations are overhead that should not be discussed in public. Sitting in bed on a ward is often boring and patients cannot help but listen to staff talking, or watch what members of staff are doing.
- It is not professional to hear staff criticising others, nor is it good for patients to witness staff not doing their job properly. Patients will realise very quickly which members of staff will help them immediately and which one is lazy. However, very few will actually say anything to a senior member of staff, but will tell friends and family what they have seen/heard. This can give out a bad impression and often tars everyone with the same brush. Unfortunately, it is horror stories that are repeated and passed on much more than the good ones.



OUR PERFORMANCE THIS YEAR

Quality Standards

Every area of the Trust's work is judged against a national set of standards to ensure that we are meeting Department of Health targets in the way we treat and care for our patients. The Trust's Review of Services, required under the NHS (Quality Accounts) Regulations 2010, can be found at **Appendix A**. In addition, the tables below show how the Trust is doing in a wide variety of our activities.

2.1 Patient Safety

| | 2010/11 Target | Performance | | |
|--|----------------|-------------|-------------|-------------|
| | | 2008/09 | 2009/10 | 2010/11 |
| Serious untoward incidents as a % of total admissions (first finished consultant episodes) in the period | No target | 1.36% | 0.88% | 0.05% |
| Number of medication errors (all prescribing and administration errors including no harm incidents) | No target | 479 | 591 | 619 |
| Number of patient falls resulting in a fracture | No target | 31 | 30 | 27 |
| Patient Safety Alerts | No target | 2008 | 2009 | 2010 |
| Received / relevant to Trust | | 112 / 47 | 101 / 37 | 128 / 63 |
| Completed / Closed | | 111 | 100 | 126 |
| Outstanding | | 1 | 1 | 2 |

2.2 Clinical Effectiveness and Outcomes

| | 2010/11 Target | Performance | | |
|--|----------------|-------------|--------------------|--------------------|
| | | 2008/09 | 2009/10 | 2010/11 |
| Hospital standardised mortality rate (HSMR) | 100 | 111.1 | 103.7 | 100 |
| Stroke – 30 day mortality (National Sentinel Stroke Audit) | N/A | 19.10% | 13.30% | 12% |
| Readmissions within 28 days | 7% | 7.49% | 7.79% (Apr-Feb) | 7.91% (Apr-Feb) |

| 2.3 Patient Experience | 2010/11 Target | Performance | | |
|---|---------------------------|-------------|------------|------------|
| | | 2008/09 | 2009/10 | 2010/11 |
| Number of formal complaints Received Resolved within timeframe | 455 80% within 30 days | 940 773 | 569 473 | 671 420 |
| Number of PALS enquiries Received | No target | 8209 | 9988 | 7218 |
| Number of Ombudsman cases (decided) | No target | 10 | 1 | 4 |
| Percentage of patients who always felt they were treated with dignity and respect (Annual Inpatient Survey) | N/A | 70.00% | 72.00% | 74.00% |
| Percentage of patients who were always given enough privacy when discussing their condition or treatment | N/A | 63.00% | 64.00% | 67.00% |

| 2.4 Existing and National Priorities | 2010/11 Target | Performance | | |
|--|---|---|---------------------------------|---|
| | | 2008/09 | 2009/10 | 2010/11 |
| 18 week referral to treatment waiting times Admitted (90%) Non-admitted (95%) | Standard no longer monitored ⁴ | 93.52% 96.94% (Q4 reporting period) | 91.44% 95.73% (April–Feb) | Standard no longer monitored ⁴ |
| A&E waiting times 4-Hour max. wait in A&E from arrival to admission, transfer or discharge | Q1=98% Q2-4=95% | 96.02% | 97.31% | 95.30% |
| Access to genito-urinary medicine (GUM) clinics | 98% | 99.16% | 99.93% | 99.06% |
| Cancer urgent referral to first outpatient appointment waiting times 2-Week GP referral to first outpatient appointment | 93% | 99.00% | 99.75% | 96.65% |
| Cancelled operations Cancelled operations not re-admitted within 28 days | 5% | 2.87% | 2.33% | 2.65% (Apr-Feb) |
| Cancer diagnosis to treatment waiting times 31 Day diagnosis to treatment – all cancers | 96% | 95.40% | 96.89% | 99.90% |
| Cancer urgent referral to treatment waiting times 62 Day urgent referral to treatment – all cancers | 85% | 82.10% | 81.62% | 83.69% |

4 Standard was reintroduced from 1 April 2011

| 2.4 Existing and National Priorities (Contd.) | 2010/11 Target | Performance | | |
|---|--|--|---|--|
| | | 2008/09 | 2009/10 | 2010/11 |
| Clostridium difficile infections | See individual targets in each column. | Cases identified 126 Max. No. ₅ of cases 219 | Cases identified 82 Max. No. ₅ of cases 145 | Cases identified 110 Max. No. ₅ of cases 128 |
| 5 Department of Health guidance changed splitting acute trust numbers from community numbers identifying hospital acquired and community acquired infection. | | | | |
| Delayed transfers of care Percentage of inpatients with delayed transfer of care | 3.5% | 2.63% | 3.78% | 4.28% |
| Engagement in clinical audits | | | | |
| Local | No targets | 319 | 347 | 384 |
| National | | 32 | 44 | 49 |
| Ethnic coding data quality Ethnicity recorded for all inpatients | 95% | 94.90% | 96.34% (April-Feb) | 97.74% |
| Inpatients waiting longer than the 25 week standard | No longer a target | 75 | 1 | No longer a target |
| MRSA bacteraemias ⁶ | See individual targets in each column. | Cases identified 37 Max. No. of cases 40 | Cases identified 28 Max. No. of cases 39 | Cases identified 15 Max. No. of cases 11 |
| ⁶ The 'cases identified' figures are those numbers of patients who acquired MRSA and the 'maximum numbers' shown are those allowed under the Department of Health targets. | | | | |
| Outpatients waiting longer than the 13 week standard | No longer a target | 6 | 0 | No longer a target |
| Participation in heart disease audits | N/A | Yes | Yes | Yes |

| 2.5 Screening | 2010/11 Target | Performance | | |
|--|----------------|-------------|---------------------|---------|
| | | 2008/09 | 2009/10 | 2010/11 |
| Antenatal screening for Down's syndrome offered to all women (OSCAR) | 100% | 100% | 100% (April-Feb) | 100% |
| Breast screening – proportion of those screened with results within 2 weeks of screening | 100% | 97.10% | 97.80% | 97.38% |
| Cervical screening – laboratory sample results turnaround time within 4 weeks) | 98% | 72.5% | 48.8% | 100% |
| Proportion of TB patients >16 who have had recorded offer of HIV testing | 100% | 88.50% | 96.10% | 99.4% |
| 2-Week maximum wait for rapid access chest pain clinic | 100% | 100% | 100% | 100% |

2.6 CQUINS

CQUINs (Commissioning for Quality and Innovation) were introduced in 2009/10 as a way of bringing about quality improvements in patient care. Originally all CQUINs were agreed locally but for 2010/11, 20% were decided nationally with the remaining 80% split equally between regionally and locally decided priorities. Each CQUIN target has a named lead and an action plan developed to achieve the specific requirements. Senior Trust committees monitor progress against each CQUIN scheme on a monthly basis. Achieving the targets generates extra income for the Trust and delivers better patient care and treatment.

