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Health and Social Care Scrutiny Sub (Community and Children's Services) Committee

Date: **TUESDAY, 4 FEBRUARY 2014**

Time: **1.45pm**

Venue: **COMMITTEE ROOMS, WEST WING, GUILDHALL**

Members:
Wendy Mead (Chairman)
Dhruv Patel (Deputy Chairman)
Deputy Billy Dove
Randall Anderson
Judith Pleasance
Emma Price

Enquiries: **Philippa Sewell**
tel. no.: 020 7332 1426
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Lunch will be served in the Guildhall Club at 1pm

John Barradell
Town Clerk and Chief Executive

AGENDA

Part 1 - Public Reports

1. **APOLOGIES**

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**

3. **MINUTES**
   To agree the public minutes and non-public summary of the meeting held on 11 November 2013.

   For Decision
   (Pages 1 - 4)

4. **COMMUNITY NURSING SERVICES – NEAMAN PRACTICE**
   Presentation from the Homerton University Hospital.

   For Information
   (Pages 5 - 6)

5. **GP OUT OF HOURS SERVICE**
   Presentation from the Clinical Commissioning Group.

   For Information
   (Presentation)

6. **CARE QUALITY COMMISSION INSPECTION OF BARTS HEALTH NHS TRUST**
   Report of the Care Quality Commission.

   For Information
   (Pages 7 - 44)

7. **HEALTHWATCH CITY OF LONDON UPDATE**
   Report of the Chair of Healthwatch City of London.

   For Information
   (Pages 45 - 78)

8. **INNER NORTH EAST LONDON JOINT OVERVIEW AND SCRUTINY COMMITTEE MEETING - 17TH FEBRUARY**
   Strategy & Performance Director for Community and Children's Services to be heard.

   For Information
   (Verbal Item)

9. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

10. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**

11. **EXCLUSION OF THE PUBLIC**
    MOTION - That under Section 100(A) of the Local Government Act 1972, the public be excluded from the meeting for the following items on the grounds that they involve the likely disclosure of exempt information as defined in Part I of the Schedule 12A of the Local Government Act.

    For Decision

Part 2 - Non-Public Reports

12. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**

13. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT AND WHICH THE COMMITTEE AGREE SHOULD BE CONSIDERED WHILST THE PUBLIC ARE EXCLUDED**

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HEALTH AND SOCIAL CARE SCRUTINY SUB (COMMUNITY AND CHILDREN'S SERVICES) COMMITTEE
Monday, 11 November 2013

Minutes of the meeting of the Health and Social Care Scrutiny Sub (Community and Children's Services) Committee held at Committee Room - 2nd Floor West Wing, Guildhall on Monday, 11 November 2013 at 1.45 pm

Present

Members:
Wendy Mead (Chairman)
Dhruv Patel (Deputy Chairman)
Randall Anderson
Judith Pleasance
Emma Price

Officers:

Katie Odling	-	Town Clerk's Department
Ade Adetosoye	-	Director of Community & Children's Services
Farrah Hart	-	Department of Community & Children's Services

1. **APOLOGIES**
An apology for absence was received from Deputy Billy Dove.

2. **MEMBERS' DECLARATIONS UNDER THE CODE OF CONDUCT IN RESPECT OF ITEMS ON THE AGENDA**
There were no declarations of interest.

3. **MINUTES**
RESOLVED – That the Minutes of the meeting held on 16 July 2013 be approved.

4. **MINOR INJURY UNIT REPORT**
A report of the Director of Community and Children's Services was received which provided a brief update from Bart's Hospital Trust in respect of the promotion of the Minor Injuries Unit as an alternative A&E and the outpatients booking system.

In considering the report, it was agreed that a follow up report would be presented to the Committee on the outpatients booking system, once it had been in operation for 1 year. It was also agreed that a more detailed plan as to how the booking system would be promoted would be provided to the Sub Committee.

Further clarity was sought regarding the difference between A&E and urgent care and what was categorised as a 'minor injury'. The representative of Healthwatch, David Simpson agreed to take these points back to the next Board meeting.

5. **CONSULTATION ON CANCER AND CARDIO**
A report of the Director of Community and Children's Services was received which provided an overview of the public engagement and consultation processes for the

reconfiguration of cancer and cardiovascular service across north and east London and west Essex.

Members agreed the document needed to clarify the City of London was not a London Borough. It was noted that the Deputy Chairman would be attending the next meeting of the JHOSCs and he would therefore report the outcome of this meeting to the Sub Committee.

The Sub Committee also made reference to the need to make services available for City workers.

The Director agreed to provide a written response to the Committee on the results of the consultation.

6. **CLINICAL COMMISSIONING GROUP - COMMISSIONING INTENTIONS UPDATE**
The Sub Committee received an update from the NHS City and Hackney Clinical Commissioning Group who had been unable to be present for the meeting.

The Sub Committee discussed the report and it was agreed that a letter would be written to the Commissioning Group which set out the concerns of the Committee. The agreed points to be included were as follows -

- Whilst the sub-committee agreed that the commissioning intentions identified a number of important areas, it would like to know which clinical areas or services would see disinvestment;
- There did not appear to be any mention of rough sleepers and therefore the Sub-Committee sought clarification of the CCG's role in commissioning services for this very vulnerable group of health care users, including services that prevented multiple admissions to A&E. The Sub-Committee requested clarification on the consultation process for these intentions;
- Clarification was sought regarding the City of London Healthwatch's involvement to date in shaping the commissioning intentions, and whether it played a role in co-production.
- With regards to improved screening for dementia, clarification was sought on how this would be achieved;
- The Sub-Committee welcomed joint working on health visiting and requested reassurance that budgets would not be lost in 2015 when health visiting became a local authority function;
- A question was raised regarding how the CCG proposed to work with CCGs in neighbouring boroughs to ensure effective services were delivered to all City residents, and not just those who were registered with a City and Hackney GP; and
- The Sub-Committee were interested to know about the longer-term commissioning intentions of the CCG, as these only covered a single year and whether the CCG was working to a longer-term strategic commissioning plan.

7. **QUESTIONS ON MATTERS RELATING TO THE WORK OF THE COMMITTEE**
There were no questions.

8. **ANY OTHER BUSINESS THAT THE CHAIRMAN CONSIDERS URGENT**
There were no items of urgent business.

The meeting ended at 2.30 pm

Chairman

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Chris Pelham
Neal Hounsell
Dr Vasserman

By email only

20th January 2014

Dear all

Re Community Nursing services – Neaman Practice

I am writing further to our discussion on Monday 13th January regarding the above topic. I committed to respond to you in writing once I had looked into the plans around community nursing services in more detail, particularly related to individual practices. I apologise that I am a day late in forwarding this.

I have spoken to Louise Egan, Head of Nursing for Integrated Medicine and Rehabilitation Services (which incorporates community nursing). The plans for the community nursing services have been discussed for several months and have heavily involved a group of four representative GPs from City & Hackney CCG/practices. The proposal was established during the summer months following an extensive fact finding review. This proposal was discussed with the GP representatives and amendments made accordingly prior to being circulated to all GP practices on 10th October 2013. I am aware that Louise has spoken to a significant number of GPs directly, including I think, Dr Vasserman. I have attached a copy of the paper that was circulated.

As we discussed, the proposal involves bringing together a large number of very small teams into four larger teams. It is intended that each team is located on the same site and in the case of the Neaman Practice, this will be at the Rushton Practice. However, it has been agreed with the Practice Manager at Neaman that the nurses attached to the practice will continue to have a desk available to them which they can use.

The intention of this change is not intended to reduce communication with the practices, indeed focus has been placed on improving the communication. A named nurse will be identified for each practice and this individual can be contacted directly. Previously much of the communication was managed through the administrative offices.

Key drivers for these changes have been as follows:

- Improve the communication between clinical teams, necessary for covering leave and absences.

- Provide robust clinical supervision for all members of staff to assist in ensuring a safe and high quality service. The previous arrangements did not facilitate this.

- To introduce a Practice Development Nurse for each team to further develop and enhance skills and knowledge within the community nursing teams

I would like to assure you that the intention of these changes is in no way intended to remove the community nursing service from supporting the practice but it is intended to enhance the quality of the service to the benefit of patients and GPs alike. However, I do recognise that the accommodation changes could be perceived as a loss to the practice site. The enhanced communication arrangements should mitigate this and indeed, overall develop into a better operating arrangement.

I am sorry that this change has caused anxiety across the City. Every effort was made to liaise with GPs and, as stated above, a representative group were involved in the design and sign off of the service.

I hope that the attached report provides further information. Please do not hesitate to contact Louise Egan, Sheila Adam, Chief Nurse or myself to discuss further.

Yours sincerely

Tracey Fletcher
Chief Executive

cc. Louise Egan
Sheila Adam
Osian Powell, Divisional Operations Director

Care Quality Commission

Barts Health NHS Trust

Quality report

Trust Offices, Aneurin Bevan House
81 Commercial Road, London E1 1RD
Telephone: 020 7377 7000
www.bartshealth.nhs.uk

Date of inspection visit: November 2013
Date of publication: January 2014

This report describes our judgement of the overall quality of care provided by this trust. It is based on a combination of inspection findings, information from our 'intelligent monitoring' system, and information given to us from patients, the public and other organisations.

Overall summary

Barts Health is the largest NHS trust in the country, having been formed by the merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust on 1 April 2012. Barts Health is a large provider of acute services, serving a population of 2.5 million in North East London.

The trust has three acute hospitals: the Royal London, Whipps Cross University Hospital and Newham University Hospital, and three specialist sites: The London Chest Hospital, St Bartholomew's Hospital and Mile End Hospital – acute rehabilitation site. The trust also has two birthing centres: the Barkantine Birthing Centre and the Barking Birthing Centre.

Barts Health offers a full range of local hospital and community health services from one of the biggest maternity services in the country to end of life care in people's own homes. The trust is also part of UCL partners, Europe's largest academic health science partnership, whose objective is to translate research and innovation into measurable health gains for patients.

The Royal London hosts one of the country's busiest trauma centres with state-of-the-art facilities and a dedicated paediatric accident and emergency (A&E) department. It is also the base of the London Air Ambulance service. Both Whipps Cross and Newham also have A&E departments. St Bartholomew's Hospital has a minor injuries unit.

The trust covers four local authority areas: Tower Hamlets, the City of London, Waltham Forest and Newham. Tower Hamlets is one of the most deprived inner city areas in the country, coming seventh in a list of 326 local authorities. Fifty six per cent of the population of Tower Hamlets come from minority ethnic groups, with 56% coming from the Bangladeshi community. Life expectancy in the borough varies, with those who are most deprived having a life expectancy of 12.3 years lower for men and 4.9 years lower for women than in the least deprived areas.

By comparison, the City of London is more affluent, coming 262nd out of 326 in the Index of Multiple Deprivation. It is less ethnically mixed with 21% of the population coming from minority ethnic groups, the largest group being Asian with 12.7% of the population. Newham is again more deprived coming third out of 326 in the Index of Multiple Deprivation. Eighty per cent of the population of Newham come from minority ethnic backgrounds, with Asian being the largest constituent ethnic group at 43.5% of the population. Life expectancy for both men and women living in Newham is lower than the England average.

Summary of findings

Overall summary (continued)

Finally Waltham Forest comes 15th out of 326 with a culturally mixed population. Nearly 48% of the population of Waltham Forest come from minority ethnic communities, with Asian constituting the single largest group at 10% of the population. All four of the local authority areas have young populations, with the majority of residents aged between 20 and 39 and the highest concentration aged 20 to 29.

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

Barts Health was included in the first wave of the Care Quality Commission's (CQC's) new hospital inspection programme, as it had been shown to be at 'high risk' on several indicators in the new 'intelligent monitoring' system – which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Over recent years the trust has faced significant financial challenges and has been a persistent outlier on some key quality of care indicators, including:

- Poor results on the cancer patient experience survey.
- Non-achievement of the four-hour accident and emergency waiting time standard.
- Poor results on the national staff survey.
- A high number of never events (events so serious they should never happen).
- Non-compliance with regulations recorded on several CQC inspections since it was registered, especially in maternity services and wards caring for older people.

In August 2013 we took enforcement action following an inspection of Whipps Cross University Hospital. We served Warning Notices in two clinical areas: the care of the elderly wards where we found that staff were not adequately supported, and the maternity services were we found the environment to be unclean and equipment not available. During this inspection we checked that the trust had met the requirements of the Warning Notices – they had and so we were able to remove the Warning Notices.

The trust's board is well-established and is committed to improving quality. Quality initiatives have been developed across the trust, although many have only started within the past few months and it is too early to tell if they will deliver the required improvements. New systems are being embedded and the development of site-specific management is a welcome development. All senior nurses work clinically on Friday mornings, and on the first Friday of the month, all Executive Board members visit hospital wards. However, the visibility of the board is variable, with many staff being unaware of the 'First Friday' initiative. Morale across the trust is low, with staff being uncertain of their future with the trust and a perception of a closed culture and bullying. Too many members of staff of all levels and across all sites came to us to express their concerns about being bullied. Many only agreed to speak with us if they could be anonymous. In the 2013 staff survey 32% of staff reported being bullied; the average score for trusts in England was 24%. Staff told us they felt stressed at work and said there were not equal opportunities for career development. This must be addressed urgently if the trust's vision is to be realised.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Generally services at Barts Health are safe. The hospitals are clean and, on the whole, well maintained and the risk of infection is minimised. There are policies and procedures for practice but not all staff are aware of them. While there is learning from incidents on individual sites, this is rarely the case across the trust. There are risk registers in all departments but on many occasions we found that the risk register was not acted upon and some identified risks were not being dealt with.

Staff levels are variable, however, and this meant that people did not always receive care promptly. Across all sites there is a reliance on agency staff which has an impact on timeliness and quality of care.

Equipment is not always available and this may put patients' safety at risk.

Are services effective?

The effectiveness of services varies across the trust. In the smaller hospitals, care was consistently effective and guidelines for best practice were followed and monitored. In the larger acute hospitals this was less consistent. Multidisciplinary teams are still establishing themselves and there is ongoing work towards having senior staff available on site at all times.

Are services caring?

The majority of patients and relatives we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect. However, we heard about a number of concerning instances of poor care at our listening events and from people contacting us during the inspection. The trust must ensure that the positive experiences we saw and heard about during the inspection are maintained, and that instances of poor care are minimised and dealt with appropriately.