The 2010/11 CQUIN targets focus on a wide range of topics such as improving patient safety and increasing effectiveness of discharges and outpatient care planning. Also covered by the scheme were the development of care pathways for dementia patients, reducing avoidable death from venous thromboembolism, and improving care for patients suffering from long-term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. There were CQUIN targets relating to the Trust's maternity services and for making general nursing improvements such as reducing falls, stopping in-hospital inappropriate weight loss and dehydration, staffing levels, pressure ulcer management and reducing infections that have been defined by the Chief Nursing Officer's 'High Impact Changes'. Critical care for patients is also the focus of a number of CQUIN targets for 2010/11.

Overall the Trust made good progress in 2010/11 and estimates it achieved 67% across the range of CQUINs.



IMPROVEMENTS WE HAVE MADE

2009/10 Quality Account Update

In the Trust's 2009/10 Quality Account we documented our priority areas for improvement. A brief update on progress with this work is detailed below for those topics that have not been included elsewhere in this report.

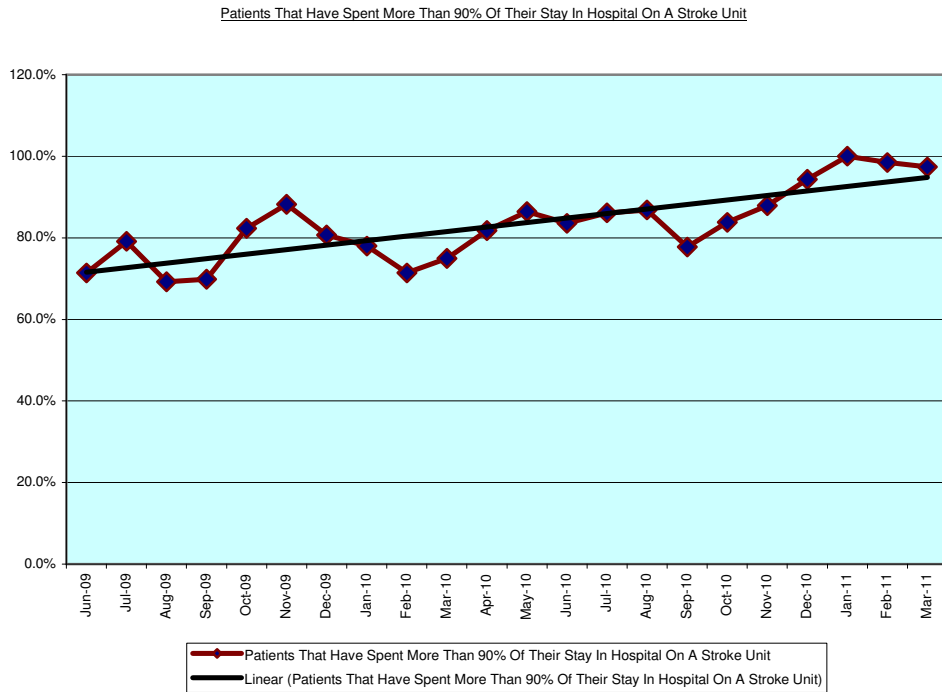
3.1 Patient Safety

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| <p>Hospital Standardised Mortality Ratio (HSMR)</p> | <p><u>Maternity</u></p> <p>In April 2010 the Trust responded to a CQC concern that there were indications of a high rate of emergency maternal readmissions within 28 days for the April-December 2008 period. A comprehensive review of readmissions was carried out and a number of issues were identified. A Programme Manager for maternity was appointed to coordinate the individual steams of work needed to meet the needs of local women. Key actions included:</p> <ul style="list-style-type: none"> • The development of a specific pathway of care for women who need medical attention within the first month following the birth of their baby, principally through the maternity day unit to prevent unnecessary inpatient stays • Improve the information given to women after delivery • Exploring the possibility of a GP hotline for direct access to senior members of the obstetric team • Ensuring all members of the maternity team is aware of the guidance in relation to perineal suturing. <p><u>Stroke</u></p> <p>In June 2010 the Trust responded to similar CQC concerns around stroke mortality rates for emergency admissions based on data for the period October 2008 to June 2009. BHRUT carried out a full review and evidence was provided to show that the Trust's stroke service had improved its performance since June 2009 and there had been a corresponding decrease in mortality.</p> <p>The Trust's review team found that the issues identified by the CQC had been addressed and the Trust was designated as a stroke unit.</p> <p>The CQC has since confirmed that the information provided to them was sufficient to close the matter.</p> |
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HSMR (contd.)

The Stroke Network undertook a series of assessments of the Trust’s stroke service on behalf of the Outer North East London commissioners. The Stroke Service showed compliance against the standards for its acute stroke unit. Performance against the Hyper Acute Standards is currently being assessed we believe there is sufficient evidence to serve the enhanced tariff for our services.

The Trust is now leading on the development of a multidisciplinary training programme together with South Bank University and has applied to take part in an international trial for extending the opportunities for thrombolysis treatments.



Coding

The Dr Foster data highlighted anomalies with the Trust’s coding. An investigation showed that the Trust’s coding accuracy levels were very good, but the quality of information written into patients’ records was skewing the Trust’s results. It became apparent that clinicians were not always recording a patient’s other conditions (co-morbidities) when they came through the A&E Department, and by not doing so the increased risk of death was not recorded, resulting in the Trust being flagged as an outlier against national data. Audits carried out in areas identified as being an outlier showed that inclusion of other conditions improved the position to the national norm or below. The importance of recording patients’ long-term/serious conditions has been highlighted so that the coding error can be rectified. Through consistent review and monitoring the Trust has reduced its HSMR to below 100 and its re-based figure by 8 points.

Aggregated Data

The Trust has introduced an aggregated data report that is shared with Divisions and reviewed at all high level Trust Committees including the Trust Board.

The report includes a range of data such as incidents to staff and patients, the number of falls experienced by patients and staff, the number of fire incidents, safety alert compliance, risks from the risk register, the numbers of complaints and PALS enquiries, claims and inquests.

The data within the report helps Directors and Managers identify problem areas that may require particular attention.

3.2 Clinical Effectiveness

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| Nurse to Bed Ratio | Following the approval of the business case reported last year, we have had successful recruitment campaigns in Ireland and Italy where we have recruited 38 new midwives. We also hope soon to recruit more midwives, a consultant midwife in normality and a matron for the labour ward. Our funded ratio of midwives to patients is 1:29.6. |
| Reduction in CVP Line | Central venous line training is provided for all grades of doctors, offering guidance on the insertion of central venous lines to ensure patient safety. A protocol is also available based on the guidance from NICE. The Trust's Visible Leadership programmes include auditing venous line insertion performance with the results fed back to the ward managers. Where necessary, action plans are generated to ensure improvements are made. |

3.3 Patient Experience

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| Enhanced Recovery Programme | <p>An Enhanced Recovery Programme in urology for radical cystectomies has been successfully implemented at the Trust. The 2009/10 report outlined plans to implement these programmes in colorectal surgery at Queen's and King George Hospitals, but due to numerous factors these plans have not reached fruition.</p> <p>It is the Trust's intention that Enhanced Recovery Programmes in Colorectal surgery for cancer and benign conditions and for Gynaecology will be rolled out by January 2012. It has been shown that Enhanced Recovery Programmes in musculoskeletal surgery (MSK) reduces length of stay from eight to three days and, with improved benefits to clinical outcomes, patient experience and saving of bed days. The Trust aims to roll out this programme in MSK by January 2012.</p> |
| Complaints | <p>Since the last Quality Account the number of complaints received for 2010/11 has risen although the number of concerns raised with our Patient Advice & Liaison Service has reduced. In an effort to improve the quality of patient care and accountability, the complaints and PALS service were move under the management of the Directorate of Nursing. The more direct involvement of the senior nurses in responding to complaints is allowing quicker and better responses to be made to patients reducing the number of requests for local resolution meetings. The high standard of investigations and the new style of responses appear to be satisfying more people and it is anticipated that the number of complaints will drop.</p> <p>A full review of how our resources are best used is underway with the aims of ensuring complaints handling is effective and satisfies more of our patients; reducing the potential for the Ombudsman to investigate cases in future.</p> |
| Maternity Matters | <p>All women are offered choice of place of antenatal, postnatal care and birth whether it is in the home or hospital and, with the increase in staffing numbers; we aim to offer 1:1 care to all women in established labour.</p> <p>Maternity support staff work in the community and we are working towards attaching one to each team so that they can support women with breast feeding. We also have breast feeding advocates within the hospital funded by the PCT.</p> |