Are services responsive to people's needs?

Most people told us that the services they used were responsive their needs. However, in some areas of the trust, people's needs were not being met. There were problems in both the Royal London and Whipps Cross hospitals with patient flow through the hospital, bed occupancy and discharge planning. This was not such a problem in Newham University Hospital.

Young people felt that their needs were not addressed, as there are no dedicated facilities for caring for adolescent patients.

The other area where people felt the trust was not responsive was when they had cause to complain. Across the trust, people we spoke with and who contacted us consistently told us that they were unhappy with the way their complaints had been handled. The Patient Advice and Liaison Service in the trust has recently become centralised and this has been a cause of frustration for people who wish to raise concerns.

We had concerns about written information for patients, both in respect of its general availability and the languages it was available in. This caused anxiety for people who did not want to bother staff.

Summary of findings

The five questions we ask about services and what we found (continued)

Are services well-led?

There is variability in leadership across the hospital. The trust's Executive Team is well-established and cohesive with a clearly shared vision. They are well supported by non-executive directors. However, they are not visible across the trust.

Below board level, some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new. The Clinical Academic Group (CAG) structure was introduced in October 2012 but is not yet embedded across the organisation. The exception to this is the Emergency Care and Acute Medicine (ECAM) CAG.

The CAGs, when embedded, could provide a clear route for board to ward engagement and governance but it needs time to become embedded and effective. The trust recognised this and had taken action to address some shortcomings in the governance structure, such as the introduction of site-level organisational and clinical leadership.

Staff feel disconnected from the trust's Executive and feel undervalued and not supported. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied. This must be addressed if the trust's Executive Team's vision is to be successful.

Summary of findings

What people who use the trust say

The trust scored below the national average for the NHS Family and Friends Test and in line with, or above, the England national average for A&E but there was also a lower overall response rate. The trust performed within the bottom 20% of trusts in England for 50 out of 64 questions in the 2013 Cancer Patient Experience Survey with information, communication and confidence in the staff all featuring.

Comments posted on the Patient Opinion and NHS Choices websites highlighted that care by doctors and communication by all staff could be improved, although these also featured in positive comments. This was also apparent in our inspection visits where patient opinions of care was polarised, with some telling us of care that went beyond the call of duty and others telling us about very poor care.

People who had cause to complain about their care frequently told us they did not feel listened to and, over the course of this inspection, we were contacted by a number of people who were dissatisfied with the trust's response to their complaints.

Areas for improvement

Areas where the trust MUST improve:

- The trust must ensure that action is taken on identified risks recorded on the risk register.
- The trust must ensure that there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely and to an appropriate standard.
- The Executive Board must urgently re-engage with staff: they must listen to staff, respond to their concerns and adopt a zero tolerance to bullying.
- Provision must be made for adolescents to be treated in an appropriate environment and not within the general paediatric wards.
- Equipment must be readily available when needed.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs.
- Some parts of the hospital environment do not meet patients' care needs. The hospital environment in the Margaret Centre (at Whipps Cross) and outpatients compromises patients' privacy and dignity.
- Patients are not aware of the complaints process and the hospital does not always learn effectively from complaints.

Other areas where the trust could improve:

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all clinical academic groups (CAGs).
- Improve access for all staff to suitable IT to enable them to report incidents quickly.
- Consultant cover on site should be 24 hours a day, seven days a week to provide senior medical care and support for patients and staff.
- Provide accessible information for patients who speak English as a second language.
- There should be pain protocols in place for children and children should be seen by the pain team.
- The reasons for waits, and likely length of waits in outpatients should be better communicated to patients.

Summary of findings

Good practice

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

- The Royal London's 'EA' (Emergency Assessment) model. A team approach, led by a consultant or registrar, that aims to ensure patients are treated in the most suitable area by the appropriate professional. This includes redirection to GPs when the patient has primary care needs or seeing patients in the urgent care or emergency care area when they require immediate medical intervention, such as patients who have sustained an injury.
- The ready availability of interventional radiology – patients requiring this treatment receive it within an hour of identified need. It is available 24 hours a day, seven days a week.
- The development opportunities available for medical records staff – staff are supported to complete an accredited clinical coding course, which leads to alternative employment opportunities.
- The majority of patients were complementary about the care and compassion of staff.
- Staff were compassionate, caring and committed in all areas of the hospital.
- Palliative care was compassionate and held in high regard by staff, patients and friends and family.
- We saw some good practice in children's services, particularly in relation to education and activities for children while in hospital.
- Internet clinics via Skype for diabetic patients.
- Reminiscence room provided by volunteer service.
- Patients who had had a heart attack received equal treatment, whether admitted during the day or at night.
- There was good support for relatives when patients were in a life-threatening situation or when difficult decisions needed to be made about continuing care.
- There was a dedicated exercise classes for Bengali women following a heart attack.

Are services safe?

Summary of findings

Generally services at Barts Health are safe. The hospitals are clean and, on the whole, well maintained and the risk of infection is minimised. There are policies and procedures for practice but not all staff are aware of them. While there is learning from incidents on individual sites, this is rarely the case across the trust. There are risk registers in all departments but on many occasions we found that the risk register was not acted upon and some identified risks were not being dealt with.

Staff levels are variable, however, and this meant that people did not always receive care promptly. Across all sites there is a reliance on agency staff which has an impact on timeliness and quality of care.

Equipment is not always available and this may put patients' safety at risk.

Our findings

Safety/incident reporting/never events/ managing risk

Between October 2012 and September 2013, there were 10 'never events' (serious, largely preventable patient safety incidents) at Barts Health. Never events are not acceptable in any circumstances. While it is impossible to directly compare Barts Health with any other trust due to its large size, there is one trust that has almost as many 'bed days' and this trust reported seven never events for the same period. Most of the trust's never events (six) occurred at Newham University Hospital. Learning had been implemented and shared across the trust. Yellow wrist bands were introduced for patients who had swabs left in place following an operation that needed to be removed before the patient was discharged. This system was introduced shortly before our inspection so it is too early to say if this will prevent further never events of this nature. However, in the London Chest Hospital, a yellow wrist band is used to identify a patient who is at risk from falling. Although this has reduced the number of falls at the London Chest Hospital, there is a risk in itself of the same colour wrist band being used to identify different risks.

All trusts are required to submit notifications of incidents to the National Reporting and Learning System – and between October 2012 and September 2013, there were 522 serious incidents at the trust. Forty two per cent of these happened on the wards, with 10% occurring in maternity services. There was clear evidence that learning from incidents is shared across the maternity department.

There is a strong commitment to improving practice through learning from incidents. When incidents occur there are investigations, and in some areas learning from those incidents will be shared in clinical governance meetings. But this is not the case across the trust. There were safety measures in place across the trust to manage risk and to monitor care. In December 2012, the trust was above the English average for the development of new pressure ulcers – that is, more patients than average developed pressure ulcers in Barts Health hospitals. The trust has worked to reduce this and now the rates are close to, and at times lower, than the national average. However, while this information is displayed on some wards, it is not consistent across the trust and so some staff are unaware of this.

Managing risk across the trust presents a mixed picture; on many, but not all, wards there is information displayed about patient safety. The information relates to key risk areas such as pressure ulcers, falls, hospital acquired infection, staffing levels and use of bank (overtime) staff. But this information is not consistently updated and good practice is not widely shared across the trust. The trust's risk register is not used effectively, with many risks being identified but not then addressed. This must be addressed.

Staffing

Staffing levels are variable across the trust. Some wards had enough nursing staff with the right experience and qualifications to work in the clinical areas they were based in. However, many wards had nursing staff vacancies and, following a review of staffing grades, a number of nursing staff have resigned. Staff told us that it is often difficult to get staff to cover short-notice absences – for example, when people phone in sick at the beginning of a shift – and this can leave patients at risk from unsafe care.

This was not the case in all areas. The Emergency Departments (EDs) across the trust generally had enough staff of all levels on duty, including consultant staff on duty at all times. Junior doctors working in the ED felt supported,

Are services safe?

as did nursing staff. Although, this was not uniform across other departments within the trust. In the General Medical Council's National Training Survey, completed by junior doctors in training during March to May 2013, junior doctors rated their workload and their clinical supervisor on whether they felt forced to deal with clinical problems beyond their experience and competence; they rated this to be 'within expectations'. In the medical wards, junior doctors reported feeling under pressure and unsupported, particularly at night times and weekends. In surgery there was a similar picture.

Cleanliness and infection prevention and control

In the 2012 Department of Health NHS Staff Survey, Barts Health came in the bottom 20% of trusts nationally, regarding the proportion of staff stating that hand-washing materials were readily available. On our inspection, we saw that there were adequate hand-washing facilities and we saw staff taking care to wash their hands. There was information about the importance of hand washing and we saw visitors to the hospitals washing their hands before going onto wards.

The trust's infection rates for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (*C. difficile*) were within a statistically acceptable range.

All the wards we inspected in the eight hospital locations were clean. Some of the buildings are old and the trust has plans to move some services into newer locations; where this has already happened, the facilities themselves were kept clean. We heard patients and visitors comment on the cleanliness.

Medicines management

Generally medicines were managed well with very few errors in administration. We found incidents across the trust where drug trolleys were left unlocked and drug cupboards were left unlocked or locked but with keys hanging nearby. On each occasion we brought this to the attention to the person in charge of the ward and medicines were secured.

Environment

Both Newham University Hospital and the Royal London Hospital are new buildings; they are clean and spacious. Whipps Cross is an older building and some of the areas would not be considered appropriate for a modern hospital, although the ED and medical assessment unit are newly built. The London Chest Hospital is due to close in 2014 and the facilities will be moved to a new building on the site of St Bartholomew's Hospital.

Safeguarding vulnerable adults and protecting children

All staff we spoke with understood the importance of safeguarding vulnerable adults and protecting children. The trust showed us records confirming that staff had received training at the appropriate level for their grade. However, there is no one member of staff at the trust who is the dedicated lead for safeguarding, nor is there a clinical person in each of the hospitals with this responsibility. While it is clear that staff believe safeguarding is the responsibility of all staff, if no one person has oversight, there is a risk that safeguarding concerns may not always be recognised.

Medical equipment

Throughout the trust, medical equipment was generally clean, serviced and fit for use. There were some instances where this was not the case. However, there were also areas where there were chronic shortages of essential equipment – for example, the older people's wards at Whipps Cross have one bladder scanner between them. Bladder scanners are used to detect urinary retention, which can be a cause of urinary tract infections (UTIs). Between August 2012 and August 2013, the trust's rates for UTIs were consistently above the rate for England for patients both under and over the age of 70. We would recommend that the trust gives consideration to what is the safe level of equipment in departments. In the maternity services at Whipps Cross, we found that there was more equipment available on the wards.

Are services effective?
(for example, treatment is effective)

Summary of findings

The effectiveness of services varies across the trust. In the smaller hospitals, care was consistently effective and guidelines for best practice were followed and monitored. In the larger acute hospitals this was less consistent. Multidisciplinary teams are still establishing themselves and there is ongoing work towards having senior staff available on site at all times.

Our findings

Mortality rates

Mortality rates across Barts Health are within expected parameters. There have been no mortality outliers for Barts Health in the year to October 2013. Out of 40 mortality rated indicators, as identified by the Information Centre for Health and Social Care Hospital Episode Statistics, Barts Health scored 'tending towards worse' or 'worse than expected' in nine areas. However, statistically this does not make Barts Health an outlier and figures are from 2011.

NHS Safety Thermometer

The NHS Safety Thermometer is designed to measure a monthly snapshot of four areas of harm: falls; pressure ulcers; catheter related urinary infections; and assessment and treatment of venous thromboembolism (VTE). The number of falls in Barts Health for all patients fluctuates. The trust performed better than the national average in the year from August 2012 to August 2013 and many wards have initiatives to identify and support those at risk from falling. As stated, the trust peaked for the development of new pressure ulcers in December 2012, but since then has been consistently below or the same as the rate in England overall. However, many staff told us about a shortage of readily available pressure-relieving mattresses and this poses a risk for the trust in its continuing effort to reduce the rate of people developing pressure ulcers.

The trust's rates for urinary infections are higher than the national average. The VTE rate has fluctuated either side of the national average. In January 2013, there was a spike in the number of people being treated for a VTE. Throughout the year from August 2012 to August 2013, the numbers of people being treated for VTE has fluctuated.

National guidelines

Before we inspected the trust, we looked at data we held about Barts Health. For most of the indicators we considered, Barts Health was performing within expected parameters. We knew that in some of the maternity wards the trust performed a higher number of caesarean section operations than expected. We asked the trust to explain this and, although it was able to provide an explanation, it also identified areas of care that could be improved. We saw evidence on all sites that care was delivered according to national guidelines published by the National Institute for Health and Care Excellence (NICE) and by professional bodies. The trust had recently stopped using the Liverpool Care Pathway – the care pathway for delivery of end of life care, in line with guidance from the Department of Health. Although there was other guidance available in the trust, not all staff who may have looked after dying patients were aware of it.

Clinical audits

We saw that audits were carried out and changes to practice were being implemented to improve patient care. But the audits were not disseminated across the trust, even within CAGs. Departments also participated in national audits and guidance was updated in line with national guidance.

Collaborative working

The CAG structure has great potential for collaborative working. Some CAGs are better established than others, with staff identifying with being part of Barts Health NHS Trust rather than part of the hospital staff where they are based. However, this is not the case in all CAGs We were impressed with the collaborative working of clinical staff and the levels of support across disciplines.

Are services caring?

Summary of findings

The majority of patients and relatives we spoke to described staff as caring and compassionate. We saw staff treating people with dignity and respect. However, we heard about a number of concerning instances of poor care at our listening events and from people contacting us during the inspection. The trust must ensure that the positive experiences we saw and heard about during the inspection are maintained, and that instances of poor care are minimised and dealt with appropriately.

Our findings

Patient views and feedback

Barts Health was one of 155 acute NHS trusts to take part in the 2012/13 Cancer Patient Experience Survey. There were 64 questions where Barts Health had enough responses to base findings, and in 50 of these, Barts Health was rated by patients as being in the bottom 20% of all trusts. In the 2012 Adult Inpatient Survey, Barts Health scored 'within the expected range' in nine of the 10 areas. In the NHS Family and Friends Test in August 2013, the combined scores of the trust's hospitals was 59.5, which is above the national average and 93.9% of those who took part in the test that month said they would be 'likely' or 'extremely likely' to recommend the ward they had been on to others.