Safeguarding Adults and Children

Safeguarding Adults

The Trust continues to consider safeguarding adults as a priority and progress is monitored by the Trust's Adult Safeguarding Committee and the multi-agency local Adult Safeguarding Boards. During the past year much of the Trust's safeguarding focus has been on patients with learning disabilities as this was felt to be an area needing improvement.

Adoption of the guidance from national reports has generated a number of changes. This included specialist community matrons, patients and the voluntary sector coming together as members of a Learning Disability Committee to drive the improvements and changes required to implement the Ombudsman's Six Lives Report. This led to a number of educational events for staff aimed at helping them identify the specific needs of these patients and their carers. In addition Protecting Adults at Risk was published and its findings and recommendations used to revise the Trust's Safeguarding Adults Policy.

Staff training has always been a key initiative in the implementation of Safeguarding Adults practice. Progress over the last 12 months includes improving training sessions for staff on caring for learning disability patients, enabling them to understand the implications of the Mental Capacity Act, the process for carrying out mental capacity assessment and when and how to involve IMCAs (Independent Mental Capacity Advocates) for patients who do not have capacity to make decisions for themselves. The Trust has also been able to make specific wash facilities available for carers when they spend time attending learning disability patients.

For the future, the Trust's IT systems are being improved to allow patients with a learning disability, who regularly attend the Trust, to be highlighted on the system. This will enable staff to be aware at an early stage of their specific needs. The Trust's Safeguarding Team is also developing easy-read information for patients with learning disabilities, and reviewing the specific antenatal care needs of expectant mothers with learning disability.

Safeguarding Children

Significant numbers of children and families who are seen by the Trust face specific safeguarding situations, and need additional and responsive support and interventions to keep children safe and promote their welfare. Safeguarding children therefore remains a high priority.

Staff that work with children are required to have enhanced Criminal Record Bureau (CRB) checks prior to employment and all clinical staff are required to attend safeguarding training at the level appropriate for their roles and responsibilities to ensure that 'at risk' children are identified and appropriate safeguards put in place. However, during the Registration process the Care Quality Commission felt that we needed to demonstrate that all our clinical staff had attended the required training on an annual to biannual basis, and as a result, the Trust embarked on an intensive review and targeted training programme; increasing uptake to between 81 and 96% at each level.

To ensure early intervention, all children who are subject to a child protection plan in Barking and Dagenham, Havering and Redbridge are 'flagged' on the Trust's patient administration and A&E systems. There are approximately 500 children with alerts at any one time. All unborn babies who have been made the subject to a child protection plan are highlighted on the maternity database so that at birth the child can be immediately flagged on the relevant IT systems.

Serious case reviews (SCRs) are declared by each of the local Safeguarding Children Boards (LSCBs), usually after the death of a child. The Trust's safeguarding team fully participate in these. The impact of adult needs including alcohol misuse, domestic abuse and mental health problems on parenting continues to be a significant factor in these SCRs.

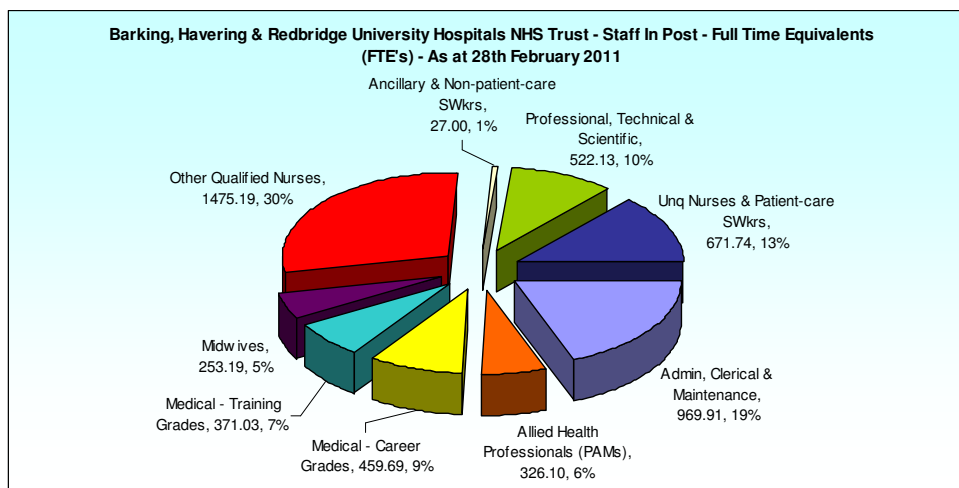
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| <p>Safeguarding (contd.)</p> | <p>The Trust's Safeguarding Children Committee oversees the safeguarding children activities and focuses on improving internal standards. During the last year the Trust has also engaged in the NHS London's Safeguarding Improvement Team peer review visits. Although we have limited involvement, the three separate visits were undertaken with the Trust's partnership local Primary Care Trusts.</p> |
| <p>Targets</p> | <p>Emergency Care Targets</p> <p>Whilst the Trust did not achieve the target for the period 2010/11, for the first time since November 2010 the Trust has achieved above 95% for the emergency access standard. The Type one access performance has been consistently below the 95% standard since August but has improved week on week to now be at 94.19 % Trust-wide.</p> <p>From April 1st 2011 eight new A&E Quality Indicators come into being, five of which have performance targets against them. The Trust is working hard to ensure these are implemented on time. We are able to report against all five targets that are monitored. The challenge is to deliver the required performance against them.</p> <p>Key work streams have been identified to improve the quality of care and deliver on the new indicators, to ensure we are delivering both safe care and a good quality patient experience. This covers work to develop clinical pathways for admissions for specific conditions, and ambulatory care (without hospital admission) for people with specific conditions such as pulmonary embolism or COPD.</p> <p>Delayed Transfer of Care</p> <p>There has been significant improvement in delayed transfers of care in the last six months with the figure at its lowest for some time, reduced to 2-3% of total inpatients. This has been achieved by improving the Trust's own processes together with key local partners. One of the key improvements has been setting up a single data set to use across the whole area to ensure consistency of information to act upon. This has enabled the rehabilitation and interim bed requirements to be clear for our PCTs and the Acute Commissioning Unit. In addition the implementation of a discharge management tool that is monitored by senior BHRUT management and clinicians with senior Community partners has significantly improved patient flow through their inpatient pathway. This is ensuring patients are treated quickly as well as improving the A&E standard.</p> <p>Length of Stay (LoS)</p> <p>The Medical specialty ward reconfiguration across both sites planned for 2010/11 - which included specialty based wards, an Acute Elderly unit with a step down facility and a Level 1 medical unit - have now been implemented. The reduction in length of stay seen this year is being maintained and for some specialties there were significant decreases, in particular Care of the Elderly.</p> <p>The LoS plans for 2011/12 will focus on avoiding admission and readmission into acute beds with our Community partners and safe discharge planning for admitted patients.</p> <p>As part of the service level agreement (SLA) with its local commissioners, the Trust has a Quality Schedule that has been agreed with PCTs and reflects the local quality issues. This schedule is reported to Commissioners on a monthly basis and forms an agenda item at the Health Economy Operational Meeting allowing the Acute Commissioning Unit and PCTs to act as an external monitor.</p> |

Although senior leaders in the Trust have been instrumental in the development of this report, we are also indebted to members of the Local Involvement Networks for their involvement and contributions. As required under the Regulations we have circulated the Quality Account to other involved stakeholders for their comments on whether they feel we have provided informative and accurate information on the quality of our services; their comments can be found at **Appendix B**.