In August 2013, the trust launched a 'call for action for compassionate care across the trust'. The campaign was called 'Because We Care' and introduced initiatives such as 'hourly chats' with patients and healthcare support workers in A&E. There are posters around the hospitals about the campaign, but not all staff we spoke with were aware of the campaign or their role in it. For instance, one of the wards at Newham Hospital has created the acronym SMILE to describe how they should act: S = Say hello, M = make the person feel at ease, I = introduce yourself, L = look and listen, and E = explain clearly. However, not all staff were able to tell us what the acronym stood for.

Privacy and dignity

In the annual Patient Environment Action Team (PEAT) assessment, the trust scored 'good' for treating people with privacy and dignity. Staff respected patients' privacy and dignity. During our inspection we saw examples of staff ensuring curtains were closed around patients' beds when care was being delivered. We saw patients being treated respectfully and being spoken to about the care they were about to receive. However, we also saw instances when patients' notes were left on desks on wards, which could potentially breach confidentiality. On a previous inspection of the maternity services in Whipps Cross, we overheard staff speaking in a disrespectful way about patients – we did not overhear any such comments in maternity services on this inspection.

Food and drink

In the annual PEAT assessment, the trust scored 'good' for food. We heard mixed reviews about the quality of food during this inspection. Generally patients were satisfied with the quality of food they received. Some people told us they would have liked to be able to reheat food but they could not do so as there were no facilities on the wards. We saw people being supported to eat when necessary. We saw that water and other drinks were put close to patients. The trust had protected meal times which meant that, when it was meal time, general care should not be carried out and patients should be assisted to eat and drink if necessary. Many members of staff told us this wasn't always adhered to and we saw some cases of general care continuing at meal times.

End of life care

In line with the Department of Health's guidance, the Liverpool Care Pathway, the care pathway for delivery of end of life care, is no longer in use. Interim guidance had been introduced, although not all staff were aware of this. There is a purpose-built palliative care unit in the grounds of Whipps Cross hospital and staff from the unit provide support and guidance to the main hospital site. However, at other sites the palliative care team was only available between the hours of 9am and 5pm Monday to Friday.

Are services responsive to people's needs?
(for example, to feedback)

Summary of findings

Most people told us that the services they used were responsive their needs. However, in some areas of the trust, people's needs were not being met. There were problems in both the Royal London and Whipps Cross hospitals with patient flow through the hospital, bed occupancy and discharge planning. This was not such a problem in Newham University Hospital.

Young people felt that their needs were not addressed, as there are no dedicated facilities for caring for adolescent patients.

The other area where people felt the trust was not responsive was when they had cause to complain. Across the trust, people we spoke with and who contacted us consistently told us that they were unhappy with the way their complaints had been handled. The Patient Advice and Liaison Service in the trust has recently become centralised and this has been a cause of frustration for people who wish to raise concerns.

We had concerns about written information for patients, both in respect of its general availability and the languages it was available in. This caused anxiety for people who did not want to bother staff.

Our findings

Responding to patients' needs

The trust performs below the expected national target for waiting time in the A&E department, although this was less likely to happen in Newham University Hospital. The trust also performs below the national average for people leaving A&E without being seen. The CAG for emergency medicine worked to ensure that each of the trust's A&E departments had enough staff with the right skills on duty at all times.

Wards were generally busy and people told us that staff did not seem to have the time to talk with them; rather, they carried out what care was required and then moved onto the next patient. Staff agreed that this was often the case and told us they thought there were not always enough staff on duty.

Discharge

Discharge planning was mixed. Staff told us that, on medical wards, people who were ready to be discharged sometimes couldn't be, because equipment wasn't available or housing needed to be arranged. There had been a 'bed manager' at the Royal London, although this post no longer exists and staff told us they felt that not having a dedicated person to ensure that beds were available caused a delay in discharging some people. Across all three main hospitals, there was a perception that some patients had delayed discharges because of social issues, such as waiting to be rehoused; the trust should work in conjunction with the local authorities to ensure this is not the case. If patients had a very short life expectancy, of less than three months, there was a 'fast track' process to facilitate funding and ensure that a care package could be put in place speedily. However, nationally the trust was performing similarly to other trusts in response to questions about discharge planning.

Information

Patients told us they would have liked more written information. They told us that they couldn't always remember what they had been told about their procedures and future plans and didn't like to keep asking. This was a consistent message across all sites. The written information that was available was exclusively in English. All of the hospitals in Barts Health care for people from a number of different ethnic groups, not all of whom speak and/or read English. In the Royal London Hospital, many people told us they found the hospital hard to get around and the lack of signage made this more complicated.

The trust employed a large number of staff from different ethnic groups and staff are willing to translate for patients. Staff may also access a telephone translation service, although patients told us they usually had relatives with them who could translate.

Are services responsive to people's needs?
(for example, to feedback)

Complaints and feedback

The trust recently restructured the Patient Advice and Liaison Service. This service provided information to patients and helped them with complaints. Until recently, each hospital site had an office with staff. Each of these offices are now closed and there is a central telephone number for people to call instead. People who have concerns or complaints should then be directed to the correct person to speak to. This is a new development and during our inspection we saw that leaflets about the new service were being distributed. However, patients told us that they did not understand how the system worked and when we rang the number, on a number of occasions, there was no response.

During the inspection, we were contacted by a number of people, either directly or at one of our listening events, who told us they had complained about their care or a relative's care and had not been satisfied with the response. In maternity services, it was clear that work had started on learning from complaints in order to improve people's experience, but this was not the case across other departments.

Are services well-led?

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

Summary of findings

There is variability in leadership across the hospital. The trust's Executive Team is well-established and cohesive with a clearly shared vision. They are well supported by non-executive directors. However, they are not visible across the trust.

Below board level, some areas were well-led, but others were not and this had an impact on patients' care and treatment. The clinical leadership structure was relatively new. The Clinical Academic Group (CAG) structure was introduced in October 2012 but is not yet embedded across the organisation. The exception to this is the Emergency Care and Acute Medicine (ECAM) CAG.

The CAGs, when embedded, could provide a clear route for board to ward engagement and governance but it needs time to become embedded and effective. The trust recognised this and had taken action to address some shortcomings in the governance structure, such as the introduction of site-level organisational and clinical leadership.

Staff feel disconnected from the trust's Executive and feel undervalued and not supported. The culture was not sufficiently open and some staff felt inhibited in raising concerns. Morale was low across all staffing levels and some staff felt bullied. This must be addressed if the trust's Executive Team's vision is to be successful.

Our findings

Leadership and clinical governance structures

Barts Health NHS Trust came into being on 1 April 2012. It was created by a merger of Barts and the London NHS Trust, Whipps Cross University Hospital and Newham University Hospital. In October 2012, the trust introduced a clinical leadership structure (the Clinical Academic Group (CAG)) covering specific specialties, such as emergency medicine or surgery, across all Barts Health sites. There are distinct advantages to this structure: it creates the opportunity to share best practice, make improvements, streamline services and innovate. However, there are also risks, particularly in the way the trust implemented the new structure. Some staff reported difficulties in working across the three main hospitals. They said that it was sometimes difficult to know who was in charge in specific areas. At times, they found that the governance structure prevented issues being addressed. The trust had recognised this and strengthened site level leadership at operational and clinical levels. This had been implemented just before our inspection so its impact could not be assessed. It is, in our view, a positive move.

The CAG structures were not effectively embedded in all areas. The emergency care and acute medicine CAG was the most developed and was working relatively well. The CAG had introduced staff working across all sites and there was effective leadership at all levels in the CAG. This was not the case across other CAGs. The trust is committed to learning from care and participated in 38 out of 39 clinical audits for which it was eligible. Sharing the learning from these audits should ensure care improves.

We found some areas of the hospital were well-led but this was not consistent; we found well-run wards in both surgical and medical departments and outcomes for patients in these wards were better.

The trust's Executive team had a vision for Barts Health and were committed to being highly visible. They were supported by non-executive directors. We were told that the executive team each visit the clinical areas of the hospital on the first Friday of the month. The executive team were confident that staff knew who they were and that they knew about this initiative. Staff, however, were largely unaware of this and said they felt the trust's board was distant and remote.

Organisational culture

Barts Health does not have an open culture that allows staff to raise concerns without fear of reprisals or bullying. As part of our inspection we held focus groups with staff of all disciplines and all grades. We also interviewed individual members of staff and held drop-in sessions. Consultant medical staff told us that leadership positions were largely given to consultants who had worked in the Royal London rather than Newham or Whipps Cross hospitals.

Are services well-led?

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

A nursing reorganisation was underway, which will result in some members of nursing staff having their band downgraded; this was having a negative impact on staff morale across all hospitals within the trust. Many nursing staff told us they were considering leaving and doctors told us that they felt their nursing colleagues were not valued.

It was not just nursing staff who felt unsupported and were leaving. We spoke with two acute consultants who had left the trust because of their significant concerns about the infrastructure and safety of practice in the acute admissions unit. We were also contacted by consultant staff who were concerned about medical cover at night time and at weekends. Over the course of the inspection we were contacted by a large number of staff who would only speak with us if we would agree they could be anonymous. They told us they were concerned there would be repercussions and that they felt under pressure not to tell us where there were concerns.

Most staff felt that support and leadership at ward and department level was effective but there was a sense of a disconnect regarding the trust's executive and non-executive teams. Despite this, sickness levels at the trust are better than expected and the trust also scored better than expected on the percentage of staff feeling pressure to return to work while still unwell. In the last NHS Staff Survey, there were concerns about the proportion of staff experiencing abuse from staff, and also about job satisfaction and staff motivation at work.

The General Medical Council's National Training Scheme Survey in 2013 identified a number of areas of concern, including undermining of junior doctors by consultants, teaching, workload, hours of education and trainee compliance. Action plans were in place and these were being monitored, but junior doctors told us that, at times, they felt unsupported – this was particularly the case on medical wards at weekends and overnight.

Although the merger was relatively recent, there is little sense of staff working for Barts Health NHS Trust – staff still related very much to the hospital they were working in than the trust overall or the CAGs.

Care Quality Commission

Barts Health NHS Trust

St Bartholomew's Hospital

Quality report

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Date of inspection visit: 8 November 2013
Date of publication: January 2014

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

Overall summary

St Bartholomew's Hospital is in the City of London and provides a full range of local and specialist services, which include centres for the treatment of cancer, heart conditions, fertility problems, endocrinology and sexual health conditions. It is part of Barts Health NHS Trust, the largest NHS trust in England.

CQC has inspected St Bartholomew's Hospital once since it became part of Barts Health on 1 April 2012. Our most recent inspection was in February 2013 when we looked at cancer care patients undergoing surgical procedures. We found that the trust was meeting all of the 16 national standards of quality and safety. As part of this inspection, we were assessing whether the trust had addressed the shortfalls in other locations, as well as taking a broader look at the quality of care and treatment in a number of departments to see if the hospital was safe, effective, caring, responsive to people's needs and well-led.

Our inspection team included CQC inspectors and analysts, doctors, nurses, allied health professionals, patient 'experts by experience' and senior NHS managers. We spent one day visiting St Bartholomew's Hospital. We spoke with patients and their relatives, carers and friends and staff. We observed care and inspected the hospital environment and equipment. Prior to the inspection, we also spoke with local bodies, such as clinical commissioning groups, local councils and Healthwatch.

We found the wards and departments we visited were clean and infection rates were low. Patients were treated with dignity and respect and were involved in decisions about their treatment and care. The majority of people were satisfied with the service they had received and were complimentary about the care and compassion shown by staff.

Staff were committed to providing good standards of care in all circumstances. Staff morale was low in some areas, mainly due to the implementation of a staffing review. Best practice professional guidelines were used. Most staff had received training to undertake their role and the trust had focused on ensuring staff completed mandatory training.

Services were well-led and staff used quality and performance information to improve. There was evidence that the clinical academic group CAG management structures and leadership were effective.

However, we found there were a number of areas for improvement in some of the services we inspected.

There were not enough staff on some medical wards to meet minimum staffing levels to ensure patients received care and attention in a timely manner. In surgery there were concerns the dependency of patients was not taken into account when staffing levels were set. Across all

Summary of findings

Overall summary (continued)

services, patients and staff raised concerns about the quality and quantity of the food served to patients.

There were systems in place to report incidents, but some staff reported that they did not have access to the IT system to do so. There were also problems with the speed and functionality of the IT system.

The five questions we ask about hospitals and what we found

We always ask the following five questions of services.

Are services safe?
Patients were protected from the risk of infection and the hospital was clean. There was a focus on safety and quality and this was embedded through the clinical academic group (CAG) structures in the clinical areas visited. However, we found staffing in some medical wards did not meet the minimum staffing levels at the time of the inspection and patient needs may not be met in a timely manner. There were also concerns that patient needs may not be met due to the reliance on bank (overtime) and agency staff in some areas.

Are services effective?
National guidelines and best practice was followed. Care was effective and patients' needs were met.

Are services caring?
Patients told us staff were caring and compassionate and they were treated with dignity and respect. We observed staff were polite, kind and caring in their interactions with patients, visitors and colleagues. However, we had concerns about the standard of the meals provided by the hospital which patients described as "inedible".

Are services responsive to people's needs?
Patients told us that the hospital services had responded to their needs. We found discharge arrangements were coordinated through multidisciplinary teams and patients were aware of their expected date of discharge. Patients' wishes were taken into account in the planning and delivery of care.

Are services well-led?
There was effective leadership and governance at all levels of the clinical academic groups. Staff were clear about their responsibilities and were supportive of each other.

Summary of findings

What we found about each of the main services in the hospital

Accident and emergency

There were no emergency services provided at the hospital. There is a minor injuries unit (MIU) providing a service to people working in local offices and businesses. Patients were seen and treated within acceptable time limits. Nurse practitioners provided the service and patient treatment was provided in accordance with agreed protocols.

Medical care (including older people's care)

Staff had appropriate skills and training. Some of the areas we visited were short of staff. However, the staff were caring, compassionate and the majority of people we spoke with told us that they were happy with the care. The areas were well-led at the point of service delivery, although some staff told us that there was a disconnect between the executive team and the wards. Patients were admitted either directly to the wards via the outpatient department, day units or from other hospitals within the trust as well as from other external providers.

Surgery

Patients were treated in accordance with national guidance, for example, cardiac and thoracic surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were not, however, aware of learning from incidents to improve patient safety.

Staffing levels were in line with professional guidance. However, there were some concerns that the staffing levels did not take into account the dependency of patients on surgical wards at night and weekends, and the impact of using high levels of agency staff. Patients were not discharged over the weekend on one ward which could lead to an extended length of stay for the patients.

Intensive/critical care

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty to provide 24-hour care. Systems were in place to monitor the quality and safety of patient care provided. Staff were aware of the incident reporting system and received feedback. They told us they were encouraged by senior staff to report incidents and raise awareness of patient safety issues.

Summary of findings

What people who use the hospital say

The NHS Family and Friends test scores showed the trust average score was above the national figure. Cancer patient's rated the trust in the bottom 20% of all trusts nationally. The NHS Choices website showed St Bartholomew's Hospital had a star rating of 4.5 out of 5.

Areas for improvement

Action the hospital MUST take to improve

- Ensure there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely in a timely manner.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs.

Other areas where the hospital could improve

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all CAGs.
- Improve staff access to suitable IT to ensure timely incident reporting by all staff.

Good practice

Our inspection team highlighted the following areas of good practice:

- The majority of patients were complimentary about the care and compassion of staff.

Care Quality Commission

St Bartholomew's Hospital

Detailed findings

Services we looked at: Accident and Emergency; Medical care; Surgery, Intensive/Critical care

Our inspection team

Our inspection team for Barts Health NHS Trust was led by:

Chair: Dr Andy Mitchell, Medical Director (London Region), NHS England

Team Leader: Michele Golden, Care Quality Commission

Our inspection team at St Bartholomew's Hospital was led by:

Team Leader: Sue Walker, Care Quality Commission

Our inspection team included CQC inspectors and analysts, doctors, nurses, student nurses, allied health professionals, patient 'experts by experience' and senior NHS managers.

Why we carried out this inspection

We inspected this trust as part of our new in-depth hospital inspection programme. The inspection took place on 8 November 2013 we are testing the new approach in 18 NHS trusts. We chose these trusts because they represented the variation in hospital care in England, according to our new 'intelligent monitoring' system – which looks at a wide range of data, including patient and staff surveys, hospital performance information, and the views of the public and local partner organisations. Using this model, Barts Health NHS Trust was considered to be a high-risk service.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team inspected the following services at this inspection:

- Accident and emergency (A&E)
- Medical care
- Surgery
- Intensive/critical care

Before visiting, we looked information we held about the trust and also asked other organisations to share what they knew. The information was used to guide the work of the inspection team during the announced inspection on 8 November 2013.

During the announced inspection we:

- Held four focus groups with different staff members as well as representatives of people who used the hospital.
- Held one drop-in session for staff.
- Looked at medical records.
- Observed how staff cared for people.
- Spoke with patients, family members and carers.
- Spoke with staff at all levels from ward to board level.
- Reviewed information provided by and requested from the trust.

The team would like to thank everyone who spoke with us and attended the focus groups and drop-in sessions. We found everyone to be open and balanced when sharing their experiences and perceptions of the quality of care and treatment at the hospital.

Are services safe?

Summary of findings

Patients were protected from the risk of infection and the hospital was clean. There was a focus on safety and quality and this was embedded through the clinical academic group (CAG) structures in the clinical areas visited. However, we found staffing in some medical wards did not meet the minimum staffing levels at the time of the inspection and patient needs may not be met in a timely manner. There were also concerns that patient needs may not be met due to the reliance on bank (overtime) and agency staff in some areas.

Our findings

Patient safety

Patients told us they felt safe in the hospital and the majority had experienced good care. Comments included, "Staff are always visible and never rush even though I know they are short-staffed and busy". Another person said, "We always have our call bells to hand and staff usually responded promptly".

There was a focus on safety. Staff reported incidents and were encouraged to do so by their managers. Staff also confirmed that they received feedback and incidents were analysed and used to improve the quality and safety of services. Staff were not aware of learning from incidents that had occurred in other parts of the trust which suggests systems to share learning were not effective.

Serious safety issues and avoidable harm were reported to the National Reporting and Learning Service. The number of reported serious incidents for St Bartholomew's Hospital was 12 and a third of those related to grade 3 and 4 pressure ulcers.

Staffing

Staff reported they were often "stretched" and under pressure at busy times, particularly in the nursing workforce. We were told there were adequate numbers of doctors. Junior medical staff and student nurses told us they were usually well supported by senior staff. There were systems in place to order additional nursing staff to cover vacant posts and short-term absence. However, we saw on several wards that the minimum staffing levels and skills mix necessary to meet patients' needs were not achieved.

Cleanliness and hospital infections

Patients were protected from the risks of infection. The trust infection rates for Clostridium difficile (*C.difficile*) and methicillin-resistant staphylococcus aureus (MRSA) were within an acceptable range taking account of the trust size and national infection levels. The wards visited displayed information regarding their individual infection rates for staff and patients to see.

All the wards we visited were clean, with schedules followed by cleaning staff. Patients and visitors were provided with information on how to prevent infections. There was hand hygiene gel at the entrance of every ward and by every patient bed for staff, patients and visitors to use. Staff were seen wearing personal protective equipment (gloves and aprons) and washing their hands in between attending to patients. Patients were screened prior to admission. Patients with a spreadable infection were treated in isolation in side rooms. We also saw that patients vulnerable to infections were nursed in isolation for their protection.

Managing risks

The hospital was managing patient safety risks. There were safety measures in place to monitor patient falls, development of pressure ulcers, blood clots and catheter urinary tract infections. There was ongoing monitoring to improve safety and ward-based quality monitoring and performance results were displayed on ward notice boards for staff and patients to see.

Patient records

Patient records contained information regarding patients' wishes with regard to end of life care and, where appropriate, 'do not attempt resuscitation' decisions were documented and discussed with patients.

Medical equipment

Equipment seen in the hospital was clean and had been serviced and maintained. Emergency equipment was available in all areas and records showed daily checks were carried out.

Are services effective?
(for example, treatment is effective)

Summary of findings

National guidelines and best practice was followed. Care was effective and patients' needs were met.

Our findings

Clinical management and guidelines
Patients received care according to national guidance. The trust used National Institute for Health and Care Excellence (NICE) and professional guidelines. The trust participated in national audits and there were staff in place to ensure these were implemented and monitored. We observed good multidisciplinary team working in the services visited.

Staff skills
Staff did have appropriate skills and training. The trust supported staff to have the appropriate skills, knowledge and training. Staff attendance at mandatory training was monitored and reminders sent when an update was due. Records seen showed mandatory training rates had increased from August 2013.

Are services caring?

Summary of findings

Patients told us staff were caring and compassionate and they were treated with dignity and respect. We observed staff were polite, kind and caring in their interactions with patients, visitors and colleagues. However, we had concerns about the standard of the meals provided by the hospital which patients described as "inedible".

Our findings

Patients' feedback

Patients we spoke with told us, without exception, that staff were kind, caring and treated them with dignity and respect. They told us the care they received was "excellent" and the staff were "fantastic". Comments included: "Staff always give me the time I need, they never rush me even though they are busy and short-staffed most of the time"; and "I'm lucky to have had such wonderful care".

Information on the NHS Choices website included a number of positive and negative comments. Most of the comments were positive and highlighted excellent care and that staff were kind and caring. The negative comments highlighted the poor conduct and attitudes of some staff and poor environmental standards.

Patient treatment

Patients were supported to ensure their care needs were met. We saw patients had food and drink when they needed it. They were supported with their personal care and to manage their pain. Staff were observed to be kind, compassionate and caring. They were also honest about when the quality of care did not meet their standards due to a lack of staff.

Staffing levels

Nursing staff told us there were frequent occasions when patients were not attended to in a timely manner due to a shortage of staff or because patient dependency was higher than anticipated particularly during evenings and weekends. We saw staff worked very hard to meet the needs of patients and were caring and compassionate towards patients.

The trust had undertaken a review of nursing establishments and posts. Staff across all disciplines expressed concerns that the numbers of experienced staff were reducing and the quality of care provided would be affected.

Patient privacy and rights

Staff respected patients' privacy and dignity and their right to be involved in decisions and make choices about the care and treatment. We observed communication between staff and patients that was polite, professional and respectful.

Food and drink

Patients were provided with a choice of food and drink. We were concerned, however, that the majority of patients we spoke with told us the food served was "unacceptable" and "tasteless". Comments included, "The food is terrible, the portions are small and the food isn't always hot". Other patients told us the food was "horrible, burnt" and "shrivelled", and often "inedible".

Staff attending some of our focus groups and drop-in session confirmed patients' comments. We raised the concerns directly with the responsible deputy director to take action to address our concerns that patients were not receiving adequate amounts of nutritious food.

Are services responsive to people's needs?
(for example, to feedback)

Summary of findings

Patients told us that the hospital services had responded to their needs. We found discharge arrangements were coordinated through multidisciplinary teams and patients were aware of their expected date of discharge. Patients' wishes were taken into account in the planning and delivery of care.

Our findings

Patients' feedback

Patients told us they were happy with the responsiveness, care and attention they had received from the services in the hospital.

Information on NHS Choices website included a number of positive and negative comments. Positive comments highlighted prompt attention in minor injuries unit (MIU) and excellent care and attention for inpatient wards. The negative comments related to lengthy processes to book and waiting times in the outpatients department.

The trust used the NHS Family and Friends test to gather patient feedback and results were displayed in most areas. The information published on the NHS Choices website showed the vast majority of people using the hospital would "be extremely likely" to recommend the hospital to people they knew.

Discharge of patients

Most patients were discharged appropriately and were coordinated by the multidisciplinary teams. Patients told us they were aware of the plans for their discharge. Records showed discharge planning commenced at the pre-admission stage of the patient pathway. However, we were told staff could not discharge patients over a weekend on Vicary Ward and patients waited until the Monday to be discharged reducing the effectiveness of the service and extending the patient's length of stay.

Accessible information

Information was available in various formats and was made available by staff. The hospital had a translation and advocacy service for people whose first language was not English.

Are services well-led?

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

Summary of findings

There was effective leadership and governance at all levels of the clinical academic groups. Staff were clear about their responsibilities and were supportive of each other.

Our findings

Leadership

Staff told us they had access to good management and leadership. They said they felt supported and valued by their colleagues and direct line managers. There had been a recent staffing review and a re-grading process was ongoing which had affected staff morale.

There was a clear management structure in place and there was evidence of effective systems and communication at all levels of the CAG. Ward managers and senior clinicians had a good understanding of the performance of their wards and departments. Staff told us the chief nurse and senior nurses in the trust undertook 'clinical Fridays' and spent time on the wards. This allowed senior staff to see the quality of care and gather first-hand feedback from patients and staff. Staff were less aware of other senior managers in the trust and reported that they did not recall seeing them in the clinical areas.

Managing quality and performance

The trust Board had established the CAGs and devolved the management for performance, quality and governance to the CAG leadership board. There was evidence that quality and performance monitoring data was reported on at the CAG leadership meetings and senior managers in the hospital reported they attended.

We observed safety and quality of care was monitored and action taken in response to concerns at ward level. Staff demonstrated a good understanding of the clinical governance framework, how risks were managed, controlled and mitigated against. Communication of performance, quality and governance information was apparent from 'ward to board'.

Accident and emergency

Information about the service

There were no emergency services provided at the hospital. There is a minor injuries unit (MIU) which is staffed from the London Hospital emergency department (ED) and is open from 8am to 4pm Monday to Friday, providing a service to people working in local offices and businesses.

We spoke with staff but were unable to speak with patients as none were in the department at the time of our visit.

Summary of findings

Patients were seen and treated within acceptable time limits. Nurse practitioners provide the service and work to agreed protocols.

Are accident and emergency services safe?

Services in the minor injuries unit were safe.

Patient safety

The MIU was staffed with two senior staff members that were trained in dealing with minor injuries and minor ailments. Staff told us that there was always two staff present in the unit to ensure patient and staff safety was maintained.

Staff told us that all incidents were reported electronically via the computer system and they demonstrated a good understanding of the type of incidents to report. There was, however, no information regarding incidents available in the unit and staff were unsure of how many incidents had been reported.

Managing risks

The risks to patients were managed and monitored on a daily basis. We observed that individual patients were discussed at handover and information recorded on a board which identified issues such as pressure ulcers or falls. Staff told us they were able to access suitable equipment such as pressure relieving mattresses when needed and that equipment was cleaned and maintained.

However, on the outpatient area staff told us that one of the blood centrifuge machines was only checked annually and it was felt that this may be insufficient.

All the areas we visited had resuscitation equipment in place which had been checked regularly, although, due to time constraints, we did not check the emergency checks had been completed in the MIU.

Cleanliness and hospital infections

Staff had a good understanding of how to protect patients from the risk of infections. The MIU was clean and there were adequate sinks, paper towels and hand hygiene gel available. Information about the prevention of infections was available for patients and visitors. Hand-washing audits were completed and the majority of the results showed 100% compliance.

Are accident and emergency services effective?

Services in the minor injuries unit are effective.

Clinical management and guidance

Patients were seen, assessed and treated by experienced nurse practitioners who worked to agreed clinical protocols. The department used the same protocols and procedures as other units across the trust, which the staff stated were informative and provided clear guidance.

Staff told us that the x-ray department is not co-located to the MIU and does cause some delay for patients to walk between departments. All x-rays are viewed on the computer system and the staff can ask for opinions from specialist teams if they need to.

Staff skills

The MIU staff were employed to work in the emergency department at the Royal London Hospital and had the appropriate qualifications such as advanced life support (ALS) to deal with unforeseen emergencies.

Staff told us they worked in the MIU from 8am to 4pm and then, as all staff work long days, they return to the Royal London ED to finish the shift. We were told the journey on public transport can take up to one hour and staff felt this was not an effective use of their time.

Accident and emergency

Are accident and emergency services caring?

Services at the minor injuries unit are caring.

Patient feedback

There was no information regarding the NHS Family and Friends test available in the waiting room. Staff were unsure how patient feedback was collected and reported on for this part of the service. We could not determine whether the information was collated as part of the Royal London Hospital ED surveys or specific to the MIU. We were unable to ask people about their experiences as the unit was very quiet on the day of our inspection.