OUR WORKFORCE An Invaluable Resource

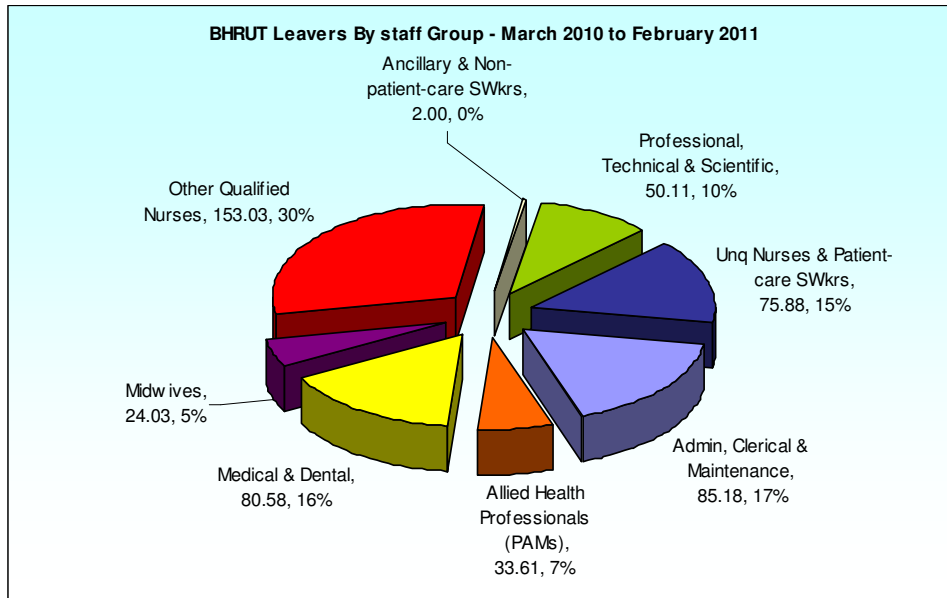
4.1 Our Workforce – Current Staff



The Trust currently employs 5,621 staff or 5,075.97 Full Time Equivalents (FTEs), with approximately 70% of our overall workforce working in direct clinical care and 11% in clinical support roles. The remaining 19% (969.91 FTEs), relate to admin and clerical roles, 70% of which support front facing clinical areas, whilst 30% relates to back office and corporate functions.

From 1st March 2010 to 28th February 2011 our actual number of Full Time Equivalents (FTE) staff in post increased by 141.16 over the year. The effect of our ongoing recruitment campaigns was negated in part by 504.41 FTEs (574 headcount) leaving the Trust. However, monthly monitoring of our annualised turnover rate showed that from May 2010 to date turnover did not go above the NHS average or Trust target of 12%.

Leavers by Staff Group



Consolidation of Workforce

A Trust-wide consultation began on 26 October 2010 to support the Trust's cost improvement programme. The consultations were in corporate areas. As a result, 15 staff have been redeployed to different posts, 22 have or will shortly be leaving the Trust on the grounds of voluntary or compulsory redundancy. Redeployed staff posts and redundant posts will not be replaced, reducing the overall establishment.

In House Bank

The Trust stopped using NHS Professionals as its core provider of temporary staff in June 2010 at which point the Trust's own In House Bank (IHB) went live to deliver this function.

The IHB centralises all temporary staffing requests and bookings, which are maintained electronically via the Trust's Staff Bank system. Central management of all temporary staffing via the In House Bank allows the Trust to monitor the use of flexible workers and ensure that each worker assigned to a duty complies with at least the minimum training, recruitment and governance standards.

Requests for temporary staff are filled from the pool of 3,100 staff registered on the IHB. All IHB registrants have to comply with the same training requirements as substantive staff in equivalent roles, and management arrangements for appraisal and training are in place. All flexible workers recruited to the IHB undergo full employment checks which include CRB, ID checks, references and Occupational Health clearance. In addition to Trust-wide training and induction, IHB staff also receive a local induction so they are familiar with each of the areas they work in.

If there is no suitable member of staff available through the IHB, we work with external agencies to provide staff who have met recruitment, training and induction requirements. BHRUT uses agencies through the Buying Solutions framework which regularly audits suppliers to ensure the required standards are maintained.

Volunteers

The Trust has just over 200 volunteers that help in a variety of departments including outpatient clinics, information desks, anti-coagulation clinics, cancer services, antenatal clinics, wards, PALS, chaplaincy. The League of Friends and Hospital Radio also carry out voluntary work in the Trust's hospitals; work that is much valued and appreciated.

The duties the volunteers carry out are many and varied and can include making refreshments for patients, directing and escorting patients around the hospital, answering enquiries at the information desks, running errands for staff or helping with administrative duties in other departments. Those volunteers working on the wards may assist patients to fill out their menu cards, help to give out meals, make refreshments for the patients or generally assist staff. Many volunteers befriend individual patients and visit patients on the wards.

The difference these volunteers make is truly valued not only by the patients and staff they help, but by the whole organisation.

4.2 Staffing Levels

During 2010/11, BHRUT has worked to recruit more high quality staff to replace leavers, reduce reliance on locums and agency staff and improve the continuity of care and staffing levels.

Our recruitment work has identified a shortage of staff in the local area and in the UK in certain specialties - particularly in critical care and maternity. This has necessitated recruitment from outside the UK. All interviews are conducted in English to ensure new recruits can communicate well with our patients. Twenty-three midwives together with 37 A&E and critical care nurses have been appointed from Portugal, and further staff from Ireland and Belgium.

All applicants are required to take and pass a basic assessment test before interview, which ensures their ability to understand our requirements. All applicants are required to have a face to face interview as part of the recruitment process to ensure they can understand and communicate effectively with patients and other staff.

Medical Workforce

The Trust has a recruitment strategy to identify needs for future medical recruitment well in advance. This is particularly important given the long time needed to fill positions and the need to ensure continuity of care. As a teaching hospital, we work closely with the London Deanery who supplies junior doctors.

Over the coming year, fewer training posts will be funded, meaning the Trust will be allocated fewer junior doctors. We are working to fill any gaps, including planning recruitment open days to fill the vacancies that will become open in August.

The Trust relies heavily on the recruitment of overseas doctors, and overseas recruitment campaigns last year successfully filled all our hard to fill posts in Paediatrics, A&E and Trauma and Orthopaedics. The focus this year has shifted to retention. Overseas doctors' programmes have been piloted in the A&E department, building on established relationship with universities and the Royal College. This programme offers a training programmes and career development for those doctors who choose to remain with BHRUHT. The initial pilot launch in December 2010 is now progressing with appointments to basic grades. These doctors will be offered a career map taking them up to speciality doctor/consultant level. The programme will be further developed in partnership with Divisions to offer rotational posts for August 2011.

A review on our methods to recruit to consultant posts took place at the end of December 2010 which identified the long lead time to recruit, placing pressures on divisions. To supplement this process the fixed term recruitment guidelines were launched and approved in January 2011. Revised recruitment guidelines were also launched building in steps to more effective recruitment planning to substantive posts. In support of the guidelines, recruiting managers are offered coaching through the guidelines by a dedicated Consultant recruitment advisor, which has reduced delays in recruitment.

Alternative workforce solutions are being developed as a pilot with the Paediatrics department, where there is a national shortage of middle grade doctors. An expansion of the consultant

numbers is required to deliver a consultant-led service. We are developing a new role, that of a hybrid consultant, who will provide this enhanced level of senior doctor care, in time for the August intake of doctors.

Following the implementation of European Working Time Directive in August 2009, rota management has been devolved to the Divisions to allow decisions for safe cover to be taken within the service providing patient care. All rotas have built in an adequate handover period for shifts, and in the event of unplanned absences access to our in house bank is available for temporary staff to cover if needed. The Trust undertakes monitoring of all rotas on an annual basis and submits the diary card returns to NHS London.

4.3 Sickness Absence

Trust-wide sickness absence for 2010/11 was 4.53% - a reduction of 1% on 2009/10, but just above the average rate of other acute large Trusts at 4.2%. The rate is calculated using the Electronic Staff Record (ESR) where all reported sickness absence is recorded. ESR is able to calculate a percentage sickness absence rate using the total number of day's absence recorded and total number of working days available.

In light of our improvements and in line with national, regional and local requirements to improve workforce productivity and efficiency the Trust's Executives we have reviewed and revised our sickness absence target to 3.60%. This target is being supported by a Wellbeing Strategy aimed at generating a healthier, happier workforce; improving staff morale; improving employee retention and reducing employee turnover; reducing sickness absence and promoting good employee/management relations.

Sickness Absence % for 12 month period March 2010 to February 2011

| Division | % |
|--------------------|-------------|
| Clinical Support | 4.77 |
| Corporate | 3.61 |
| Emergency | 5.14 |
| Medical | 4.49 |
| Surgical | 3.76 |
| Women & Children | 6.21 |
| Trust Total | 4.53 |

The HR Department is fully aware of the underlying hotspots shown in the table above and to ensure accurate and timely information is available have changed the workforce reporting process to a score card style approach that provides in-depth information to managers within the Divisions on a monthly basis. The Divisions are required to feed action/progress taken to tackle their sickness absence issues back to the HR advisors creating a continuous cycle of monitoring actions and review. Overarching reports are provided to the Executive Team and Trust Board. The actions taken to manage sickness absence include:

1. Continuous monitoring of absence data with the Divisional Managers
2. HR Advisors then hold 1 to 1 meetings with General/Service Managers and Matrons to review their data
3. Training in the procedure on Sickness Absence Management has been rolled out with sessions being run across the Divisions

Work has also been undertaken in relation to Medical staffing absence reporting/recording - medical staffing co-ordinators have absorbed this work and data is recorded onto ESR.

As an example of the detailed work being undertaken within the Trust, we would cite the A&E Workforce Recruitment Focus Group that was established in November 2010 comprising HR advisers and key A&E senior staff with the aim of:

- Working collaboratively to identify the key workforce issues in terms of A&E recruitment and retention – relating to medical staff and bands 5 and 6 nurses
- Consider options to address including ‘doing things differently, new roles/new ways of working’
- Formulate action plans to address
- Identify key players and those responsible for delivery
- Identify obstacles to success and escalate where necessary in order to move forward
- Sustain delivery momentum
- Monitor progress.

This work was approved and is monitored by the Workforce Committee with regular updates to senior managers within the organisation.

Similar action plans have been put in place to address the hotspots within the Women’s & Children’s Division with an over-recruitment strategy approved for paediatrics. The proposals for improving midwife recruitment is built on the foundation of improving the public perceptions of the Trust’s maternity service as current poor media coverage is adversely affecting our ability to attract and retain high quality staff. In addition, a review of the internal recruitment process has been carried out to remove delays in the recruitment process from advert to commencement in post. Finally, the Trust is developing incentives to encourage midwives to apply to work at our hospitals by developing a package for all midwives to support their professional development, the introduction of a payment for midwives who mentor students and, a small annual lump sum for 2-years to support trips back home for those midwives recruited from overseas.

4.4 Staff Survey 2010 and Actions Taken

The findings of the eighth annual survey of NHS staff were published by the Care Quality Commission on the 16 March 2011. The results help Trusts review and improve the experiences of their staff so they in turn can provide better care to patients.

Almost 306,000 NHS staff were asked about their experiences between October and December 2010. Of these nationally 54% responded. At BHRUT 381 members of staff completed the survey, a response rate of 47%.

The Trust performed well on appraisal which reflects the efforts put into this in the last 18 months. Few staff, compared to similar organisations, experienced physical violence from patients, service users, their relatives or other members of the public in the previous 12 months.

However, there are a number of important areas where we performed poorly. We must use the findings to inform and implement changes to improve the work experience of all our staff. We need to start this work immediately and focus on the following:

- staff engagement
- job relevant training, learning and development
- work life balance
- work related stress
- staff retention
- effective team working
- improved incident prevention and hygiene and reporting of incidents
- preventing harassment, bullying, abuse and discrimination

Each division will be preparing an action plan and the Trust's Executive Team will be working to engage with staff, understand their perspectives and support them in the delivery of high quality care.

4.5 General Training

A wide variety of training, learning and development activities were provided and attended during the period covered by this report.

Some of these activities took place at academic places of study such as universities and colleges of further education. Others were at organised clinical and non-clinical conferences and specialised learning events. These were tailored to specific needs identified in advance, and on an ongoing basis throughout the year and were part of the Personal Development Planning process. Staff from various groups and pay bands were included in the planning and provision of education to meet Continuing Personal and Professional Development (CPPD).

Much of the in-house training centred on essential activity linked to clinical skills such as resuscitation, and the requirements contained within mandatory programmes. Programme reviews took place to ensure national and local priorities were included.

We are about to implement a Leadership and Management Programme to complement the accredited management courses run by external consultancies or delivered at other places of study. The training will take into account the changes to the way we need to manage in the current economic climate and financial constraints of the Trust. HR and Education in conjunction with Leeds University will roll out the programme.

Workforce planning will also be covered to ensure managers and supervisors can identify potential gaps within their staffing and have recruitment and retention initiatives to improve this. There will be an emphasis on the support and training needed to retain staff. Managers and supervisors will be supported to understand the basic principles of leading a team and managing change.