We saw that patient feedback on the NHS Choices website was positive and noted that staff were professional, caring and compassionate.

Are accident and emergency services responsive to people's needs?

Services at the minor injuries unit are responsive to the needs of patients.

Environment

The MIU comprised a waiting area that was able to accommodate approximately 20 or more patients, there were three treatment areas and a separate resuscitation bay. We were told that, if a patient needed urgent transfer to an A&E, staff called the emergency services via a 999 call which meant that the response was quick and the patient received immediate care.

Accessible support and information

Staff told us the trust had reversed a decision to reduce the opening hours of the MIU following requests from local businesses.

There were a variety of information leaflets available in English to advise patients on minor injuries and care.

Are accident and emergency services well-led?

The minor injuries unit is well-led.

Leadership

The MIU is managed from the Royal London Hospital ED and comes under the clinical academic group (CAG) of Emergency Care and Acute Medicine (ECAM).

Staff told us they are able to access the necessary mandatory training and specialist qualifications and they received supervision and debriefing regarding any difficult situations encountered as part of their work in the department. The records for this were not held at the MIU.

Staff told us there had been no communication from the trust management team regarding the removal of hospital transport for staff to be taken back to the Royal London Hospital ED. They commented told us that they now have to use public transport to get back to the ED at The Royal London Hospital which does not seem to be an effective use of their time while on duty.

Medical care (including older people's care)

Information about the service

General information

We inspected three wards and an outpatient department. The wards and outpatient specialities included haemo-oncology and endocrinology providing services for patients with cancer.

We talked with 10 patients, two relatives and 13 members of staff which included doctors, nurses, support staff, administrative staff and allied health professionals such as physiotherapists. We observed care and looked at care records.

Summary of findings

Staff had appropriate skills and training. Some of the areas we visited were short of staff. However, the staff were caring, compassionate and the majority of people we spoke with told us that they were happy with the care. The areas were well-led at the point of service delivery, although some staff told us that there was a disconnect between the executive team and the wards. Patients were admitted either directly to the wards via the outpatient department, day units or from other hospitals within the trust as well as from other external providers.

Are medical care services safe?

Improvements are needed in the medical units for care to be safe. Some of the wards we visited did not have enough staff on duty.

Patient safety

There were systems in place to report incidents electronically. Staff told us they reported incidents and most felt they were encouraged and able to do so. However, some students working on the wards told us they did not have access to the system and relied on the ward staff to report issues on their behalf. Most staff said that they received an acknowledgement and feedback if they had reported an incident. The wards had display boards which identified any incidents that had been reported and the results of infection control audits that had been completed.

Patient feedback

Patients told us they felt safe and comments included, "Staff are always visible and never rush even though I know they are short-staffed and busy". Another person said, "We always have our call bells to hand and staff usually responded promptly". The majority of patients felt the care delivered by the doctors and nurses was excellent. Although some patients told us they had experienced problems with outpatient appointment letters and had been sent to the wrong hospital to have tests carried out which had caused delays, as appointments needed to be rearranged in some cases.

At our listening event, people expressed concern about the central appointments system. They gave examples of being sent to the incorrect department and hospital for tests and outpatient appointments. People told us that staff were always apologetic and the clinic staff were very helpful. One person said, "The appointment system is a shambles you can never get through to check things, but the care in hospital is fantastic".

Patient treatment

Patients' medical needs were assessed appropriately in all the areas we visited to reduce the risk of unsafe or inappropriate care. Patients who attended the day unit for chemotherapy were assessed to ensure they were well enough to continue being treated or admitted to the appropriate ward if necessary. Records were fully completed and risks identified. This included falls, skin integrity and risk of infection which was recorded within their care plans. Staff told us that people were occasionally moved within the ward from a four-bed bay into a side room to reduce the risk of infection if their condition required.

Patient records and end of life decisions

Patient records contained information regarding patients' wishes with regard to end of life care and, where appropriate, 'do not attempt resuscitation' decisions were documented and discussed with patients.

Staffing

The majority of areas we visited were short of nursing staff. The treatment provided was very specialised and we were told there were adequate numbers of doctors. Junior doctors and student nurses told us they usually felt supported by senior staff. Some doctors told us that low levels of permanent nurses and the high use of bank (overtime) and agency staff was impacting on patient

Medical care (including older people's care)

care. Some of the wards we visited had a 33% vacancy factor and staff told us that there was also a high sickness rate. Staff told us they were able to get approval for bank or agency staff to cover shortages. We were told that the process was lengthy and sometimes delays in getting approval meant that shifts remained unfilled. Staff told us it was difficult to achieve the appropriate staff skills mix required to ensure the safe delivery of the complex treatment patients received. Staff told us that delays in treatment due to staff shortages were reported as incidents.

The majority of staff were able to access mandatory training and senior staff covered the wards to enable training to go ahead. Nurses' competency in giving chemotherapy drugs was reviewed annually to ensure safe practice. We were told that junior nurses all take a medication calculation test at interview and were not able to give chemotherapy until they had completed the appropriate competency framework for their speciality. This ensured that staff maintained safe practice.

Are medical care services effective?

Services in the medical unit are effective.

Clinical management and guidelines

Patients received care according to national guidelines and the appropriate drug therapy regimes were followed in line with pharmacy instructions. The trust participated in national audits, for example, the trust's urinary tract infection (UTI) rates are consistently above the national average and venous thromboembolism (VTE) rates had fluctuated either side of the national average. One of the ward areas had identified UTIs and catheter care as topics for the trust's Safety Cross system to highlight to staff the appropriate clinical management and care.

Staff skills

Staff had the appropriate skills and their competency was regularly monitored. On each of the areas we visited we saw that staff were professional and competent in their interactions with patients. Staff told us that they were able to access mandatory training. We were told that senior nursing staff provided individual training or training days to cover specialist topics. Staff said that study days occasionally had to be cancelled due to staff shortages but senior staff tried to cover to enable the training to go ahead. Staff told us that they received computer training at induction. However, it was reported across all areas that the computers were slow and crash regularly in all areas we visited.

Are medical care services caring?

The staff on the medical wards are caring but people told us the food was inedible.

Patient feedback

Most patients told us they were happy with the care they received. People told us the care is excellent and staff were fantastic. One person said, "Staff always give me the time I need, they never rush me even though they are busy and short-staffed most of the time" and "I'm lucky to have had such wonderful care". Patients were asked to complete the NHS Family and Friends test. We saw the scores for Garrod Ward had improved for two out of the previous three months. Patients we spoke with told us the main problem they had related to the quality of food provided.

Patient treatment, privacy and dignity

Staff told us that patients that attended for chemotherapy on Ward 4B had a choice of being able to receive their treatment in bays with other people or in single rooms. Staff told us that, where possible, they tried to accommodate people's wishes. We saw that staff treated patients with dignity and respect.

Some patients and staff felt there was insufficient privacy in curtained areas for sensitive conversations to be held. However, staff tried to maintain confidentiality but it was difficult due to the lack of space. Staff reported they were able to facilitate 'fast track' discharges for patients wishing to receive end of life care in their own home. Staff told us that charitable agencies such as the Macmillan nursing team and the community nursing services provided enormous support to families and enabled staff to facilitate rapid discharges for end of life care.

Medical care (including older people's care)

Children under the age of 12 were not allowed onto the main ward. However, staff told us they made arrangements so that patients with young children could meet in single rooms.

The wards had processes in place for reviewing care plans and risk assessments. Staff told us that patient care and treatments were reviewed by the multidisciplinary teams on a weekly basis and more frequently if a patient became unwell.

Food and drink

Patients were provided with food and hydration. The majority of patients reported that the food was unacceptable and tasteless. One patient said, "The food is terrible, the portions are small and the food isn't always hot". Patients told us that, when they had complained about the food, in some cases the chef had provided an alternative meal. Staff told us the menus catered for medical conditions such as diabetes, gluten intolerance as well vegetarians and religious needs. Some wards had house-keepers who did milkshake and snack rounds and people felt this helped to support an adequate diet and stopped them feeling hungry.

Are medical care services responsive to people's needs?

Services on the medical wards at St Bartholomew's Hospital are responsive to people's needs.

Patient feedback

Patients told us that they felt cared for and that staff responded to their needs and requests in a timely manner. For example, if people became very unwell or had reduced immunity, staff would transfer people into side rooms. We were told that staff could admit people fairly quickly if they became unwell during chemotherapy sessions and were not fit enough to go home.

Ward environment

The ward environment was appropriate for patients. All the wards had single-sex bays and side rooms with en suite facilities. The side rooms were used to accommodate patients needing either end of life care or isolation to protect them from the risk of infection or vice versa. One ward had a dedicated clinical treatment area for patients to have minor procedures carried out to enable staff to complete the task more quickly.

Patient records and end of life decisions

Patient records contained information regarding patients' wishes with regard to end of life care and where appropriate 'do not attempt resuscitation' decisions were documented and discussed with patients. Information regarding conditions and treatments were available in all the areas in English but could be requested in other languages.

Are medical care services well-led?

Medical care was well-led.

Leadership

Senior doctors told us that they were involved in the performance of their individual clinical academic groups (CAGs) and that the teams were starting to work well together. Information regarding the NHS Family and Friends test was regularly distributed to all the ward and outpatient areas.

Some staff told us that senior managers visited the wards on a regular basis and they were aware of the initiative 'clinical Fridays'. This is where the senior nurses in the trust worked in the clinical settings. Other staff told us they were familiar with the matrons and heads of nursing but had never met anyone above that designation. Ward managers told us that regular updates and information was distributed by the CAG management team.

Staff told us the consultation process relating to the review of grading of some of the clinical staff had been communicated through the CAG. Staff confirmed they had received the information but felt there had been little recognition of the impact this had on staff morale and the impact of staff resigning as a result of management's decision. Some staff felt there was a 'disconnection' between the wards and the trust Board and the impact the consultation was having on care.

Surgery

Information about the service

We visited surgical care services on Vicary Ward (cardio thoracic), Ward 5b (surgical oncology) and the theatre suite in the George V block.

We spoke with a number of patients, staff working in the surgical areas including doctors, senior managers, nurses and support staff. We observed care and treatment and looked at care records.

Summary of findings

Patients were treated in accordance with national guidance, for example, for cardiac and thoracic surgery. Risk management processes were in place and staff were aware of how to report incidents. Staff were not aware of learning from incidents to improve patient safety.

Staffing levels were in line with professional guidance. However, there were some concerns that the staffing levels did not take into account the dependency of patients on surgical wards at night and weekends, and the impact of using high levels of bank (overtime) and agency staff. Patients were not discharged over the weekend on one ward which could lead to an extended length of stay for the patients.

Are surgery services safe?

There are improvements needed to ensure there is sufficient equipment in good condition available and enough staff on duty to provide a safe level of care.

Patient safety

There was a system in place to record serious incidents that occurred. This was through the use of a computerised logging system. The ward managers of all the areas we visited were familiar with the system and told us they used it. Other staff we spoke with on Ward 5b, including staff nurses and student nurses, were unaware of the system. The last entry to the system from Ward 5b was three weeks prior to the day we inspected and was associated with a fall. However, staff told us they had been short of staff for the previous two shifts (night duty and morning shift) which they said was the type of incident that should be reported as patient safety was compromised. On Vicary Ward, doctors and nurses were aware of the system but said that access to a computer was unlikely to be available because there were problems with both the number of available computers and slow running of the IT systems.

Staff we spoke with were unaware of any learning from incidents that had occurred throughout the trust. This meant that the systems in place were not effective and opportunities for lessons to be learned to improve standards may be missed.

Medical equipment

Resuscitation trolleys in all areas visited had been checked daily and were complete and in date. Records of the checks were available and showed consecutive entries. Staff told us equipment such as pressure-relieving mattresses was available with minimal delay.

The theatre in the George V block did not have a blood gas machine in the unit and staff were required to obtain one from the intensive therapy unit (ITU) if needed. We also noted there was no overnight 'O negative' emergency blood stored in the theatre and staff told us they had to obtain this from another building if it was needed. The delay in availability of emergency blood may compromise the safety of patients.

Staffing

At the time of our inspection, staffing levels were safe and met national guidance. However, staff on Vicary Ward told us that staffing levels on an evening and at a weekend reduced to one qualified nurse to nine patients without any indication as to how the changing needs of the patient or dependency levels were taken into account. This may compromise patient safety. The duty rotas we looked at confirmed these staffing levels.

We found the staffing levels on Ward 5b met national guidance, but staff told us this did not take into account the dependency needs of the patients. This ward also used a high percentage of agency nurses to cover short-notice absence.

Staffing levels in the theatres in George V block were adequate during the day. However, there was no on-call rota for theatre staff and a second on-call emergency team from the Royal London Hospital would attend if required.

The staff in all areas we visited had a cohesive team and a positive attitude towards the provision of care. Staff had completed mandatory training but reported that access to developmental training was limited.

Surgery

Cleanliness and hospital infection

Patients were protected from the risk of infection. Areas we visited were clean and the patients we spoke with confirmed this. Hand hygiene gel was available in the ward areas and at the foot of each patient's bed. Staffs wore personal protective equipment such as gloves and were observed to wash their hands between caring for each patient. It was observed that one of the hand gel dispensers at the entrance to Ward 5b was empty.

Transfer of patients

If a patient's condition deteriorated on Ward 5b, transfer to the high dependency unit (HDU) in the Queen Elizabeth unit a separate building would require a qualified nurse to accompany the patient. Staff we spoke with and the duty rotas confirmed that this may impact on the safety of patients on the ward if a nurse was required to leave the ward to transfer a patient.

Are surgery services effective?

Services in the surgical ward are effective.

Clinical management

Patients felt their care and treatment had been effective at each stage from consultation to successful surgery and discharge. Staff were enthusiastic to ensure that patients had successful outcomes. The care records we looked at were complete and included risk assessments and effective discharge planning which commenced pre-admission.

National guidelines

Patients received care in line with national guidelines. Integrated pathways of care were used for patients undergoing cardiac or thoracic surgery. Multidisciplinary wards rounds were carried out on a daily basis during the week. Although the consultant surgeon was not present, staff told us this did not compromise the care the patient received. However, staff told us that, on Vicary Ward, they were unable to discharge patients at weekends and patients waited until Monday to be discharged, reducing the effectiveness of the service and lengthening the patient's hospital stay.

Staff skills

Staff had completed mandatory training and records seen confirmed this. Staff spoken with confirmed they received annual appraisal.

Are surgery services caring?

Although staff are caring on the surgical ward patient's complained that the food offered is boring and inedible.

Patients' feedback

We saw, and patients told us, that staff treated patients with kindness and respect. Patients were pleased with the care they received and, on Vicary Ward, the ward manager was particularly complemented for her care and compassion.

The wards and theatres we visited were very busy and the care needs of the patients were complex.

We were told by staff that they used the NHS Family and Friends test to obtain feedback from patients about their experience. On Ward 5b, a monthly report was received from the Patient Advice and Liaison Service (PALS) who analysed the feedback. The ward manager told us there had not been any adverse reporting.

Privacy and dignity

Patients' privacy and dignity were maintained. Some wards were mixed-sex with segregated male and female bays. There was adequate signage for male and female toilet and bathroom areas. We observed screen curtains were used by staff to maintain dignity and patient communication was carried out in private.

Food and drink

We were told by patients and staff that the quality of the food served was poor. Patients described the food as "horrible, burnt" and "shrivelled", and often "'inedible". Meal times were flexible and the food trolleys on each ward meant that the food could be served warm. We raised the concerns with the deputy director responsible for catering.

Surgery

Are surgery services responsive to people's needs?

Services are responsive on the surgical wards.

Patient treatment

We observed, and the care records we looked at confirmed, that staff responded appropriately to the changing needs of patients. Patients were regularly monitored and their observations recorded. The elective admission system was planned and coordinated from the consultation through to a successful discharge.

Discharge planning

The care records we looked at included a discharge plan which had commenced at the pre-admission stage and was updated during the patient's stay. There was information in the plan to indicate the tentative discharge date and the support that was required on discharge. Patients we spoke with confirmed that they were informed of the planned arrangements for discharge.

Accessible information

St Bartholomew's Hospital had a high percentage of patients for whom English was not their first language. Staff we spoke with explained the arrangements in place for obtaining translation services through the use of Language Line phone service and interpreters. Information booklets were available in a range of languages for patients. However, they were not on display. Staff we spoke with knew where to access the information booklets.

Are surgery services well-led?

Services in surgery were well-led.

Leadership

Senior managers had a good understanding of the performance of their department. There was cohesiveness in surgical teams, although patients reported not seeing their consultant cardio-thoracic surgeon from the initial consultation prior to admission until following discharge. There was a management structure in place and there was evidence of effective systems and communication at all levels of the CAG.

Managing quality and performance

Overall, patients said they were very pleased with the care they had received and felt the service was well run. They were complimentary about how hard the staff worked in the wards. Safety and quality of care was monitored and action taken in response to concerns. Risk registers were maintained for the CAG and fed into the overall trust risk register. Risks were militated against.

Intensive/critical care

Information about the service

The intensive therapy unit (ITU) and high dependency unit (HDU) cared primarily for patients who had cardiac or thoracic surgery post-operatively. At the time of the inspection, there was only one patient in ITU. Further patients were expected later that day, following surgery.

Summary of findings

Patients received appropriate care and treatment in accordance with national guidelines. There were sufficient numbers of staff on duty to provide 24-hour care. Systems were in place to monitor the quality and safety of patient care provided. Staff were aware of the incident reporting system and received feedback. They told us they were encouraged by senior staff to report incidents and raise awareness of patient safety issues.

Are intensive/critical care services safe?

Intensive care services were safe.

Patient safety
The unit had in place a range of systems and processes to ensure the safety of patients. Relevant patient safety data was collected and submitted to the Intensive Care National Audit & Research Centre (ICNARC).

Staffing
Nursing staff worked on a one-to-one ratio for patients in ITU at level 3 and one-to-two ratio for patients in HDU.

Hospital Infections
The building was old but was clean, and all the equipment we observed was clean. Hand hygiene gel was available and staff were observed to use it. Hand wash basins with soap and disposable towels were available. Infection control information was available for patients and visitors. The unit had not reported any incidents of hospital-acquired infections in the past 12 months.

Transfers
Transfer of patients in and out of the unit was mostly planned.

Are intensive/critical care services effective?

Services in the intensive care unit are effective.

Clinical management
Patients received care and treatment in line with national guidelines. Staff working in the unit had received appropriate training.

Patient mortality
A national independent survey by ICNARC highlighted that there were no unplanned readmissions to the unit. The comparative figures showed that 25% of patients being discharged from the St Bartholomew's unit experienced a delayed discharge, 1% of these occurred after 10pm. The unit is about average for hospital mortality however, the total number of admissions is very low.

Are intensive/critical care services caring?

Services are caring in the ITU.

Patient privacy and dignity
Staff were observed to be respectful and maintained the privacy and dignity of the sole patient in ITU. Staff were seen to be polite and spoke in a respectful way. Staff told us there was a system in place for obtaining patient feedback.

Are intensive/critical care services responsive to people's needs?

Services in ITU are responsive to people's needs.

Patient care
The unit provided a service 24 hours a day, seven days a week. The trust had in place networks and arrangements with other NHS trust regional centres should a patient require transfer to another unit outside of the trust.

We saw the patient was monitored closely in the unit and staff were observed to respond quickly to any changing needs. The records we looked at supported the monitoring we observed.

Intensive/critical care

Translation services

St Bartholomew's Hospital had a high percentage of patients whose first language was not English. Staff we spoke with explained they had access to Language Line and interpreters when required.

Are intensive/critical care services well-led?

Services in ITU are well-led.

Leadership

There was a management structure in place and staff said they felt well supported by their line managers in the unit.

Monitoring quality and performance

The ITU carried out a range of audits. Information was provided to ICNARC which helped to ensure services are delivered in line with good practice. Regular meetings ensured that staff openly discussed concerns about the service and critical care.

Good practice and areas for improvement

Areas of good practice

Our inspection team highlighted the following areas of good practice:

- The majority of patients were complimentary about the care and compassion of staff.

Areas for improvement

Action the trust MUST take to improve

- Ensure there are sufficient staff with an appropriate skills mix on all wards to enable them to deliver care and treatment safely in a timely manner.
- Ensure patients receive nutritious food in sufficient quantities to meet their needs

Other areas where the trust could improve

- Improve the visibility of senior leaders in the trust.
- Address concerns about the implementation of the review of nursing posts and the effects of this on the skills mix of nursing staff.
- Improve the dissemination of 'lessons learned' from serious incident investigations across all CAGs.
- Improve staff access to suitable IT to ensure timely incident reporting by all staff.

This section is primarily information for the provider.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder and injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. The registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulated activity	Regulation
Treatment of disease, disorder and injury	Regulation 14(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs. The registered person must ensure that patients are protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration in sufficient quantities to meet patients' needs. Regulation 14(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs.

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Committee(s):	Date(s):
Health and Wellbeing Board (for information) Health and Social Care Scrutiny Sub Committee	31 Jan 2014 4 Feb 2014
Subject: Healthwatch City of London Update	**Public**
Report of: Chair Healthwatch City of London	**For Information**

Summary

The following is Healthwatch City of London's first regular update report to the Health and Wellbeing Board as agreed from the last Board meeting in November 2013. It was agreed that the report would cover updates on recent activities and member feedback.

This report covers the following points:

- Healthwatch City of London response to the Call for Action consultation
- Barts Health Trust
- Healthwatch City of London GP survey
- Outcomes and Impact assessment of Healthwatch City of London.

Recommendation(s)

Members are asked to:

- Note this report, which is for information only

Main Report

Background

1. Healthwatch City of London was established on 1st April 2013. In the nine months to date, the organisation has established contacts with residents and developed a membership base. We have begun the process of establishing the areas of health and social care that local residents and the worker population have highlighted as being important to them.

Current Position

2. Healthwatch has begun establishing working relationships with the major health providers - Homerton University Hospital, and the hospitals comprising the Barts Health Trust, the East London Mental Health Trust, the City and Hackney Clinical Commissioning Group (CCG) and UCL Health Partners, as well as having planned visits to University College Hospital this year. The Corporation of London has been very helpful in assisting with access and representation on committees such as on the Adult Advisory Group and Safeguarding Group, and their support has been appreciated by the staff team.

3. Regular meetings are planned for 2014, between Healthwatch members, residents and workers in the City of London, as well as with the Homerton and Barts Trust.

4. Detailed below are some activities and member feedback from the last three months.

   - **Healthwatch City of London response to the Call for Action consultation**

     The Call for Action consultation was brought to the attention of the Health and Wellbeing Board in 2013. Healthwatch City of London consulted its membership and after consultation with our members Healthwatch City of London has identified the important features for service users and included these in the attached report as well as summarising the below:

     - Patients want better access to primary care and fuller weekend services as well as access to more joined-up care.
     - Any changes can only be implemented though close cooperation with patients.
     - A greater focus is needed on preventing ill-health both for public benefit and for cost-effectiveness.
     - London is a leader in mental health innovation which should be a priority in provision of resources.
     - Patients want 7 day access to services provided near their homes and places of work. This is especially important for Healthwatch City of London bearing in mind the working population of upwards of 400,000, who also work at weekends. Pharmacies are also an important element.
     - A growing and ageing population with increasing long term will require better primary care and more integrated care.
     - Only about 12% of patients with long-term conditions have been told they have a care plan.
     - Research and education need to be better integrated.
     - More resources need to dedicate to health education.
     - Individuals need support, instruction and consideration to enable them to take more responsibility for their own health.
     - Greater support and instruction in the use of technology is needs to enable people to book online and use online facilities.
     - Ease of appointments, effective treatments and considerate aftercare are the areas that make the biggest difference to improving patient experience.
     - Improved training for hospital staff is needed.

- **Barts Health Trust**

  Along with the other Healthwatch organisations in areas that geographically aligned with Barts Health Trust, Healthwatch City of London has been pressing for clarity on future services for residents of the City of London. In particular we have focused on how the financial pressures will impact on local delivery.We continue to have a regular meetings and correspondence with Barts Health Trust

  The responses to these are included in the main report which is attached.

- **GP Survey**

This survey was conducted in October and November 2013 and the results will be fed back to NHS England and local services. There were 16 responses to the survey in total.

- 30% of responses were from workers in the City of London
- 60% of responses were from residents in the City of London
- 10% of responses were from parents who did not indicate that they were either workers or residents in the City.
- With regards to the location of the GP practices under discussion, 63% were in the City of London and 37% were located outside the City of London.

Key Findings

- The overall level of satisfaction was far higher for the practice within the City of London rather than for those located outside the City with 90% of City residents/workers commenting that their practice was either “Very Good” or “Good”. Practices outside the City did not receive any “Very Good“ results but a third of respondents commented that their practice was “Good”. This is a good indication of satisfaction of the services provided within the City of London.
- The 111 service is being greatly underused with none of the City practice respondents saying they had used it for the health conditions featured in the survey and only 10% of respondents from practices outside the City said they had used it for ‘choking, chest pain or blacking out’ with 40% for that question still calling 999.
- Those registered at practices outside the City were more likely to use the 111 service with 40% having used it at some point compared to 20% from those registered within the City.
- People registered at the City practice use their practice much more with 80% having visited their GP in the last 6 months compared to 66% outside the City. This is reflected in the generally higher levels of satisfaction for the City practice which means that people are more likely to visit the surgery.

- Appointments at the City practice were booked using a variety of methods such as on the phone, in person or online whilst 100% of those booking at practices outside the City used the phone. Again, this is a positive sign that the City practice is finding a variety of ways to encourage bookings which is resulting on greater use of the services and higher levels of satisfaction. 70% of those booking at the City practices said they found it either Very Easy or Easy to get an appointment compared with only 16.5% of those outside the City saying it was Easy to book and no respondents saying it was Very Easy.

General Comments

- Reception staff often encourage patients to call on the day to book an urgent appointment rather than waiting for a particular doctor to be available. Some doctors are very popular and difficult to see.
- The Neaman practice is described as outstanding by one respondent.
- One City resident described their GP, team and reception staff as understanding, professional and dedicated. Another said that the City GP practice had excellent doctors, staff and receptionists.
- There were requests for more slots outside working hours from some City residents and a request that doors should not be shut during the lunch break. It was also mentioned that reminders about flu jabs would be useful. Evening and weekend clinics were described as insufficient.
- The Hoxton surgery was described as satisfactory with a personal and reassuring service and trustworthy relationship between patients and doctors. Interaction between patients who attend PPG meetings indicates equal levels of satisfaction.
- A complaint was made from a resident outside the City that reception staff were unhelpful to those with English as a second language and could offer better advice on the services rather than referring patients to A&E or the walk in centre.

- **Survey Conclusion**

- This survey indicates the high satisfaction of patients for the Neaman Practice based in the City and the high attendance could be due to the fact that the practice is the main source of services for the City. Further investigation is required to identify the GP practices outside the City boundary and to work with the appropriate borough Healthwatch in raising the satisfaction level for patients using those facilities.
- The 111 service is still not being accessed to its full extent but this is not a problem just within the City of London. This is a problem throughout the London Boroughs and the country.

- Future work will include Community Services – what is available, who uses them and what are the gaps to ensure that patients in the City have an accessible and seamless service in spite of many services being based outside the City boundaries.

- **Outcomes and Impact Development**

  The outcomes and monitoring framework has been agreed with the Corporation of London. This will be used to demonstrate the progress that Healthwatch City of London is making in terms of its role as the consumer champion for Health and Social Care. The framework is included in the attached report. The Healthwatch City of London mission is summarised below:

Healthwatch City of London understands its purpose and external stakeholders understand the purpose of Healthwatch City of London.	Healthwatch City of London mission statement developed with involvement of stakeholders through consultation with local communities.	Local communities can understand the purpose of Healthwatch City of London and know how to contact it reflected through annual survey of needs identification and numbers of appropriate referrals to Healthwatch by phone, email, letter, social media, newsletter entries or website visits and .personal referrals when giving talks and presentations.

Conclusion

5. This is the first report to the Health and Wellbeing Board. The draft priorities for 2014 will be agreed at the Healthwatch Board Development day in January and circulated for consultation in February. After input from members the priorities will be finalised in February 2014. The future reports will identify progress on the priorities agreed by the membership of Healthwatch City of London, and any urgent items that are identified as part of the routine work of the organisation.