APPENDIX A

REVIEW OF SERVICES

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| 1. | <p>During 2010/11 Barking, Havering & Redbridge University Hospitals NHS Trust (BHRUT) provided and/or sub-contracted the following NHS services for the provision of:</p> <ul style="list-style-type: none"> • General health services to NHS Barking & Dagenham; • General health services to NHS Havering; • General health services to NHS Redbridge; • General health services to NHS South West Essex; • Brentwood Community Hospital; • Pharmacy (high cost drugs); • Sexual health services; • Transport <p>BHRUT has reviewed all available data available to them on the quality of care in the key NHS services listed above.</p> <p>The income generated by the NHS services reviewed in 2010/11 represents 95% of the total income generated from the provision of NHS services by BHRUT for 2010/11.</p> |
| 2. | <p>During 2010/11 BHRUT took part in 49 National clinical audits (54 National audits were listed for inclusion into Quality Accounts) and 100% National Confidential Enquiries (NCEPOD) of the national clinical audits and national confidential enquiries which it was eligible to participate in.</p> <p>The national clinical audits and national confidential enquiries that BHRUT participated in, and for which data collection was completed during 2010/11, are listed below. Alongside we show audits funded by the DOH and commissioned by the Healthcare Quality Improvement Partnership (HQIP).</p> <ul style="list-style-type: none"> • Management of Fractured Neck of Femur in A&E • RCOP Continence Care Audit (NCAPOP) • Matching Michigan National Audit • AUGIS – National Oesophago Gastric Audit (NCAPOP) • National Mastectomy & Breast Reconstruction Audit (NCAPOP) • RCOPH Epilepsy 12 Audit (NCAPOP) • National Comparative audit of the use of Red Cells in Neonates & Children • RCOP National Audit of Falls & Bone Health in Older People (NCAPOP) • National All Party Parliamentary Hepatology Group – Hepatitis C • RCOP National Inflammatory Bowel Disease Audit (NCAPOP) • UK Trauma Audit & Research network (TARN) = 450 cases • ICNARC – Neuro Critical Care • ICNARC General Critical Care • MIDatabank for UK Medicines Information Service National Data collection • RCOPH National Neonatal Audit (NCAPOP) • MINAP – Myocardia ischaemia National audit Project (NCAPOP) • RCOP National audit of the Management of Familial Hypercholesterolaemia • National Royal College of Ophthalmologist Ocular Tissue Transplant Audit • National Sentinel Stroke audit = 90 cases (NCAPOP) • Surgical Site Surveillance – Orthopaedic procedures • National Invasive Cervical Cancer Audit • BHIVA Nat audit on Management of HIV / Hepatitis B and C co-infected patients • National Joint Advisory Group for Gastroenterologists audit (JAG) • BSG National Liver Survey • RCPsych National audit of Dementia Care (NCAPOP) • National BTS Non Invasive Ventilation Audit • National Blood Transfusion/RCP Comparative use of Group O Negative RhD Red blood cells • NHFD National Joint Registry (NCAPOP) • National Neonatal Nasogastric Tube Audit • National BTS Pleural Procedures audit • National RCOP audit of Depression detection & management of Staff on Long Term sickness |

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| | <ul style="list-style-type: none"> • London Regional Transfusion Committee - Use of Cryoprecipitate • National Survey of positions in labour & birth • National (CEM) audit of Renal Colic • National Hip Fracture Database (NHFD) (NCAPOP) • CEM National audit of Feverish Children • CEM National audit of Vital signs • BTS Bronchiectasis Audit • BTS Adult Asthma Audit • RCOP National comparative audit of Platelets in Haematology • Second National Diabetes Inpatient Audit (Diabetes UK) • RCOP Implementing NICE Guidance for Health & Work. National Organisational Audit • National audit on CVP Line usage in Neuro anaesthesia • National Vascular Database • NVS Acute Kidney Injury (NCAPOP) • National care of the dying audit (Marie Curie Palliative Care Institute) • NASH National audit of seizure management in hospitals (CEM) • National Lung Cancer Audit (NCAPOP) • BTS National Community Acquired Pneumonia Adult Audit <p>During the period 2010/11 BHRUT participated in 100% of National Confidential Enquiries (3) (NCEPOD) that it was eligible to participate in. Listed below are the enquiries participated in alongside the number of cases submitted.</p> <ul style="list-style-type: none"> • Perioperative care = 326 number of cases submitted • Surgery in Children = 20 data sets • Cardiac Arrest = 29 data sets <p>The reports of 29 National clinical audits were reviewed in 2010/11 and BHRUT intends to take actions to improve the quality of healthcare provided as described below:</p> <ul style="list-style-type: none"> • All completed national audit outcomes are reviewed by the Divisions, the appropriate Directorate or Specialty and/or the Clinical Audit Committee. There is also regular monthly learning from Clinical Audit presentation meetings at Clinical Grand Round when audit reports and resulting actions, both National and Local are reviewed. Local gap analyses/action plans are completed when report recommendations are published to confirm compliance or actions planned in response. <p>The reports of 90 Local clinical audits were reviewed in 2010/11 and BHRUT intends to take actions to improve the quality of healthcare provided as described below.</p> <ul style="list-style-type: none"> • Local clinical audit reports were reviewed by the Specialty or Directorate who undertook them. Audit recommendations are pasted into an action plan template and returned to the auditor and Clinical Lead for completion and return so actions can be recorded. As a result of review issues can be escalated to the Divisional Boards if appropriate and included in the Divisional Risk Register if required. Monthly Learning from Clinical Audit presentation meetings at Clinical Grand Round is a forum for sharing audit outcomes and learning to a wider audience. |
| 3. | <p>The number of patients receiving NHS services provided or sub-contracted by BHRUT in 2010/11 that were recruited during that period to participate in research approved by BHRUT is not recorded centrally as only NIHR Portfolio projects are obliged to report patient accrual figures. In 2010/11 BHRUT has recruited 5782 patients into those portfolio projects. In addition, BHRUT had 145 active trials/studies and 76 studies closed to recruitment in 2010/11.</p> |
| 4. | <p>A proportion of BHRUT income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between BHRUT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available at http://institute.nhs.uk/word_class_commissioning/pct_portal/cquin.html</p> |