Appendices

- Appendix 1 - Report to the City of London Health and Wellbeing Board on Healthwatch City of London recent activities

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Report to Health and Wellbeing Board January 2014

This report is for information and will cover four areas:-

1. Healthwatch City of London response to the Call for Action consultation
2. Barts Health Trust
3. Healthwatch City of London GP survey
4. Outcomes and Impact assessment of Healthwatch City of London.

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1. Healthwatch City of London response to the Call for Action consultation

After consultation with our members, Healthwatch City of London has identified the following important features for service users:

- Patients want better access to primary care and fuller weekend services as well as access to more joined-up care.
- Any changes can only be implemented though close cooperation with patients.
- A greater focus is needed on preventing ill-health both for public benefit and for cost-effectiveness.
- London is a leader in mental health innovation which should be a priority in provision of resources.
- Patients want 7 day access to services provided near their homes and places of work. This is especially important for Healthwatch City of London bearing in mind the working population of upwards of 400,000, who also work at weekends. Pharmacies are also an important element.
- A growing and ageing population with increasing long term will require better primary care and more integrated care.

- Only about 12% of patients with long-term conditions have been told they have a care plan.
- Research and education need to be better integrated.
- More resources need to dedicate to health education.
- Individuals need support, instruction and consideration to enable them to take more responsibility for their own health.
- Greater support and instruction in the use of technology is needs to enable people to book online and use online facilities.
- Ease of appointments, effective treatments and considerate aftercare are the areas that make the biggest difference to improving patient experience.
- Improved training for hospital staff is needed.

Some challenges to the document London – A Call to Action

- Incremental changes at service user level can be even more effective than great organisational changes, which are stressed too much in this document. A "bottom-up" rather than "top-down" approach is recommended.
- Pollution is not highlighted sufficiently, air, noise, light.
- Low-level mental health problems are increasingly more prevalent among City workers and this is a hidden time bomb; work stress is a major contributor - economic circumstances and management bullying.
- Traffic congestion in the square mile and its environs can impede access for ambulances, especially if there is more centralization of acute specialist services.
- Good nutrition and help with food for patients is all part of "dignity and respect", as well as an important ingredient in recovery.
- Discharge arrangements in London hospitals need to be improved.

- Increased use of digital technology is encouraging but many technical aspects need to be looked at and the difficulties faced by some patients who are unable to access the internet need to be addressed.

- There is no mention of public transport to hospitals in the document. We recommend transport availability 24hours 7 days a week. If units are being closed there needs to be transport provision for people to travel to further away units.

- There is no mention of 'walk in' clinics which are supposed to be used instead of A & E. A section on this would be useful to encourage people to use the clinics rather than A&E.

- There is little focus on young people as an age bracket in the document – young people often have distinct requirements that need to be addressed.

2. Barts Health Trust

Along with the other Healthwatch organisations in areas that geographically aligned with Barts Health Trust, Healthwatch City of London has been pressing for clarity on future services for residents of the City of London. In particular we have focused on how the financial pressures will impact on local delivery.

Specifically we have raised the following questions in Bold below and the answers from Barts Health Trust below:-

Progress on the financial position

Can you give us a better understanding of what you mean by "recover the income due to us under our payment by results contract and avoid contract penalties?"

For 2013/14, Barts Health moved into a Payment by Results (PbR) contract with our commissioners. The PbR contract is based on the amount of attendances, admissions and treatments we provide. Moving to this contract, which applies to most trusts in the NHS, requires significant improvements in ensuring our activity is accurately recorded so we are paid in full for the work we do. Since June, we have placed a huge amount of effort on improving our processes, ensuring that we report accurately - such as timely recording of patients who have attended our outpatients departments or were discharged promptly - as well as reviewing and implementing accurate clinical coding across all our services.

Contractual fines and penalties from commissioners are inherent in a PbR contract if we do not deliver against key performance indicators – for example national operating standards (i.e. 18 weeks, 31 cancer waiting times, A&E waiting times and mixed sex accommodation occurrences). The Trust is working hard to consistently meet NHS performance targets, not just to avoid contractual fines but also to make a real difference to the quality and timeliness of the care that our patients receive.

When you advise we need to make these changes at a greater pace, do you mean a greater pace than advised earlier in the year?

By working at a greater pace, we were just highlighting that more will and can be done as we get closer to our year end position, and that we will sustain the pace of change we were seeing when we first moved ourselves into turnaround.

Where do you envisage the £16million savings being found in current year with less than six months to go?

Financially, our turnaround programme is about eliminating our underlying deficit within two years, by accelerating the development and delivery of safe cost improvements and meeting our income goals.

This year we aim to stabilise our finances, and will continue to address the above shortfall by identifying further cost improvement schemes and delivering on current identified schemes, resolving our budget overspends, delivering on planned elective activity, avoiding contractual fines and securing payments under agreed CQUIN (Commissioning for Quality and Innovation) schemes.

Developing clinical site strategies

Can you give us your view as to what an ideal patient focused pathway would look like?

Good patient pathways involve colleagues in all disciplines and departments working together so that each patient receives the right treatment in the right place at the right time. An example of this is in cancer, where regular multi-disciplinary team meetings are held, involving a wide range of clinical staff, at which every patient with a particular type of cancer is reviewed and plans are agreed for their on-going treatment. For the patient, a good pathway should mean that they move smoothly through the system, they know when and where each appointment is taking place and what it is for, and the clinical teams they meet at each appointment have all the patient's records and medical details available to them so that decisions and treatment can take place as planned. The example in the

briefing of the changes we are making to our colorectal service shows how, by working better together, different teams can ensure the patient pathway is smooth and takes the patient's needs fully into account. We will be able to provide more examples in future briefings and presentations.

How are the Trust managing the potential conflict between an ideal patient pathway in clinical terms with the desire to maintain strong local services?

Each of our hospitals have a vital role to play in caring for local people and we should shortly be able to describe with our CCG colleagues some of the fixed points for future services at our local hospitals, and in so doing allay many of the concerns that local people have. Any significant changes we propose at any time will be based on safety and risk, meeting clinical standards, improving clinical outcomes and service quality.

Workforce consultation

Can you give us details of how this consultation will impact on staff numbers and whether it will have any impact on the 1:7 average staff to patient ratio. Will the consultation result in losing more experienced long serving staff?

The workforce consultation review was an essential part of making sure our structures and processes are fit for purpose and to ensure that we have the right blend of experience and resources and the same commonly applied standards at all our hospitals, so that we can provide our patients with excellent, safe care wherever they are treated. This included clarifying reporting lines and ensuring that senior supervisory support is available on all wards and in all clinical areas.

Following the consultation, and the changes made to the proposals as a direct result of staff feedback, there will be 161 fewer nursing posts – less than 3% of the total number of nursing posts across the Trust - and 59 fewer administrative, clerical and management posts. It is extremely important to point out that these are posts not people, and every effort will be made to re-deploy staff whose position is lost to vacant roles. This may mean that roles previously filled by agency staff will now be filled permanently by staff members whose current position has become redundant in the review. We cannot comment specifically if long serving staff will be affected by the review; but we are doing everything possible to support our staff during what is understandably an anxious and unsettling time and have a dedicated team in place to work proactively with affected staff.

We will need to adopt a flexible approach which will allow us to ensure that staffing levels are appropriate for every ward at any one time. The 'Safe Staffing Alliance' study and recommendations found that patient safety is compromised at a ratio of 1:8 and therefore we have chosen to staff at a 1:7 average ratio across non-specialist adult areas. The RCN (2012) Guidance on safe nurse staffing levels in the UK recommended a registered to unregistered ratio of 65:35 and we will continue to remain slightly above this ratio. The proposals in the workforce consultation are reflective of this. However the implementation of 1:7 ratio of registered nurse to patient in non-specialist adult areas is an average, and the ratio will always be safe and appropriate to each individual service. Specialist areas

such as intensive care, hyper acute stroke care, critical care and neonatal care require specialist skills and different levels of nursing input, which can include ratios of 1:1 or 1:2. It is also important to note that the 1:7 ratio is specific to registered nurses and does not include additional staffing resources and senior support on the wards.

Proposals for changes to cardiovascular and cancer care

How will the change of location of London Chest and The Heart Hospital be managed so that the service at St Bartholomew's is not affected in terms of standards?

Through these changes we want to ensure that we build on existing successful practices and working cultures from all our hospitals. If the proposals are agreed, the new heart centre at St Bartholomew's would fall under the management of Barts Health and we would want to continue to provide the high level of standards patients have come to expect. There is also an independent governance structure being established for the Integrated Cardiovascular System (ICVS), which would include a board with an independent chair. This board would oversee progress across UCLPartners towards the achievement of world class services and prevention to ensure the most rapid delivery of benefits to patients.

We would like to get local people involved in the public engagement, and would welcome details of who to contact

NHS England is leading this work and, in conjunction with local CCGs, will be the decision makers on any proposed changes following the development of a business case. Further information about the proposals, including a case for change and supporting documents, is available on NHS England's website. You can contact them directly by:

- Emailing: cancerandcardiovascular@nelcsu.nhs.uk
- Writing to: Cancer and cardiovascular programmes, c/o North and East London Commissioning Support Unit Clifton House, 75-77 Worship Street, London EC2A 2DU
- Calling: 020 3688 1086

Investment in Whipps Cross Hospital

In terms of the Emergency Department, is the department meeting time limits during the busy periods, and is there any impact following the removal of the walk in clinic, with regard to unneeded attendances at the Emergency department

All patients who attend the Emergency Department at Whipps Cross on foot are assessed at the front door of the Urgent Care Centre, where they are then streamed appropriately into the correct area for their needs – this will either be to see a GP or to be seen in the Emergency Department. This therefore limits inappropriate admissions. There has been no removal of a 'walk in clinic' as there has never been a walk-in clinic for GP services at Whipps Cross or in the local area.

We have put a number of measures in place across our three Emergency Departments (Whipps Cross, Newham and The Royal London) to ensure that patients are seen, treated and either admitted or discharged within the four hour standard. These changes include additional medical and nursing support in the Emergency Departments and assessment areas. At Whipps Cross, we have introduced to a team in the Emergency Department to support discharge for patients with care needs who do not need bed based medical care. This team has had a positive impact on elderly patients who present to the Emergency Department and who previously may have been admitted. At the Royal London, changes to the bed configuration of the Acute Assessment Unit has created 8 additional assessment beds to support the high demand for short stay admissions. Weekend plans at all three sites have increased the level of senior decision making and clinical support service access and this has improved performance across the weekend. In October, provisional data shows that all three Emergency Departments met the four-hour standard for all patient categories.

Getting Ready for Winter

Please can you keep us updated with how the funding of £12.8 million will be used by the Trust

As mentioned in the briefing, we are working with our commissioners and local providers to agree how best to make use of the funds. There are three workstreams which are covering activity in hospitals and in the community - admissions avoidance and effective discharge; assessment capacity; and inpatient processes. For Whipps Cross and its local area, there is a particular focus on frail elderly people and the high numbers of acutely ill patients who attend the A&E department. We will continue to keep you and our other stakeholders up to date as plans progress.

We continue to have a regular meetings and correspondence with Barts Health Trust

3. **GP Survey**

REPORT ON HEALTHWATCH CITY OF LONDON GP SURVEY

This survey was conducted in October and November 2013 and the results will be fed back to NHS England and local services. 16 responses were received.

30% of responses were from workers in the City of London

60% of responses were from residents in the City of London

10% of responses were from parents who did not indicate that they were either workers or residents in the City.

With regards to the location of the GP practices under discussion, 63% were in the City of London and 37% were located outside the City of London.

Key Findings

- The overall level of satisfaction was far higher for the practice within the City of London rather than for those located outside the City with 90% of City residents/workers commenting that their practice was either Very good or Good. Practices outside the City received no Very Good results and a third of respondents commented that their practice was Good. This is a good indication of satisfaction within the City of London although could be due to the population of the area who are maybe more likely to have less serious health complaints.
- The 111 service is being greatly underused with none of the City practice respondents saying they had used it for the health conditions featured in the survey and only 10% of respondents from practices outside the City said they had used it for 'choking, chest pain or blacking out' with 40% for that question still calling 999.
- Those registered at practices outside the City were more likely to use the 111 service with 40% having used it at some point compared to 20% from those registered within the City.
- People registered at the City practice use their practice much more with 80% having visited their GP in the last 6 months compared to 66% outside the City. This is reflected in the generally higher levels of satisfaction for City practices which means that people are more likely to visit the surgery.
- Appointments at the City practice were booked using a variety of methods such as on the phone, in person or online whilst 100% of those booking at practices outside the City used the phone. Again, this is a positive sign that the City practice is finding a variety of ways to encourage bookings which is

resulting on greater use of the services and higher levels of satisfaction. 70% of those booking at the City practice said they found it either Very easy or Easy to get an appointment compared with only 16.5% of those outside the City saying it was easy to book and no respondents saying it was Very easy.

General Comments

- Reception staff often encourage patients to call on the day to book an urgent appointment rather than waiting for a particular doctor to be available. Some doctors are very popular and difficult to see.
- The Neaman practice is described as outstanding by one respondent.
- One City resident described their GP, team and reception staff as understanding, professional and dedicated. Another said that the GP practices had excellent doctors, staff and receptionists.
- There were requests for more slots outside working hours from some City residents and a request that doors should not be shut during the lunch break. It was also mentioned that reminders about flu jabs would be useful. Evening and weekend clinics were described as insufficient.
- The Hoxton surgery was described as satisfactory with a personal and reassuring service and trustworthy relationship between patients and doctors. Interaction between patients who attend PPG meetings indicates equal levels of satisfaction.
- A complaint was made from a resident outside the City that reception staff were unhelpful to those with English as a second language and could offer better advice on the services rather than referring patients to A&E or the walk in centre.