| 5. | <p>BHRUT is required to register with the Care Quality Commission and its current registration status is 'Registered'.</p> <p>BHRUT has the following conditions on registration relating to:</p> <table border="1" data-bbox="225 309 1441 741"> <thead> <tr> <th data-bbox="225 309 730 353">Condition</th> <th data-bbox="730 309 1441 353">Action Taken / Condition Status as at 31.3.11</th> </tr> </thead> <tbody> <tr> <td data-bbox="225 353 730 398">Resuscitation training</td> <td data-bbox="730 353 1441 398">Deadline Met – CQC Decision Awaited</td> </tr> <tr> <td data-bbox="225 398 730 443">Appraisals</td> <td data-bbox="730 398 1441 443">Deadline Met – CQC Decision Awaited</td> </tr> <tr> <td data-bbox="225 443 730 488">Discharge Planning</td> <td data-bbox="730 443 1441 488">Deadline Met – Compliant</td> </tr> <tr> <td data-bbox="225 488 730 533">Pressure Damage</td> <td data-bbox="730 488 1441 533">Deadline Met – CQC Decision Awaited</td> </tr> <tr> <td data-bbox="225 533 730 577">Staffing levels</td> <td data-bbox="730 533 1441 577">Deadline Met – Condition Lifted</td> </tr> <tr> <td data-bbox="225 577 730 622">Child protection training</td> <td data-bbox="730 577 1441 622">Deadline Met – Condition Lifted</td> </tr> <tr> <td data-bbox="225 622 730 667">Nurse mandatory training</td> <td data-bbox="730 622 1441 667">Deadline Met – Condition Lifted</td> </tr> <tr> <td data-bbox="225 667 730 712">Training rooms</td> <td data-bbox="730 667 1441 712">Deadline Met - Compliant</td> </tr> </tbody> </table> <p>The Care Quality Commission has taken enforcement action against BHRUT during 2010/11. Following a responsive review of the Trust's maternity services in January 2010 the CQC issued 3 warning notices in March. The warning notices related to the care and welfare of people who use services, staffing and equipment within the Maternity Department at Queen's Hospital. The CQC also had 3 moderate concerns i.e. respecting and involving people, supporting workers and records. The Trust provided information to enable the equipment warning notice to be downgraded to a minor concern prior to the publication of their final report, and has provided the CQC with evidence to enable them to review the actions taken by the Trust to rectify the failings identified. The CQC deadlines were met and a decision is awaited from the CQC.</p> <p>The Trust developed and urgently implemented a range of actions that were monitored at the most senior level to ensure the CQC concerns were appropriately addressed. The actions taken at a high level include:</p> <ul data-bbox="284 1153 1441 1675" style="list-style-type: none"> • Increase to staffing levels in key areas i.e. labour ward Queen's, postnatal ward and antenatal ward. This has been achieved in the interim by the utilisation of temporary staff. • Increased recruitment of midwives. In total there have been 50 new recruits secured in the past 3 months, some of whom have commenced with the remainder due to start by the end of June. Further recruitment is continuing. • A new triage system for labouring women has been implemented, incorporating a telephone system and the obstetric assessment process has been changed to incorporate more senior clinician presence. Work continues on this to ensure the system is maintained 24/7. • Training programmes have been reviewed and new ones developed to incorporate new starters from differing backgrounds as well as updating and development for existing staff. • Working closer with local women to ensure changes are acceptable and meet women's needs. • Developing a programme of workshops to address communication. • Working closer with staff on the shop floor to ensure changes are developed in partnership and owned by them. | Condition | Action Taken / Condition Status as at 31.3.11 | Resuscitation training | Deadline Met – CQC Decision Awaited | Appraisals | Deadline Met – CQC Decision Awaited | Discharge Planning | Deadline Met – Compliant | Pressure Damage | Deadline Met – CQC Decision Awaited | Staffing levels | Deadline Met – Condition Lifted | Child protection training | Deadline Met – Condition Lifted | Nurse mandatory training | Deadline Met – Condition Lifted | Training rooms | Deadline Met - Compliant |
|---------------------------|--|-----------|---|------------------------|-------------------------------------|------------|-------------------------------------|--------------------|--------------------------|-----------------|-------------------------------------|-----------------|---------------------------------|---------------------------|---------------------------------|--------------------------|---------------------------------|----------------|--------------------------|
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| Appraisals | Deadline Met – CQC Decision Awaited | | | | | | | | | | | | | | | | | | |
| Discharge Planning | Deadline Met – Compliant | | | | | | | | | | | | | | | | | | |
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| Staffing levels | Deadline Met – Condition Lifted | | | | | | | | | | | | | | | | | | |
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| Nurse mandatory training | Deadline Met – Condition Lifted | | | | | | | | | | | | | | | | | | |
| Training rooms | Deadline Met - Compliant | | | | | | | | | | | | | | | | | | |
| 6. | BHRUT was subject to a nutrition and dignity review in March 2011. | | | | | | | | | | | | | | | | | | |
| 7. | <p>BHRUT will be taking the following actions to improve data quality:</p> <p>An Information Quality Assurance Group is established to drive improvements in quality of data. This group reports through the Trust's Information Governance Steering Group and forms part of an Information Governance Work Plan for 2011/12.</p> | | | | | | | | | | | | | | | | | | |

| | |
|-----|---|
| 8. | BHRUT submitted records during 2010/11 to the Secondary Users service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: 97% for admitted patient care; 98% for outpatient care; and 83% for accident and emergency care, which included the patient's valid General Medical Practice Code was 98% for admitted patient care; 99% for outpatient care; and 93% for A&E care. |
| 9. | BHRUT Information Governance Assessment Report overall score for 2010/11 was 64% and was graded red from IGT Grading Scheme. |
| 10. | BHRUT was not subject to a Payment by Results clinical coding audit during the reporting period by the Audit Commission as it had scored in the top 5% nationally in the previous clinical coding outpatient audit. |

APPENDIX B
THIRD PARTY COMMENTARIES

Outer North East London NHS

Outer North East London Cluster, on behalf of the cluster PCTs and all NHS Commissioners in London has reviewed the draft Quality Account for 2010/11. We consider that the document contains accurate information in relation to the services provided by Barking Havering Redbridge University Trust.

The report contains detailed evidence of activity during the past year to improve quality. However there continues to be considerable challenges confronting the Trust which need urgent attention. Going forward we would like the Trust to focus on the following three key priorities during 2011/12.

1. Improve patient experience and specifically reduce pressure ulcers
2. Improve maternity services to achieve best experience and health outcomes for mothers and new born
3. Provide timely care to patients seen in the A&E at Queens to optimise healthy outcomes

NHS South West Essex

No comments have been received.

London Borough of Havering Health Overview & Scrutiny Committee

I am writing on behalf of the council's Health Overview and Scrutiny Committee. The Committee has reviewed the Trust's draft Quality Account and thanks you for the opportunity to do this. The Committee has no specific comments on the Quality Account at this time.

London Borough of Redbridge Health Overview & Scrutiny Committee

On behalf of the Health Scrutiny Committee, I firstly wish to thank you and Mr Doyle for your attendance at the meeting on 16th June and for giving such open and thorough answers to questions from Members.

Thank you for extending the deadline for comments on the Quality Account report until today. The Committee acknowledges the report and would like the following comments to be placed on record:

1. We note that it is not until page 36 of the 38 page document that the CQC restrictions are mentioned. For some Members, this is the first time these concerns have been seen in writing in detail i.e. the 8 restrictions (of which 3 are still outstanding) 3 moderate concerns and a further 7 bullet-pointed concerns highlighted by the CQC.
2. On Resuscitation training, we note that the Trust is attempting to improve the compliance rate amongst clinical staff and the Committee will be keeping a watching brief on this.
3. On appraisals, we would point out that despite reaching 94.7%, had this been achieved earlier the Trust would not be in the present position.
4. On pressure damage, we are pleased that senior Nurses will visit the wards to ensure simple good quality skin care.
5. The CQC highlighted 3 moderate concerns:
 - Respecting and involving people
 - Supporting Workers
 - Record Keeping

We are dismayed that the above, while moderate, does not adhere to elementary good practice.

6. We note that the CQC have raised 7 more concerns:
- Staffing levels in key areas
 - Recruitment of midwives
 - A new triage system for labouring women
 - Training programmes for starters from different backgrounds
 - Working closer with Redbridge women
 - Developing workshops for communicating
 - Working closer with staff on the shop floor

On going through the BHRUT Quality Account 2010/11, we are not totally convinced that the measures put forward by the Trust to address these will be effective until we see some positive outcomes

7. The Committee is of the opinion that the Quality Accounts do not reflect the serious malfunctions and dangerous practice in Maternity. While the Chief Executive's Statement mentioned that CQC issued warning notices requiring improvement in Maternity in March 2011, the section on clinical effectiveness (section 1.3) which describes poorer performance creates a false impression of the situation as we understand it. Furthermore the number of midwives quoted as being recruited in the report is 38 whereas we have been verbally informed (source: HSC meeting on 16th June 2011) that it is 50.
8. With regard to Accident and Emergency Services, the Committee feels that the Quality Account does not adequately convey the frequency of ambulance diversions and breaches in the four hour waiting time.
9. We note the sickness absence levels in some service areas substantially exceed that of all other departments, and also feel that downgrading the target to 3.6% would also be counter-productive.
10. We are dismayed to note the NHS staff survey 2010 which identified 8 areas of poor managerial performance. They range from (a) staff engagement (b) job training, learning and development (c) effective team working (d) improvements in hygiene and reporting of incidents.
11. Having highlighted the issue of safeguarding adults in previous years, we are further dismayed to read that no training has taken place in this area.
12. Having also highlighted the issue of agency staff we are concerned to read in Section 4 of the Quality Account that these challenges remain.
13. Patient experience is paramount but varies dramatically depending on which hospital or department is visited. Members would like all BHRUT service users to have a positive experience and receive excellent care.
14. Finally, in future it would be helpful if the Trust could enable sufficient time for the Committee to submit comments by requesting a slot on the Committee work programme within the current municipal year.