Overall rating of GP service in the last six months

	Very good	Good	Satisfactory	Unsatisfactory	Not contacted in last 6 months
Registered within the City of London	60%	30%			10%
Outside the City of London		33%	33%		33%

For the following section of the report we have divided the results between practices within the City and those outside

Practice within the City of London

What would you normally do if you had a health problem like….	Self care	Visit a pharmacy	Call my GP	Visit my GP	Visit a walk in centre	Call NHS 111	Call 999	Visit A&E
A cough or sore throat	70%	30%						
Vomiting, ear pain, stomach ache	25%	25%	40%					10%
Diarrhoea, painful cough, runny nose	50%	15%	10%	25%				
Sprains, cuts, rashes	50%	15%	15%	20%				
Choking, chest pain, blacking out	10%		15%	10%	10%		40%	15%

Use of Services	Yes	No	No response
Have you visited/tried to visit your GP	80%	10%	10%

within the last month?			
Are you aware of the NHS 111 service?	80%	20%	
If yes, have you used the NHS 111 service	20%	60%	20%

How did you try to get an appointment?	In person	Over the phone	Have not tried	Other
	20%	60%	10%	10% Online

How easy was it to get an appointment?	Very easy	Easy	Neither easy or hard	Hard	Very hard	Have not tried
	30%	40%				10%

How long between GP contact and appointment date?	Same day, non emergency	Next day, non emergency	Up to 5 days, non emergency	Within fortnight	Not contacted
	30%	10%	40%	10%	10%

How was request assessed by	Booked straight away no questions	Asked if was urgent	Asked for details of patient/condition	Made the decision whether	Not contact GP	Other

receptionist?	asked			urgent or not		
	50%	10%		10%	10%	20% simply requested an apt for a date in following month Online

General rating of the 111 service	Very good	Good	Unsatisfactory	Satisfactory	I have not used the service	No response
How would you rate your experience?			10%	10%	60%	20%

Practices outside the City of London

What would you normally do if you had a health problem like….	Self care	Visit a pharmacy	Call my GP	Visit my GP	Visit a walk in centre	Call NHS 111	Call 999	Visit A&E
A cough or sore throat	60%	40%						
Vomiting, ear pain, stomach ache	50%	40%	10%					

Diarrhoea, painful cough, runny nose	50%	50%						
Sprains, cuts, rashes	25%	25%	10%	25%	15%			
Choking, chest pain, blacking out	10%		10%	10%		10%	40%	20%

Use of Services	**Yes**	**No**	**No response/haven't hear of it**
Have you visited/tried to visit your GP within the last month?	66%	33%	
Are you aware of the NHS 111 service?	66%	33%	
If yes, have you used the NHS 111 service	40%	40%	20%

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How did you try to get an appointment?	In person	Over the phone	Have not tried	Other
		100%		

How easy was it to get an appointment?	Very easy	Easy	Neither easy or hard	Hard	Very hard	Have not tried
		16.5%	66%		16.57%	

How long between GP contact and appointment date?	Same day, emergency	Same day, non emergency	Next day, an emergency	Next day, non emergency	Up to 5 days, non emergency	Within fortnight	Not contacted
	33%	16.5%	16.5%		33%		

How was request assessed by receptionist?	Booked straight away no questions asked	Asked if was urgent	Asked for details of patient/condition	Made the decision whether urgent or not	Not contact GP	Other
	20%	20%	20%	20%		20% – they didn't ask about condition

General rating of the 111 service	Very good	Good	Unsatisfactory	Satisfactory	I have not used the service	No response

How would you rate your experience?		16%	16%	16%	50%	

4. Outcomes and Impact Development.

Governance

OUTCOMES	ACHIEVEMENT	SUCCESS
MISSION		
Healthwatch City of London understands its purpose and external stakeholders understand the purpose of Healthwatch City of London.	Healthwatch City of London mission statement developed with involvement of stakeholders through consultation with local communities.	Local communities can understand the purpose of Healthwatch City of London and know how to contact it reflected through annual survey of needs identification and numbers of appropriate referrals to Healthwatch by phone, email, letter, social media, newsletter entries or website visits and .personal referrals when giving talks and presentations.
FOCUS ON PRIORITIES		
Healthwatch City of London is seen as a credible and effective organisation in being able to reflect the consumer views in establishing local priorities by partners in local	Healthwatch City of London gives regular informed feedback to health and social care partners and community groups at meetings and by letter.	Stakeholders are aware of the local communities health and social care priorities, through written and verbal contributions made by Healthwatch City of London and these are included in

authorities, the NHS and other statutory and voluntary organisations.		decision making.
BOARD SKILLS AND KNOWLEDGE		
Healthwatch City of London has the skill and ability in its governance function to meet its legal and financial and statutory responsibilities to effectively act.	A board role description is produced, and board members are required to meet the requirements of the role. A skills audit record is maintained. Training and development is incorporated into the governance calendar.	 Results of skills audit demonstrate the board is effective and has the required skills and knowledge. Training feedback forms demonstrate that board members are kept up to date with the required knowledge and skill..
INVOLVING LOCAL COMMUNITIES		
Healthwatch City of London has effective links in the resident and worker	An engagement strategy and work plan exists to recruit involvement in health and	The engagement strategy demonstrates involvement of both City workers and

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community across all age groups and ethnicities.	social care in the City of London	residents and reflects the local community.
ROLE OF VOLUNTEERS		
Volunteers are used to bring a wide range of skills and time to Healthwatch City of London.	All volunteers have a training, induction and supervision plan	A range of volunteers roles are developed and maintained that are filled by skilled volunteers..
Volunteers feel valued by the organisation.	Regular oversight, support and celebration of volunteers take place. Volunteers involved in training sessions with staff.	Retention of volunteers Volunteer appraisals demonstrate volunteers feel supported

Finance

OUTCOMES	ACHIEVEMENT	SUCCESS
TRANSPARENCY AND HONESTY		
Healthwatch City of London's statutory financial information is accessible to the public and other interested parties.	The board has effective financial control in place within its accounting mechanism. The Healthwatch accounts are scrutinised by an independent auditor. Financial reports are given to the Healthwatch Board at Board meetings,	Annual accounts are approved in line with regulations covering the Healthwatch City of London organisation. Statutory annual accounts are publicly available on the website when approved by the board.

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Operations

OUTCOMES	ACHIEVEMENT	SUCCESS
EASE OF ACCESS		
Healthwatch City of London is accessible to its community in terms of communication and, inclusion in influencing health and social care practise and priorities. .	There is a programme of outreach sessions across the area, including libraries, residents meeting rooms, places of worship and leisure facilities. These sessions are held at times and in locations that are accessible to the local community.	Record and evaluate community outreach sessions through participant feedback, this will include views on the content of the sessions, the location of the sessions and the willingness to participate in future sessions.
INFLUENCING HEALTH AND WELLBEING BOARD		
Healthwatch City of London is a respected voice and participant on the Health and Wellbeing Board and Health and Wellbeing Board members have a greater understanding of consumers'/service	Develop clear procedures for feeding into and back from the Health and Wellbeing Board.	Evidence of raised awareness through for example minutes of meetings among Health and wellbeing Board members about the importance of engaging with communities and the expertise and value that Voluntary and Community Organisations can bring to discussion and decision

users' experiences of local health and social care services.		making.
	Information to feed into the Health and Wellbeing Board should include data that has been collected, recorded, analysed about users' experiences of health and social care with co-operation of providers out of borough, identifying gaps in intelligence and influencing the system to fill them.	Health and Wellbeing Board regularly uses data from Healthwatch City of London to inform discussions and decisions.
Healthwatch City of London uses innovative engagement strategies that are recognised as being of value in terms of intelligence to inform decision making with Health and Wellbeing Board	Health and Wellbeing Board is kept updated with engagement strategy for the City of London, and what is successful in gathering intelligence.	Health and Wellbeing Boards development days are provided with current data collected by Healthwatch City of London
REPRESENTATION and ENGAGEMENT		
Healthwatch City of London provides	Links on website to qualitative information	Monitor enquiries and advice on access and choice to ensure that

information on Health and Social care and Public Health services to the community.	about providers of health and social care services (e.g. to CQC reports, surveys and reviews).	a wide range of contacts have been made.
Healthwatch City of London has a programme that systematically seeks the views the whole community on key health and social care issues and services.	A definitive engagement programme is developed and implemented	Health and Wellbeing Board and commissioners respond to views presented by Healthwatch City of London in developing JSNA, JHWS and commissioning plans.
There are clear arrangements for capturing views and data for diverse and under represented communities.	Under represented communities are targeted through specific actions and links to influential individuals within the communities	Health and Wellbeing Board and commissioners seek advice of local Healthwatch and Voluntary and Community partners on improving their own community engagement.
Community priorities are presented to commissioners and service providers to influence their approach.	Effective and robust community-based and data collection is undertaken.	Data collection evidence is fed into decision makers such at the Health and Wellbeing Board Local consumers can understand

Healthwatch City of London shows people that it values their views and feeds back on how it uses the information they provide and what impact it has had.	Develop methodology for "virtuous circle" of gathering views, presenting them in forums where they will have most influence and feeding back to consumers and communities on their impact.	the difference their involvement has made through newsletters and updates
CONCERNS AND COMPLAINTS AND BEST PRACTICE		
Patterns of complaints and issues raised by individuals and groups influence services for the better.	Analyse the use made of statistics collected by local Healthwatch.	Services are reviewed in response to concerns, complaints and best practice which are to be shared.

Relationships

OUTCOMES	ACHIEVEMENT	SUCCESS
CONSUMERS AND COMMUNITY		
Healthwatch City of London is fully embedded in the community and is recognised	Representative of the local community including diverse groups are involved at	Information about Healthwatch City of London reaches people from a range

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as a key element in the voluntary and community sector infrastructure.	different levels of engagement in work of Healthwatch City of London across the full range of its activities.	of channels.
Healthwatch City of London is trusted by and engaged with the diversity of people living and working in CoL to put forward their experiences, views, concerns and ideas in relation to improving health and wellbeing in the local community.	Priorities and work programme driven by input from service users and communities.	There is a diverse profile of volunteers involved engagement and reporting activities, including outreach to seldom heard groups. Evidence from use of website and social media by consumers/service users/ the evidence from events/meetings Annual report shows a wide range of engagement across all user groups.

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Healthwatch City of London uses local knowledge and intelligence to influence practise and decision making	Case Studies Stories from individuals and groups are used are used for influencing purposes with agencies involved in health and social care.	The JSNA, JHWS, commissioning and delivery contains information gathered and presented by Healthwatch City of London relating to service users' experiences and community views.
CHILDREN AND YOUNG PEOPLE		
Children and young people are actively involved in the development of Healthwatch City of London priorities and practise.	The local Healthwatch skills and experience enable it to actively engage with local organisations already engaged with children and young people. . A sub-group of Board is established to focus on children and young people and their priorities.	Outreach services are used by young people to gain information about Healthwatch City of London Young People's health and wellbeing issues are evidenced and reported to relevant committees, decision makers to influence policy and practise.
Healthwatch City of London has channels of communication with	Young volunteers are recruited and supported for engagement and	Commissioners and providers are provided with briefings regarding their understanding of needs and

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Commissioners, and service providers of children and young people's services and is supporting increased engagement of young people in in commissioning and design of services.	communication roles. To enable young people to communicate with the city of London about their Health and Social care needs.	wishes of young people
OLDER PEOPLE		
Healthwatch City of London has channels of communication with Commissioners, and service providers of older people services and is being more responsive to the needs and wishes of older people .	Greater awareness among commissioners and providers of experiences needs and wishes of older people as a result of Healthwatch engagement programme.	Commissioners and providers are provided with briefings about their understanding of needs and wishes of older people, issues of dignity and respect and the role Healthwatch City of London has played.
Greater integration across health, care and other services (e.g. education, leisure) for older people because of Healthwatch City of London's involvement.	Older users are engaged in the health and social care integration agenda, giving their views and perceptions of planned service integration across the health and social care economy.	Case studies highlighting the older peoples influence on the integrated health and social care agenda are presented to the CCG and Health and Wellbeing Board

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More support for older carers and co-carers because of Healthwatch City of London involvement.	Healthwatch City of London has a specific engagement strategy with older carers and co-carers to identify key challenges, risks and service needs of this group within the community.	Local older Carers feed into local health and social care plans.
SAFEGUARDING		
Healthwatch City of London understand safeguarding issues both for Children and Young People and for Adults and are aware of local arrangements and how to report concerns	Local training on safeguarding procedures and an understanding of safeguarding issues written into the Appraisal process	Healthwatch City of London staff and volunteers raise and report safeguarding issues to appropriate partner organisations where safeguarding matters are found.
Healthwatch is seen as the champion and community voice on safeguarding issues.	With relevant partners, follow up Healthwatch City of London enter and view visits, reports and recommendations with a safeguarding component. If necessary, report to the Adult Safeguarding Sub-Committee or the City and Hackney Children's	Healthwatch makes reports and recommendations to influence partners to make improvements in relation to safeguarding issues where they have access to safeguarding information/cases/data

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Dignity and respect are seen as key components of safeguarding and of engagement.	Safeguarding Board. Assess impact of local Healthwatch information concerning safeguarding component. Overall local prioritisation of dignity and respect.	Representations are made to ensure service users dignity and respect is recognised in partners' vision statements and work programmes.
CORPORATION		
Corporation as **commissioner of public health and social care services**	Make presentations to the Corporation Departmental Leadership Team and other meetings. Local Healthwatch demonstrates it can contribute to improving Corporation's own objective of meaningful engagement with service users, carers and communities. Corporation social care representatives involved in Healthwatch City of London training for board, staff and volunteers.	Social Care Services and other departments ask for Healthwatch City of London's assistance in developing and deepening their public engagement activities.

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CLINICAL COMMISSIONING GROUPS		
CCG(s)' public and patient engagement strategy is developed and implemented to include a stronger focus on CoL with intelligence from Healthwatch City of London	Assist CCG(s) to develop public engagement strategy. Work with CCG(s) to develop innovative forms of engagement.	Healthwatch City of London invited to participate in development of CCG commissioning strategies.
HEALTHWATCH ENGLAND AND CARE QUALITY COMMISSION		
There is mutual trust between Healthwatch City of London and CQC representatives.	Healthwatch City of London and CQC work collaboratively on their activities. Good working relationship with neighbouring local Healthwatch to aggregate and share information are established Information is regularly uploaded to Healthwatch Information Hub.	Healthwatch City of London reports back to CQC on areas of mutual activity Meetings with local Healthwatch organisations are evidenced Contributions from Healthwatch City of London Appear on the Hub
HEALTH AND SOCIAL CARE		

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PROVIDERS		
Concerns about services or good practise in service delivery highlighted through engagement activities with users and Enter and View are addressed by providers.	Well-planned, evidence-based engagement activities and intelligence gathering are in place, Enter and View visits, reports and recommendations on services users' experiences are undertaken by suitably trained and skilled City of London Healthwatch representatives and volunteers.	Timely and positive response by providers to reports provided by Healthwatch resulting in and implementation of Healthwatch City of London recommendations.