Further to the discussions on the 16th June, the Committee notes the good work undertaken, particularly in stroke services and is keen to take up the Chairman's offer to visit cancer and maternity services. The Scrutiny Co-ordinator will be in touch to make the necessary arrangements.

The Committee will continue to monitor quality improvements at the Trust and hope that this will lead to much better patient experiences.

Chairman, Health Scrutiny Committee

London Borough of Barking & Dagenham Health Overview & Scrutiny Committee

The Health and Adult Services Select Committee (HASSC) accepts the Trust's Quality Account but wishes to place on record the following comments

- The HASSC is of the opinion that the Quality Account does not reflect the serious malfunctions and dangerous practice in Maternity. While the Chief Executive's Statement mentioned that CQC issued a warning notice requiring improvements in Maternity in March 2011, the section on clinical effectiveness (Section 1.3) uses bland language to describe poorer performance which creates a false impression of the situation as we understand it. Furthermore, the number of midwives quoted as being recruited in the report is 38 whereas we have been verbally informed that it is 50.
- Similarly, with regard to the CQC restrictions, these are scattered throughout the document or not acknowledged until nearly the last page. This in no way reflects the issues which need to be addressed to ensure that the Trust delivers good quality care.
- In addition, with regard to Accident and Emergency Services, the HASSC feels that the Quality Account does not adequately convey the frequency of ambulance diversions and breaches in the four hour waiting times.
- HASSC noted the reduction of Trustwide sickness absence in 2010/11 of 1% from the previous year. However there remain two issues of real concern. Firstly the further downward revision of sickness absence targets to 3.6% will put renewed pressure on all departments as not a single department met this target in 2010/11. Secondly the sickness absence levels in both emergency and women and children, substantially exceeded that of all other departments and puts into question the ability of these departments to turn around performance over the coming 12 months.
- Although the Dr Foster mortality figures are mentioned under the heading 'Coding' as opposed to 'Mortality Rates', no reference is made to the position of the Trust as the 4th worst nationally and the data is skilled over. Indeed the mortality figures reported under patient safety are at odds with this data and no explanation is given for the figure of 100. The HASSC do not accept that the Dr Foster figures misrepresent the mortality rate because of coding issues based on the PCT analysis of the deaths reported at CETC in February 2011.
- HASSC were further dismayed to read that according to the section on Safeguarding Adults – no training has taken place in this area.
- The HASSC is pleased with the measures taken by the Trust to address problems with pressure damage (Page 8) which was the subject of a CQC condition on registration. However, the patient comment adjacent to the text seems out of place and should be moved to section 1.7 in our opinion.
- The HASSC believes that the priorities that the Trust has identified for improvement match those of the patient/public and there is clearly evidence that the Trust is engaging with local people to drive improvement.
- The HASSC would welcome the inclusion of LINK 'Enter and View' findings as a number of important issues have been raised through their reports, especially around the storage of confidential patient records.
- Members particularly like the speech bubbles with comments from service users and feel the 'Patient Experience' section of the Quality Account would benefit from exhibiting more of these comments. However, the Select Committee thinks that examples of feedback from service users should be balanced. The document states that 'Overall, patients responding to the surveys have lost confidence in the Trust and our staff' but the Trust has chosen to omit examples of negative feedback.
- With regard to infection control it would be helpful to know not only how the problem of infection is being address but also what is causing infections in the first place.
- In the past the HASSC has been concerned with the Trust's reliance on agency staff and ability to recruit to posts. Section four of the Quality Account on workforce highlights these challenges and shows that BHRUT is grappling with staff shortage problems.

- To make a more general observation, in our personal experiences and from speaking with residents we know that patient experience varies dramatically depending on which hospital or department visited. Members would like all BHRUT service users to have a positive experience and receive excellent care. This draft Quality Account highlights the inconsistencies that exist within BHRUT and does not adequately cover the reasons for this with any clarity. There is in the HASSC's opinion a lack of balance in terms of overstating the very good aspects of the Trust whilst attempting to downplay the very serious failings that have occurred within 2010/11. We hope that the Trust will continue to work hard to capture patient feedback so that problem areas are identified and dealt with.

With the exception of the issues raised above, the HASSC considers the draft Quality Account to be a true and accurate reflection of the Trust's performance during 2010/11. Moreover, Members thought that the format and style of the document made it very easy to understand.

In future it would be helpful if the Trust would liaise with LBBD so that the period for comments on the draft coincides with a select committee meeting; that way a representative from the Trust could present the draft Quality Account and engage directly with Members about the content.

We hope that improvement can gather momentum in 2011/12 and that financial difficulties will not compromise the quality of care provided.

Chair, Health and Adult Services Select Committee

Barking & Dagenham Local Involvement Network

No comments have been received.

Redbridge Local Involvement Network

No comments have been received.

Havering Local Involvement Network

Havering Local Involvement Network (LINK) welcome the opportunity to comment on Barking, Havering and Redbridge University NHS Trust (BHRUT) Quality Account for 2010/11.

Havering LINK are always mindful of the particular needs of the population of Havering and will continue to work closely with the Trust in order to be a stronger voice in how local health and social care services are delivered.

Priorities for 2010-11

Havering LINK support the nine priorities in the Trust's Quality Account.

We are pleased to see the emphasis placed on the three priorities relating to the "Patient Experience" and in particular the "real-time patient surveys". The monitoring of patients' experience of different services and wards in "real time" enabling rapid feedback is fully supported. We are of the strong opinion that this will prove invaluable and we welcome the "working with patient representatives" priority. We also support the Trust's aim to ensure the concerns of patients who may not be able to feed themselves are represented by local LINKs and other groups able to input into the Trust decision making.

Havering LINK is aware of the recent conditions place on the Trust by the Care Quality Commission and in particular those relating to maternity services. The LINK welcomes the changes put in place in Triage in the Maternity Department and agree that the development of a strong partnership with local women via the Maternity Services Liaison Committee can only enhance conditions.

The LINK understands that employees can be demoralised due to bad publicity and reports but would strongly urge senior officers to continue encouraging Trust staff.

Havering LINK congratulates the Trust on the success of the neurosurgical centre, in particular, the report that an additional 2.6 patients in every hundred brought to Queen's Hospital with serious head injuries are surviving compared to other neurosurgical centres. This outcome is something that the Trust should be proud of.

Conclusions

The LINK believe that the Quality Account is representative and provides a comprehensive statement of services provided by Barking, Havering and Redbridge University Hospitals NHS Trust.

Chair, Havering LINK

Improving Patient Experience Group

The Chair of the above Group provided comments during the production of the Quality Account and these are shown in section 1.6.

Note:

BHRUT is grateful for all the third party commentaries received and have taken the opportunity to review the comments from its partner agencies and have, wherever possible made amendments to the text within this final version of our Quality Account. However, it should be noted that some comments refer to developments that have occurred outside the reporting period for this Account.

In order to provide information on progress with the serious CQC concerns we have endeavoured to provide additional updates in section 1.1 although Appendix A does summarise the position with these Conditions at the end of the reporting period, to comply with Department of Health requirements on content